

On the Brink:  
Experiences of Women with Mental Illness on Probation

by

Philip Mulvey

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Graduate Supervisory Committee:

Scott Decker, Chair  
Kristy Holtfreter  
Cassia Spohn

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## ABSTRACT

This dissertation explores the lives of women who are on the Severely Mentally Ill (SMI) caseload at Maricopa County Adult Probation in Arizona (The Phoenix metro region). The project focuses on three primary issues: (1) what are the pathways to the criminal justice and mental health systems for women on the SMI caseload (2) how does discretion and expansive formal social control (both benevolent and coercive) impact the lives of these women on the SMI caseload and (3) what are the gendered aspects to successful completion of SMI probation. To answer these questions a mixed-methods research design was employed. First, in-depth semi-structured interviews were completed with 65 women on the SMI caseload. Second, these interviews were supplemented with a case file review of each participant, and field observations (encompassing roughly 100 hours) were conducted at the Maricopa County Mental Health Court. Third, analysis also included 5.5 years of quantitative intake data from the SMI caseload, exploring demographic information and risk and assessment needs scores. The biographies of the women on the SMI caseload revealed similar histories of victimization, substance abuse, and relationship difficulty that previous pathways research has noted. Additionally, mental health problems directly impacted the path to the criminal justice system for some women on the SMI caseload. Results also showed many aspects of expanded social control for women on the SMI caseload. This expanded control appeared to be gendered at times and often created double binds for women. Finally, quantitative analysis showed

that some predictive factors of SMI probation completion were gendered. Policy implications and summaries of findings are discussed.

## DEDICATION

This dissertation is dedicated to the women on the SMI caseload at Maricopa County Adult Probation and their probation officers. I hope I am able to tell a little piece of your story.

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## CHAPTER 1

### INTRODUCTION

This dissertation focuses on a particularly marginalized group of offenders – women diagnosed with long-term mental disorder(s) who are under the control of the criminal justice and mental health systems. In addition to being diagnosed with at least one mental health disorder, these women are also considered to have significant impairment impacting their daily lives. As a result, they have been placed on a specialized probation caseload for “Severely Mentally Ill” (SMI) offenders. For the most part these women live in the community, but many have cycled between institutionalized psychiatric treatment, drug rehabilitation, long-term residential placement, and incarceration at different points in their lives. In his book *Crazy*, journalist Pete Earley (2006) stated that some mental health professionals referred to these types of offenders as “on the brink” (p. 249). Earley summarized one such mental health professional’s opinion working in a Florida jail, “Someone who is hallucinating and yelling on a street corner is going to get everyone’s attention...but there are mentally ill people...who are always on the brink because of their illnesses. They can cope for a while, but eventually it always brings their world crashing in” (p. 249). The goal of this dissertation is to explore the experiences of this particular group of offenders. More specifically, this study is an investigation of the lives of women living *on the brink* between the criminal justice and mental health system.

The current study concentrates on women on probation for several reasons. First, criminologists have noted the traditional lack of attention and/or misrepresentation of

female offenders within the criminal justice system (e.g. Belknap, 2006; Cain, 1990; Chesney-Lind, 2006; Chesney-Lind & Pasko, 2004; Daly & Chesney-Lind, 1988; Kruttschnitt, 1996; Owen, 1998). Britton (2000) stated, “Criminology remains one of the most thoroughly masculinized of all social science fields” (p. 57). Similarly, Chesney-Lind & Pasko (2004) stated that criminology, “is almost quintessentially male” (p. 2). Consequently, the discipline has traditionally understood less about women’s experiences in the criminal justice system. The lack of focus on women is a particular concern to community corrections as over 1,000,000 women are now served by probation (Morash, 2010). Morash further noted that by 2006 women made up almost 25% of individuals on probation outpacing the rate of men. As a result, there are more women on probation and parole than any other arm of the criminal justice system.

Although criminology has largely ignored women, the field of psychiatry, despite also being dominated by male theorists and viewpoints, has historically perseverated on “the female malady” (Showalter, 1987). Multiple feminist scholars have explored how women historically have been victimized by the misogyny of psychiatry (Appignanesi, 2008; Chesler, 1972, 2005; Ehrenreich & English, 1979, 2005; Russell, 1995; Showalter, 1987; Ussher, 1991). These authors detailed meticulously how the male dominated field of medicine (specifically psychiatry) effectively silenced female viewpoints for generations. The encroachment of psychiatry into the lives of girls and women during The Victorian Era, the Institutionalization Movement, and beyond was stifling. At the



hands of the “mind doctors” women were deemed as “mad” for both adhering to and rejecting gender normative stereotypes (Chesler, 1972, 2005).

Second, scholars have emphasized that due to the unique barriers facing female offenders in community corrections, success is quite difficult (e.g. Schram et al., 2006). Women bring a unique constellation of problems with them to community corrections (Petersilia, 2003). Scholars have asserted that women in the criminal justice experience high rates of multiple forms of abuse (emotional, physical, sexual, intimate partner) and often have long histories of substance dependence and mental illness. This makes multiple facets of their lives difficult including education, employment, child custody, social welfare services and mental health treatment (e.g. Daly, 1992,1994; Holtfreter & Morash, 2003; Morash, 2010; Reisig et al., 2002, 2006; Richie, 1996, 2001).

Third, although scholarship has increasingly focused on female offenders over the past two decades, the individualized perspective of the offender with mental illness is mostly absent from empirical work. Ditton (1999) found that roughly 25 percent of incarcerated women had a prior stay in a mental health hospital or a mental illness. Girls and women with mental health problems often present some of the biggest challenges for probation and are sometimes viewed as the most difficult clients to work with given their unique needs. For social scientists, greater understanding of the offender’s specific perspective in crime is of paramount importance in order to better inform both theory and policy involving different groups of offenders (see Wright & Decker, 1994).

Fourth, the narrative in the general public about mental illness and crime is overwhelmingly male. The many mass shootings by deranged gunmen in the last decade have resulted in renewed focus on civil liberties for persons with mental illness. The shooters in the Virginia Tech, Tucson, Aurora Theatre, Fort Hood, Sandy Hook School, and Washington Navy Yard tragedies were all men with varying degrees of major mental health disorder. The constant media focus on these male dominated acts of aggression, committed upon innocent individuals during every day activities has created a new picture in the national consciousness of who an offender with mental illness is. Thus, the fear and importance of the event is magnified relative to the modal category of behavior by persons with mental illness. Walker (2011) described these occurrences as the top tier if one were to imagine the criminal justice system as a wedding cake. In his illustration, Walker argued that more frequent and smaller crimes like common public order offenses committed by persons with mental illness, make up the foundation of the cake. The very top layer encompasses the extremely uncommon, yet highly sensationalized cases featuring copious amounts of drama and publicity that plays on public fear. Rarely, do women enter this narrative about offenders with mental illness as they are regulated to the bottom tiers of the wedding cake model. Despite the narrative about mental illness, crime, and acts of violence being focused almost entirely on men, calls for policy reform are not. Proposed limitations on civil rights of persons with mental illness as a result of these acts of mass violence always include *all* persons with mental illness.

Finally, the most widely known cases about persons with mental health problems and involvement in crime (regardless of gender) involve individuals who at the time of their crime were not under the control of the criminal justice system. Far more common in the criminal justice systems are offenders who have multiple arrests for property and substance related crime. These individuals are well known by police, probation officers and the courts in their communities because of their frequent cycling in and out of the criminal justice system. Normally their mental health concerns are given little attention until they commit a violent or deadly act.

The remainder of this chapter describes the current prevalence of mental health problems in the criminal justice system. The dissertation research is specifically focused on the experience of women in the criminal justice system who have been diagnosed with mental disorder. However, in proceeding, first overviewed are the expanding concerns regarding mental illness within the contemporary criminal justice system. After, an overview of these specific prevalence rates for women is provided.

## **MENTAL ILLNESS WITHIN THE CRIMINAL JUSTICE SYSTEM**

It may come as a surprise to some that the three largest providers of institutionalized mental health care in the United States are local jails. At first guess, one might not consider Los Angeles County Jail, Riker's Island in New York, and Cook County Jail in Chicago to be at the center of inpatient psychiatric care. However, these local institutions serve as the most populated providers of inpatient mental health

treatment, trumping all other inpatient psychiatric facilities (Council of State Governments, 2007).

Other scholarship finds that the prevalence of persons with mental illness in the nation's jails is three to four times their prevalence in the general population (Council of State Governments, 2007; President's New Freedom Commission on Mental Health, 2003). The most recent prevalence studies in jails completed by Steadman and colleagues (2009) found persons with mental illness to be substantial, with over 14 percent of males and 31 percent females having a diagnosable mental disorder. Although mental illness is abundant in jail populations, Teplin (1990) noted that less than one-third of these individuals were diagnosed by the jail or treated. Other research has indicated that fewer than half of persons with mental illness living in county jails receive any type of mental health treatment (Perez, Leifman, & Estrada, 2003; Teplin, Abram, & McClelland, 1997). Jails have long been considered to be the repository for individuals with mental illness cycling in and out of the criminal justice system (Steadman et al., 1984; Teplin & Voit, 1996), where symptoms are often more acute than in longer-term state and federal prison.

There is also substantial evidence that a significant number of persons with mental illness are locked up in our nation's prisons. Human Rights Watch (2003) argued that three times more persons with mental illness are incarcerated in the prisons of the United States every day than are found in any mental institution. Proband (1998) estimated that prisons hold almost 200,000 persons with mental illness. Likewise, Ditton (1999) noted that 16 percent of state prison inmates as well as 7 percent of those living in

federal prison stated that they had a mental condition or had stayed overnight in a mental hospital. James and Glaze (2006) found that 24 percent of state prison inmates and 14 percent of federal inmates reported a recent history of a problem with mental health. Jemelka, Rahman, and Trupin (1993) posited that 10 percent to 15 percent of state prisoners are actively suffering from a disorder and in need of psychiatric treatment. Close to two-thirds of persons with mental illness in state prison stated that they had been treated for a mental illness (Ditton, 1999).

Often lost in the statistics of persons with mental illness in the criminal justice system are those who are currently living in the community but under the control of probation. Although an “underidentified and underserved population” (Lurigio, 2000, p. 317), this group is especially important because these offenders are more prevalent than persons with mental illness in jail or prison. Likewise, a majority of persons with mental illness on probation are there because of property and public order crime (Lurigio, 2000). Along with short-term offenders in local jails, these offenders with mental illness on probation make up the “typical” offenders with mental health problems that cycle in and out of the system. Lurigio and Rotenberg (1996) reasoned that persons with mental illness on probation were especially ignored as estimates suggested six percent to nine percent of probationers have a mental illness (Lurigio, 2000). Prevalence rates estimates, like those throughout the criminal justice system, vary but Ditton (1999) assessed that roughly 16 percent of individuals on probation had a mental illness. Lurigio (2000) argued that because probationers with mental illness live in the community, their

symptomology must be quite intense for probation officers to notice. Veysey (1994) concluded that persons with mental illness on probation are an underserved population and many officers are unable to provide quality supervision to offenders with mental illness. Crime type of probationers is also a concern as there is some evidence that persons with mental illness are more likely to be convicted of violent offenses than non-mentally ill probationers (Ditton 1999). Finally, when considering persons with mental illness returning to the community on parole, Lurigio (2001) concluded that the prevalence rates of serious mental illness in this population were at the lowest five percent to 10 percent.

### **Women with Mental Health Problems in the Criminal Justice System**

It is clear that individuals living with significant mental health problems are overrepresented in the criminal justice system. Although many articles regarding prevalence have been completed in a gender-neutral manner, there is a smaller body of literature that has examined the prevalence of mental health problems for women in the criminal justice system specifically. For instance, Ditton (1999) investigated the mental health and treatment of inmates and probationers in the criminal justice system. She found that women in state prisons, federal prisons, local jails, and on probation were all more likely to be identified as mentally ill when compared to male offenders. Specifically, 23.6 percent of women in state prisons, 12.5 percent of women in federal prisons, 22.7 percent of women in jails, and 14.7 percent on probation met criteria for mental illness (Ditton, 1999). These prevalence rates were more than double those of

men with mental illness in the criminal justice system. Further, women with mental illness had greater rates of past victimization than individuals without mental illness in the criminal justice system. The same study found that women with mental illness in the criminal justice system were also more likely to receive mental health services. Ditton (1999) found that over three-fourths of women in federal prison, more than two-thirds in state prisons, and over one-half of women with mental illness in local jails had received mental health services. These were all prevalence rates for treatment that surpassed those of incarcerated men with mental illness.

Other research has highlighted the staggering rates of mental health problems for women in the criminal justice system. In a foundational study of over 1,200 women in Cook County Jail in Chicago, Teplin and colleagues (1996) showed that over 80 percent of female offenders had at least one diagnosable mental health disorder. An additional article by Teplin and colleagues (1997) highlighted that less than one-fourth of women in need of mental health service actually received any treatment while in jail. Abram et al., (2003) illustrated that eight percent of women had both a serious mental disorder and a substance use disorder (co-occurring disorder) when analyzing the same dataset. These high rates of mental health problems for women involved with the criminal justice system have been supported in other studies (Fazel & Danesh, 2002; Jordan, et al. 1996)(for a review see Sacks, 2004). Furthermore, elevated rates of mental disorder are also apparent in populations of juvenile girls (e.g. Teplin et al., 2002; Veysey, 2003). Additionally, scholars have found that incarcerated women are more likely to report the use of

psychotropic medication (Peters et al., 1997). Others have noted that psychotropic medications are used up to 10 times more frequently in women's correctional facilities than in male institutions (Culliver, 1993).

## **SUMMARY**

In each of these sectors (jails, prisons, and probation) of corrections, the over representation of women with mental illness is important to recognize for multiple reasons. First, the need to establish treatment within the correctional system has resulted in a complicated and unlikely marriage between the mental health and criminal justice systems. Due to their higher prevalence rates and specific needs gender-responsive treatment for women is an important consideration. At each phase of the system, from the first exposure with the police to follow-up care post incarceration, these women are often under the control of both systems. Second, policy makers must consider the ability of women to succeed in the community with the double stigma (and social/treatment needs) as a result of having concerns over both mental health and criminal justice involvement. Finally, nearly all women with mental health disorder(s) in the criminal justice system eventually return to the community after incarceration. With the criminal justice system as a primary catchment area for all persons with mental illness, more precise analyses of prevalence, better treatment, and greater understanding of why so many offenders with mental illness bounce back and forth between the two systems is paramount to shape effective policy for offenders with mental illness.



The criminal justice system has become the “can’t say no” system involving persons with mental illness (Borzecki & Wormith, 1985). Due to the large number of persons with mental illness involved in the criminal justice system, and the even larger overrepresentation of women diagnosed with mental health disorder, it is important to consider what types of unique circumstances women with mental illness bring to the criminal justice system. Important questions abound. For instance, what actually may assist a woman with mental health problems in successfully navigating the criminal justice system? How do the therapeutic and criminal justice communities work together to exert social control over women with pervasive mental health problems? What are the offender’s perspective about their lives, their psychiatric illness, their criminal offenses, and this benevolent and coercive control of the state? In its broadest strokes, exploring the nature of these questions for women offenders with mental illness is the overarching concern of this dissertation.

The remainder of the dissertation is as follows: Chapter 2 provides a review of the foundational literature which has examined the social control of persons with mental illness with a focus on how that control has historically impacted women in unique ways. The chapter also frames the feminist pathways research exploring the multiplicity of adverse circumstances that women bring with them to the criminal justice system. Chapter 3 outlines the field study design, data points, and analytic strategies for this mixed methods dissertation. Chapter 4 explores the pathways that women take to SMI probation and how mental disorder may impact criminal justice involvement for this

sample of women. Chapter 5 investigates the expanded forms of social control that exist for women on the SMI caseload. This chapter also considers how aspects of this expansive control may be gendered in some ways. Chapter 6 focuses on quantitative analyses that examine predictors of SMI probation completion that may differ for women and men. The dissertation concludes in Chapter 7 where the findings of the study are discussed in a more global context. This final chapter also considers implications for criminal justice policy and suggestions for future research.

## CHAPTER 2

### THEORETICAL AND HISTORICAL FOUNDATIONS

#### SOCIAL CONTROL AND SOCIAL THREAT

Control, the “central notion” (Gibbs, 1989, p. 23) of sociological inquiry, is conceptualized in several different ways. Gibbs (1989) argued that one common way is through the “external control of human behavior” (p. 55), also known as *social control*. Defined by scholars, social control generally is “those acts, relationships, processes, and structures that maintain social conformity” (Liska, 1992, p. 2). Although social control has been written about for over a century, it was not until the work of Talcott Parsons (1951) and later theorists of the decade that the idea of social control was specifically linked with the concept of deviance (for an extended review see Gibbs, 1989). One important way that social control can be exerted with a deviant group is in an examination of institutionalization of persons with mental illness. Perspectives on why individuals with mental illness have endured pity, contempt, segregation and even death largely rest upon the concept of social control and a social threat model. Members of a specific culture establish what normal is, and a de facto result is that abnormal for that same culture is also defined. Unsurprisingly, it has been those achieving culturally approved normality who are responsible for governing what is atypical in society and placing subsequent social control over those deemed abnormal. From a conflict perspective (see Liska, 1992, p.8), the social threat model occurs when any group deemed as “threatening people” combined with “threatening acts” by this group makes them a

social threat and as a result these individuals are subject to subsequent social control. In his writing on the matter of madness, Porter (1987, 2002) principally argued that madness was most prominently about authority and control, going so far as to declare, “The history of madness is the history of power” (1987 p. 39). With this reasoning in mind, one might conclude that the control of persons with mental illness in the criminal justice system is simply a result of one group that had achieved culturally approved normalcy exerting its power over another group that had not.

This exertion of power through social control is essential in a society for social order to occur (Liska, 1992). Liska explained that social control has been important in sociology since the field’s earliest beginnings and it occurred as a result of societal arrangements that preserve social conformity. He proposed that not only crime control, but also even social welfare institutions such as the mental health system, could largely be explained through the lens of the conflict perspective of social control and social threat. In the view of Liska (1992), those who oversee social control and social order also authorize that control most forcibly on those who threaten the overseers.

Three forms of social control – fatal control, coercive control, and beneficent control (Liska, 1992), have been traditionally exerted over persons with mental illness who deviate from the norms of a given society. Hundreds of thousands of persons with mental illness throughout history have been slain (Porter, 2002) as the result of what was believed to be demonic possession. Described in detail by Rothman (1990) most of the social control of persons with mental illness in American history fluctuated between

coercive control (restraining behavior through confinement and arrest) and beneficent control (mental institutions and other forms of social welfare). Arvanites (1992) proposed that these two great agents of power over persons with mental illness - the criminal justice system and the mental health system- were able to exercise corresponding forms of control “between the two systems, clearly increasing society’s coercive control capacity” (p.149).

In his seminal work on social control, Cohen (1985) stated, “This is the essence of a humanistic civilization: to exert power and to do good at the same time” (p. 114). Much of the correctional and social welfare communities in the United States have been built upon this notion. Social control remains constant, but depending on the historical moment it might shift from one system (like the criminal justice system) to another (social welfare). Cohen (1985) suggested that since the 1960s the “destructuring” of institutionalization has been focused on “decriminalizing” the individual away from the prison, “deprofessionalizing” the individual who oversees the offender, “deinstitutionalizing” away from the asylum and focusing on the act (behaviorism) and not on the inherent qualities of the person engaged in that act. Although perhaps benevolent and empowering in theory, Cohen (1985) contended that as a consequence of this movement, “net widening” occurs, which essentially extends the systems of control over the individual into the community, while also making that regulation more covert. Individuals who historically have been deemed mentally ill have had unique regulation

by agents of formalized social control. In the same way, men and women have had different levels of social control exerted over them.

## **THE HISTORICAL CONTROL OF MADNESS AND WOMEN**

Social historians and philosophers have theorized on the causes of madness for millennia, and draconian social policies have been thrust upon those deemed “mad” by society for just as long. It may be that humans have always been concerned with the concept of madness. Porter (2002) examined the history of madness in western culture, arguing that, “all societies judge some people mad...it is part of the business of marking out the different, deviant, and perhaps dangerous” (p. 62). Archeological researchers have found human skulls with circular holes drilled into them that are upwards of 7,000 years old. This practice, known as cranial trephining, left dura matter of the brain exposed (Slate & Johnson, 2008) and these archeological discoveries have led scientists to theorize the holes were drilled into the skulls of ancient humans so that demons could escape (Porter, 2002). This practice may have been one of the earliest forms of social control over individuals suffering from mental health problems or who engaged in socially deviant behavior.

The ancient Greeks were some of the early examiners of mental illness as a disease of the brain. Hippocrates, the first to note that the brain was the center of function, even went as far as to consider the existence and cause of mental illnesses such as mania, anxiety and depression (Slate & Johnson, 2008). The vast scientific

knowledge of the ancient Greeks was challenged, however, by the religious and cultural beliefs in demonology. For centuries many alleged that madness (contemporary mental illness) was a result of demonic possession and witchcraft. Those believed to be suffering, were cleansed of spirits within the body by exorcism or other means (Porter, 2002). The ancient church largely disseminated the belief in possession by demons, and not all individuals fared so well because of the religious views on madness and demonic possession of the time.

### **Women and Madness Before Psychiatry**

In the classic work *Women and Madness* Chesler (1972, 2005)<sup>1</sup> argued that women always have been compartmentalized into a symbolic mother/whore dichotomy. She presented her argument using religious mythology and the role of women within it. This stereotypical dichotomy has been a problem for women for centuries. The engrained misogynistic doctrine of the church left women with the options of the virginal and passive caregiver or the promiscuous whore. Chesler argued that both options resulted in women being labeled mentally disordered. Regardless of which option a woman was handed, she would be ultimately deemed a social threat, labeled, and subjected to expansive social control.

There is significant historical evidence that women considered a social threat were punished with greater control. Ehrenreich and English (1979, 2005) illustrated that traditionally women were the primary healers. The authors stated that apart from the

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<sup>1</sup> Chesler (1972) was revised and updated with new material in 2005.

wealthiest in medieval Europe, all other women were expected to understand healing techniques and have a working knowledge of herbal treatments. Many women were also midwives and would travel long distances to practice and share information about their craft.

Ehrenreich and English (1979, 2005) explained that in the fifteenth and sixteenth centuries this all changed when misogynistic church leaders and the emerging field of medicine sought to end the practice of female healing. University trained doctors had the support of the church and treated the wealthiest members of society. Eventually these powerful men worked to permanently silence female healers and midwives. As a result, hundreds of thousands of women during this time were accused of witchcraft. Ussher (1991) argued that this practice not only occurred for female healers and midwives, but also women who were spinsters (and not attached to a man), women who were sexually active outside of marriage, women who could not cope with profound poverty, and women who had mental health problems. Many of these women were labeled witches and executed for madness. This fatal social control over poor and marginalized women spread throughout Europe. Some have estimated that the witch-hunts of the era killed millions of innocent individuals; at least 85 percent of those executed were women (Ehrenreich & English, 1979, 2005). As Russell (1995) noted, “women suffered the most. Apparently, it was believed that women, among all those possessed, were a greater source of evil” (p. 5). Ussher (1991) argued that condemning women for witchcraft was only one of the many ways that women were socially controlled at the hands of men. She



offered Indian suttee, Chinese foot binding, and clitoridectomy as other historical examples.

### **Madness and Social Control in Colonial America**

During colonial times, the majority of mad individuals in America were the responsibility of the individual's family (Rothman, 1990; Scull, 1977). Special shacks were sometimes used to confine those who were unmanageable and the few hospitals that existed, like the first hospital for the insane built in Williamsburg Virginia in 1769, primarily were used to confine individuals as a last resort for those with no family, and who could not be controlled. Rothman (1990) hypothesized that the *Discovery of the Asylum* only occurred after Jacksonian Americans assumed social disorganization was going to result from lost networks between the primary agents of socialization during the era (family, church, community). Ultimately the concern over a disordered society aiding in criminality and insanity led to the institutional movement. America went from having a handful of institutions on the East Coast in 1810 to all but five states possessing at least one public asylum by 1860 (Rothman, 1990).

The promise of rehabilitation to the individuals suffering from the abnormalities of mental health problems had begun. As Torrey (1997) described, several early reformers championed the asylum, believing the conditions within almshouses and jails were not appropriate for the mentally ill. He noted that leaders like Louis Dwight and Dorothea Dix were very successful in promoting the public psychiatric hospital so that persons with mental illness could receive proper care and no longer languish in the

deplorable conditions of other institutions where therapeutic treatment was impossible. In the most comprehensive census of insanity ever completed, it was found that of almost 92,000 individuals identified as “insane” in 1880, fewer than 500 were living in jails (Torrey, 1997). However, not all scholars and historians have looked upon the asylum with admiration as some of the early reformers did. Many have reasoned that a primary purpose of psychiatric asylums was so that the state could formally control persons with mental illness and other social deviants, keeping them from mainstream society.

### **The Institutional Movement**

The advent of the institutionalization movement and the creation of the giant asylums in the United States and Western Europe during the early 19<sup>th</sup> century were as remarkable as the movement was swift. As Rothman (1990) explained, people during this era had assumed that the mentally ill would come to the asylum (as would the criminal to the penitentiary or the homeless individual in the almshouse) and that these individuals would be quickly corrected and adequately reformed. As urban centers grew, however, and the industrial revolution was at full scale, maintaining social order changed within society as distinctions between social classes grew wider (Rothman, 1990). Multiple scholars have researched the development of social control institutions (Garland, 1990; Goffman, 1961; Ignatieff, 1978; Rothman, 1990; Scull, 1977). Most have noted that at least part of the true goal of the institutional movement was not the reformation of the abnormal individual, but the social control of the deviant by the state.

Foucault (1965) referred to the mass institutionalization of the European insane and poor as the “Great Confinement.” He contended that the bourgeois class of the time mercilessly institutionalized individuals in support of their core propositions without alternative consideration about those who were confined. He supported the notion that the move was intentional and this great confinement was used to punish those who were seen as challenging, or just dissimilar (Porter, 1987). Some scholars have argued that the rise of the asylum to house deviants was one result of the economic structure of capitalism (Ignatieff, 1978; Scull, 1971). Scull contended in his historical analysis of the institutionalization movement that Rothman (1990) failed to explain why social order became such a concern of society during the early 19<sup>th</sup> century that subsequently enabled the construction of multitudes of asylums in the United States. Scull maintained that most historical views on insanity pointed to humans gaining an understanding of their own rationality and giving up the ancient delusory ideas about madness. In his view, capitalism was responsible for the era of mass confinement because of “segregative control mechanisms” (Scull, 1977, p. 337) like asylums, prison, jails, and other facilities used to restrain social deviants. Foucault (1975) famously hypothesized that these penal systems were largely designed to create “docile bodies” to condition prisoners to be economic functions of the state able to provide services, including labor and military service, to the bourgeoisie.

Confinement, regardless of intent, was important because it protected society from an attack on social order by the deviant, and institutions provided an opportunity for

individuals to learn conformity to the expectations of the outside world. In his seminal work *Asylums*, Goffman, (1961) referred to psychiatric institutions as well as prisons, jails, leper houses, almshouses for the poor, and other facilities as “total institutions.”

Total institutions could be divided into five distinctive groups: those for individuals who are confined, mostly incapacitated, and also not dangerous; those for individuals who are unable to care for themselves and also dangerous; those designed to keep members of the general public safe from those confined; those designed for the purposes of work; and those designed to sequester individuals away from the public for religious reasons.

Goffman (1961) described the objectives of the institutions as psychiatric rehabilitation, economic obtainment, education/training, or “religious purification.” He also posited that total institutions were places where personal identity was essentially lost at the hands of the institution so one could be re-socialized to conform to the desired behavior and beliefs of the institution. These total institutions consisted of a staff that was part of the accepted culture outside the facility, and a group of inmates completely sequestered from the world beyond the institution. Goffman (1961) further noted that one inherent job of staff in total institutions was to squash any nonconforming notion a patient refusing to adhere to the rigid program of the facility might have.

Like many exertions of control by the state, the institutional movement was successful in expanding social control, but was not successful in rehabilitating the deviant. Beyond rehabilitation, scholars have illustrated that re-socialization was also a promised goal of the reformatory and institutional movement that went unfulfilled (see

Rothman, 1990). By producing model citizens and correcting behavior through the teaching of democracy, the beliefs were that wayward individuals would be newly socialized and then return to the community, “reformed.” In his extended review of the reformatories in the era (and specifically Elmira Reformatory) from the 1870s to the 1920s, Pisciotta (1994) suggested that these institutions delivered “Benevolent repression: So called ‘prison science’ attempted to instill youthful offenders with the Protestant ethic and American values: the habits of order, discipline, self-control, cheerful submission of authority, as well as respect for God, law, country, and the principles of capitalism and democracy” (p. xx). Pisciotta and other scholars noted that the re-socialization practices of the era, like similar rehabilitation practices, were overwhelmingly unsuccessful however.

The asylums, jails, prisons, and almshouses continued long after it was realized that they neither rehabilitated nor re-socialized individuals (Rothman, 1990). In fact, the asylum flourished well into the 20<sup>th</sup> century, creating the entire profession of psychiatry focused upon “therapeutic optimism” – the notion that change could occur to help the deviant while also providing “pervasive paternalism” by assisting in the control of this unfortunate population (Porter, 2002). The institutionalization movement only gained steam during this time. Torrey (1997) showed convincingly the trend of significant increases in the census of large psychiatric institutions, indicating that in 1880 there were about 40,000 individuals living in insane asylums, but that 75 years later the number had swelled to more than 500,000, outpacing the growth of the country tenfold. However,

this massive establishment of benevolent social control was about to come to an end. Waves of dramatic change altered the American landscape during the late 1950s and through the 1960s, ushering in an entirely new movement that would be as far-reaching as the initial discovery of the asylum- the deinstitutionalization era was about to begin.

### **Social Control of Women during Institutionalization**

Scholars have discussed the elevated social control that women endured as a result of the institutionalization era. Chesler (1972) suggested that the psychiatric institution was particularly harmful to women because they had little control over their admittance to these institutions. Husbands had wives committed indefinitely for little reason. Fathers had daughters admitted for being sexually active. The state institutionalized women for being poor and/or transient. Showalter (1987) found evidence that some women were housed in psychiatric institutions for over 50 years as a result of having babies out of wedlock. Scholars have reasoned that psychiatric institutionalization was a very effective way to “correct” and control female sexuality because of examples similar to these.

Many of the social constructions of madness that developed during the 19<sup>th</sup> century directly related to “women’s complaints” (Russell, 1995, p. 8). Russell suggested a female healer once treated these issues. The witch-hunts of the prior centuries had discredited this practice. Thus, male doctors now treated women and as a result many gender specific problems were pathologized. Female reproduction and specifically pregnancy, menstruation and menopause were all labeled diseases (Russell, 1995). The

social control of female sexuality became a predominant goal of doctors during the era. The scientific revolution ushered in a new medical establishment and “madness became synonymous with womanhood” (Ussher, 1991, p. 64).

In her comprehensive historical account of women’s madness in English culture, Showalter (1987) reviewed the conditions of women’s psychiatric institutions during the Victorian era. She stated that the feminization of poverty was one theory for the increase in women’s institutionalization during the time. Others believed that many women in the asylums were not mentally disordered, but were cognitively impaired, handicapped, senile, or physically ill. Some suggested that because women outlived men and were also less likely to leave institutionalization, their numbers were sometimes larger in these institutions. Showalter noted Victorian psychiatrists ignored the evidence of these theories. Instead they reasoned, “women were more vulnerable to insanity than men because the instability of their reproductive systems interfered with their sexual, emotional, and rational control” (p. 55).

Women were not only overrepresented in the institutions of the era but also provided less care. Showalter (1987) described severe punishments for women who did not adhere to gender appropriate behavior while institutionalized. Showalter suggested that women, “were sedated, given cold baths, and secluded in padded cells up to five times as frequently as male patients” (p. 81). Long periods of solitary confinement also were used to reprimand women for swearing, being violent, and other unwanted behaviors. Furthermore, the work that women completed while institutionalized was

designed to teach domestic skills only. Women were not allowed to engage in much of the physical activity and recreational play that institutionalized men were. Finally, Showalter (1987) stated that a woman's appearance was directly tied to Victorian psychiatrists' views of sanity. Women who did not conform to the "appropriate" dress of the time were considered insane by psychiatrists. However, women who overindulged in fashion or had eclectic taste were also deemed insane. Even fashion needed to be carefully considered for women who hoped to avoid institutions and women who hoped to leave them.

Russell (1995) pointed out that mental institutions of the time were not clearly distinguishable from prisons or almshouses. Each of these institutions had predominantly sought to control individuals perceived as social threats. Although psychiatric institutions sometimes held more women than men (i.e. Showalter, 1987), correctional facilities in America at the time were overwhelmingly male. This is one of many pieces of historical evidence suggesting that women's deviance was more commonly pathologized while men's deviance was criminalized. Despite the method of regulation, both were subjected to institutionalized control. Rafter (1990) reviewed the history of female prisons in the United States, finding that facilities often provided unsatisfactory programs in comparison to men. Many of the archival records she uncovered suggested similar control over women during the institutionalization era as was described by Showalter (1987). Rafter (1990) noted that women's reformatories historically subjected women to punishment as a result of having children out of wedlock, prostitution,



vagrancy and other deviance common in “fallen women” (p. xxviii). Rafter also explained that women frequently were confined to reformatories for years as misdemeanants to control their behavior. This practice of confinement was particularly gendered given that men’s prisons had no counterpart to the female reformatory model during the institutionalization era. Showalter (1987) noted in English asylums that women were subjected to gender stereotypical work. Rafter (1990) found similar practices to be the norm in American prisons for women. Most of these women would learn domestic trades and then, after confinement, be life-long housekeepers and domestic servants for wealthy families. Therefore, even after completion of their expanded confinement for minor misdemeanor offenses, women were further constrained by their employment choices. Belknap (2010) argued that incarcerating women to reformatories in this manner was as an early example of net-widening behavior by the criminal justice system. To explain, judges sought to control these women’s deviance and sexual activity by over-institutionalizing them where their behavior could be more controlled informally.

During the institutionalization era, poor, sexually active, and deviant women were clearly regulated by institutions of formalized social control in ways that men were not. This was a practice that was not unique to lower class women, however. The concept of “femininity as a disease” (Ehrenreich & English, 2005, p. 120) was a label regulated to all women. In fact, middle-class and upper-class women became an obsession of psychiatrists during the Victorian era to well into the 20<sup>th</sup> century. Most infamous among

those theorists was Sigmund Freud (i.e. penis envy, Oedipus complex). Freud's founding of psychoanalysis largely rested upon the foundation of blatantly sexist notions. As many feminist scholars have critiqued, the theory of psychoanalysis was inherently misogynistic as it pathologized women over their perceived resentment of not having a penis (Appignanesi, 2008; Chesler, 1972; Ehrenreich & English, 1979, 2005; Russell, 1995).

The "nerve doctors" of the time focused almost exclusively on women's mental health concerns. Ehrenreich & English (1979, 2005) and Appignanesi (2008) both described in detail male psychiatrists' fascination with pathologizing reproduction and motherhood. Many of these psychiatrists believed that women's primary function was to produce and raise children. In their view mental illness commonly resulted from uterus or ovaries problems. Hysteria, a prominent mental illness of the time, derives from the Greek word for uterus. (Ehrenreich & English, 1979, 2005). The authors also highlighted the "psychology of the ovary" that suggested women's personalities and subsequent insanity were a result of ovarian disease (p. 133).

Feminist critiques have been quick to point out that most of the true causes of women's "mental illness" during the time was not because of biology, but because of social factors (e.g. see Appignanesi, 2008; Ehrenreich & English, 1979, 2005; Showalter, 1987). These scholars reasoned that the Industrial Revolution and the changing economies regulated the work of many women to the home. As mentioned, societal norms suggested wealthier women's primary function should be to produce and raise

children. Thus, women often developed nervous and anxiety ridden habits out of the monotony of their lives. Ehrenreich and English (2005) stated, “No doubt the suffocating atmosphere of domesticity bred a kind of nervous hypochondria” (p. 118).

The era of institutionalization had detrimental consequences for both men and women who were labeled deviant or mentally ill. Women paid a particularly substantial price as a result of institutionalization. During the era, the advent of psychiatry was particularly harsh on women. Psychiatry considered femininity a disease and women were subjugated to the roles of wife and mother exclusively. The 1960s, however, ushered in new views of formalized social control.

### **The Deinstitutionalization Era**

From the 1930s to the mid-1950s the number of individuals living in mental institutions had increased by 200,000 (Mechanic & Rochefort, 1990), an increase of nearly 60 percent. In 1955, at the height of the institutionalization movement in the United States, there were over half a million individuals confined to public mental health asylums (Bachrach, 1978; Bassuk & Gerson, 1978; Lamb & Weinberger, 2001; Mechanic & Rochefort, 1990; Ozarin & Sharfstein, 1978; Torrey, 1997). At this time, the United States had a population of only 165 million (Lamb & Weinberger, 2001). The number of persons with mental illness living in psychiatric institutions decreased to 110,000 by 1985 (Mechanic & Rochefort, 1990) and to roughly 70,000 in 1994 (Torrey, 1997) and approximately 57,000 in 1998 (Lamb & Weinberger, 2001).

Researchers have proposed several theories to explain the decline in the number of individuals institutionalized from the late 1950s onward. First, the growing public outrage involving inhumane treatment of persons with mental illness in asylums was a core justification for deinstitutionalization, as was the massive community mental health drive (Bassuk & Gersen, 1973; Grob, 1987; Ozarin & Sharfstein, 1978; Rochefort, 1984; Talbott, 1974; Torrey, 1997). Second, the Civil Rights Movement of the 1960s altered the way society viewed persons with mental illness, and many legal rights for persons with mental illness (such as involuntary commitment laws) drastically changed (Erickson, & Erickson, 2006; Slate & Johnson, 2008; Torrey, 1997) Third, the social welfare system affected the deinstitutionalization movement in profound ways by shifting funding from the states to the federal government and providing social welfare programs for the first time (Ozarin & Sharfstein, 1978; Scull 1977; Slate & Johnson, 2008; The Sentencing Project, 2002; Torrey, 1997). Fourth, in the early 1950s the psychotropic medication called Chlorpromazine (also known as Thorazine) significantly altered the treatment options for the mentally ill (Erickson & Erickson, 2006; Lamb & Weinberger, 2001; Mechanic & Rochefort, 1990; Slate & Johnson, 2008; Torrey, 1997).

### **The Anti-psychiatry Movement and the Feminist Critique**

The anti-psychiatry movement was born from the idealism of the 1960s and came into vogue during the era of deinstitutionalization. Although Michel Foucault, Erving Goffman, Thomas Scheff, David Cooper, and R.D. Laing have all been identified as prominent anti-psychiatrists, Thomas Szasz was perhaps the most prominent figure in the

movement. His books *The Myth of Mental Illness* and *The Manufacture of Madness* were broadly read. Szasz (1960,1974) and the writings of other prominent anti-psychiatrists argued that the institution of psychiatry was a value-laden enterprise. Madness was ultimately an effective way to control individuals covertly. Mental illnesses did not exist beyond the social construction of those illnesses which were mostly just labels given to individuals considered deviant (for review see Busfield, 1996).

Feminist scholars have varied in their critiques of the anti-psychiatry movement. Some have acknowledged that anti-psychiatry arguments naturally extended to women under the control of the psychiatric establishment. Others have been less favorable in their analysis. These scholars argued that anti-psychiatrists also ignored women. For instance, Appignanesi (2008) stated, “The anti-psychiatrists’ radical attack on social control and the structures of power both in and out of the asylum hardly extended to their unexamined control over women” (p.368). Ussher (1991) noted that the phenomena society has labeled madness is real for some women. Ussher further argued that despite psychiatry’s many injustices to women, “it is no help to a woman in distress to be placed on a pedestal and told that she is a victim of societal oppression, a hero of the people, a political dissident” (p. 240). In the end, the anti-psychiatry ideal of the deinstitutionalization era may have been another way to subjugate women to the role of “other” in comparison to men.

## **The Criminalization of Mental Illness**

As a consequence of the deinstitutionalization movement of the 1960s, a simple, yet baffling question resonated for policy makers and staff members as the state psychiatric facilities were emptied throughout the deinstitutionalization era— where did all these former asylum patients go? It is clear that some transinstitutionalization occurred between the asylum and the nursing home, as the burden of paying for persons with mental illness largely shifted from state governments to federally funded nursing homes (Slate & Johnson, 2008). Many scholars speculated that persons with mental illness once housed in institutions entered the criminal justice system as a result of living in the community and having more encounters with the police. Another hypothesis assumed that as a result of being non-medication compliant, some persons with mental illness had the potential for greater criminal justice exposure. Torrey (1997) labeled this “transcarceration,” where persons with mental illness without asylums were often left deprived of proper treatment for their mental health needs or custodial assistance in the community, which in turn resulted in a higher chance they would come into contact with the criminal justice system. The net widening behavior of the criminal justice system was another way for the state to exert social control over persons with mental illness for crimes, including misdemeanors committed while the individual was in psychiatric crisis (Arvanites, 1992; Cohen, 1985). One could also conceivably speculate that this was simply a shift from the social control of one system to another with essentially identical results.

One of the first distinguished studies on the connection between psychiatric hospitalization and the criminal justice system found an inverse relationship between psychiatric institutionalization and prison censuses (Penrose, 1939). Using the psychiatric hospitalization rates in European countries and comparing them to the imprisonment rates, Penrose concluded that as psychiatric hospitalization rates decreased for a particular country its prison rates increased. The phenomenon labeled the “balloon theory” by the researcher to convey the point that contraction of one institution of social control will put stress upon another. In highlighting the work of Penrose (1939), Torrey (1997) explained that as one portion of a balloon is squeezed it forces another section to become strained and bulge. Penrose’s initial examination has been replicated in other cultures, finding support for the inverse relationship between the mental health population and prison populations in a particular region (Biles & Mulligan, 1973).

Deinstitutionalization allowed the balloon to shift from the bloated excesses of the psychiatric asylums to the criminal justice system. For the first time, research began to concentrate on how the different pieces of the system interacted with persons with mental illness. In his classic work on police discretion involving persons with mental illness, Bittner (1966) argued that the police used “psychiatric first aid” in their work with the mentally ill. That police were not normally trained to deal with persons with mental illness, although they came into contact with these individuals regularly, led to police use of discretion in these encounters. Comparable scholarship began to scrutinize the consequences of deinstitutionalization and its consequences for persons with mental

illness. Researchers posited that the result was the criminalization of mental illness, also labeled “The Criminalization Hypothesis.”

First coined by Abramson (1972), the criminalization hypothesis has a simple premise – because society has a limit to its tolerance involving persons with mental illness, if individuals cannot enter state benevolent control within the mental health system, they would instead be ushered into the coercive social control wielded in the criminal justice system. Abramson (1972) was specifically writing about the consequences of the Lanterman-Petris-Short Act (LPS) of 1968, known in California as the “magna carta” for persons with mental illness. Designed to empower persons with mental illness, the LPS act greatly increased the legal safeguards for persons with mental illness placed in psychiatric institutions against their will. Abramson reasoned that these individuals would often be non-compliant in the community, become homeless, be placed in jail where they would be medication compliant again, released, and the cycle would then repeat itself.

There has been some discussion among scholars to distinguish at which point within the criminal justice system criminalization takes place. Although no definite unanimity exists, Stuey (1991) reasoned that there are two main points of the criminalization hypothesis. First, there is a group of persons with mental illness currently within the confines of the criminal justice system once supported in the mental health field. Second, at one point there were fewer persons with mental illness in the criminal justice system than currently (Stuey, 1991). In specifying the criminalization of mental



illness, Stuey described three primary hypotheses. These included that persons with mental illness are often treated more harshly because they are labeled both mentally ill and criminal, that persons with mental illness are seen as “patients” within the confines of the criminal justice system, and finally that the mental health problems of this group are not recognized in the criminal justice system and individuals are only known as “criminal” (Stuey, 1991).

### **Women and Madness after Deinstitutionalization**

As the institutionalization movement disintegrated during the 1960s and 1970s, views of women and mental illness changed. As discussed, Chesler’s (1972) text on the subjugation of women at the hands of male-dominated psychiatry had a lasting impact. Women continued to be treated and controlled differently by the mental health establishment, however. Inside the institution in the first half of the 20<sup>th</sup> century, individuals were commonly treated with insulin induced comas, electro convulsive therapy (ECT) and lobotomy (Ussher, 1991). Some scholars have hypothesized that even these treatments had a gendered component. To explain, Showalter (1987) stated that ECT, where the brain is administered electrical shocks, often was administered to women over men at a ratio of two to one.

Outside the institution in the second half of the 20<sup>th</sup> century, psychotropic medication became the norm to suppress the symptoms of mental disorder. These new forms of medical social control were also used to control women in unique ways. To illustrate, Staub (2011) reviewed how advertising companies targeted women to take

these medications. These advertisements often focused on women's roles as mothers and wives and how medication might help in these areas. This was especially ironic considering women were not allowed to be part of the clinical drug trials for these psychotropic medications at the time (Bentley, 2005). Even research in the last two decades has found that women are overrepresented by a ratio of 10 to 1 for use of some psychotropic medications.

In 1952, at the same time formalized control was moving away from the psychiatric institution, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was created by members of the *American Psychiatric Association*. Critics have considered that this classification system was originally designed by psychiatrists to “maintain control over the other professions which were vying for a foothold in the market place of madness” (Ussher, 1991, p. 99). Ussher noted that the approach of the DSM focused on taxonomy and classification making it more similar to the respected positivistic models of physical medicine. Many of the disorders of the time (some even today) were gender specific such as post-partum depression. As a result, females with mental illness could again be attached predominantly to the gender stereotypical considerations of motherhood and caregiving. Since the earliest theories developed involving females and mental illness, the creation and control of women's madness has been inextricably tied to the gendered roles of wife and mother.

## **BEYOND THE DEINSTITUTIONALIZATION ERA**

This review has provided a brief overview of the historical and formal social control of persons with mental illness through the deinstitutionalization era. Furthermore, special attention has focused on the unique ways women have been regulated by formal social control in institutions and public. The post-deinstitutionalization era ushered in new mechanisms of control, which replaced older devices governing the behavior of individuals deemed “mad.” I now transition to review ways that the criminal justice system and mental health system have merged to form a net-widening effect (Cohen, 1985) regarding formalized social control. This review concludes with a discussion of women in the contemporary criminal justice system and gendered pathways into and away from the criminal justice system.

### **The Advent of Therapeutic Jurisprudence**

Highlighted previously, offenders with mental health problems are over represented in all areas of the criminal justice system. Partially in response to this over representation, much of the policy of the last two decades regarding persons with mental illness under the control of the criminal justice system has focused on increasing the therapeutic components of the criminal justice system to address these needs, especially in community corrections. New ideas have emerged at the forefront concerning how the criminal justice system can protect the individual liberties of persons with mental illness, while still providing therapy to these individuals and also keeping the public safe (Borzecki & Wormith, 1985; Lamb, Weinberger, & Gross, 2004). Historically the

systems of mental health and criminal justice have worked parallel to each other in the control over persons with mental illness who commit criminal offenses, leaving many to cycle in and out of each system or to be ping-ponged back and forth between each system. Recent research has started to examine how the two systems can work together to both exert social control through law; yet also provide positive therapeutic results. This developing legal concept is known as *Therapeutic Jurisprudence*.

One of the first to conceptualize the topic, Wexler (1992) reasoned that therapeutic jurisprudence seeks to move law beyond its “doctrinal focus” and analytical reasoning so that law instead actually could be practiced as a therapeutic agent. Therapeutic Jurisprudence defined is “the study of the use of the law to achieve therapeutic objectives” (Wexler, 1990, p.4). Winick (1997) argued that the “therapeutic domain” is important and “positive therapeutic effects are desirable and should generally be a proper aim of law, and that anti-therapeutic effects are undesirable and should be avoided or minimized” (p. 188). Further championed by Wexler & Winick (1996), the scholars expanded on earlier theoretical notions of therapeutic jurisprudence and conveyed that courtroom actors exerted therapeutic consequences on defendants, often without even knowing. This was the first time that law had been considered a social service, or that law possessed therapeutic properties- either positive or negative.

At the same time that therapeutic jurisprudence was being introduced in the legal literature, problem-solving courts were also gaining popularity. Berman & Freinblatt (2005) discussed that therapeutic jurisprudence was partially responsible for the

formation of problem-solving courts in coordination with dispute resolution programs, the victims' rights movement, special programs in policing like problem oriented policing and broken windows theory, and finally some of the core principles that make up the juvenile justice system. The authors further illustrated that problem-solving courts were designed for multidisciplinary teams to work together to assist the offender with the underlying behaviors responsible for this person breaking the law. Predicated upon the principles of redefining goals, making the most of judicial authority, putting problems in context, forming creative partnerships, and rethinking traditional roles (Berman & Freinblatt, 2005) problem-solving courts have continued to gain support for the last two decades. Berman & Freinblatt (2005) highlighted evidence that stated that as of 2005 there were more than 2,000 problem-solving courts in the United States, and no less than 12 different types of specialty courts.

The earliest problem-solving courts focused on drug offenses. The nation's first drug court appeared in Dade County, Florida in 1989 (Belenko, 1998; Berman & Freinblatt, 2005; Denckla & Berman, 2001; Hasselback, 2001). Drug courts were important because of the large number of drug cases entering the system and the growing awareness that addiction should be treated as a disease (Steadman, Davidson, & Brown, 2001). Described by Belenko (1998), drug courts set out to lower recidivism and prevent substance abuse relapse by having offenders engage in a specialized program involving collaboration among treatment providers, prosecution and defense lawyers, probation officers and a judge. Mandatory drug testing, judicial supervision, regular hearings and

graduated sanctions were all used as part of the drug court in order to assist the offender in successfully reentering the community.

Much attention has been paid to the effectiveness of drug and other specialty court programs. Because drug courts have been in existence the longest amount of time, and are the most prevalent (Denkla & Berman, 2001), a substantial amount of evaluation research has been completed on these problem-solving courts. Reviews of this evaluation research calls into question many of the evaluation designs and raises questions about the methodological rigor that was employed to assess the effectiveness of certain types of specialty courts (U.S. General Accounting Office, 1997). In a comprehensive review of twenty evaluations completed on drug courts Belenko (1998) conveyed several important results highlighting the effectiveness of the drug courts.<sup>2</sup> He found that the offenders were being actively engaged in treatment with supervision and monitoring of the appropriate type of client for drug courts. In addition, Belenko (1998) noted the cost savings that drug courts were providing for the criminal justice system. Other research has supported these cost saving benefits (Ridgely et al., 2007). Perhaps Belenko's (1998) most promising findings were in client impact results. Results showed drug use was significantly reduced based on urine tests and that recidivism was also reduced for offenders participating in drug courts.

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<sup>2</sup> Belenko (2001) completed a follow-up review of drug courts with similar findings to his 1998 review. The author noted, however, that long-term effectiveness was unclear as was the effects of drug courts on longer-term recidivism.

Although drugs courts have been the most studied, there is much additional work needed to consider the complete effectiveness of all types of problem-solving courts. Because of the perceived success of drug courts, criminal justice personnel began to examine what other crimes and types of offenders might be best served with this problem-solving model, including offenders with mental illness (Manasse, 2008). Also, a result of the apparent success of earlier problem-solving courts, federal funding has been quite supportive of continued funding of these programs (Slate & Johnson, 2008). Likewise, these courts have expanded in other areas that servicing offenders. Although drug courts and mental health courts share many similarities in their problem-solving approaches, drug courts focus solely on drug crime. Mental health courts, instead, have a wide range of charges with the common similarity between these offenders being their mental illness and not the offense (Council of State Governments, 2008).

### **Mental Health Courts**

The first mental health courts to appear after the advent of the problem-solving court movement of the late 1980s and early 1990s were in Broward County Florida in 1997 (Boothroyd, Poythress, McGaha, & Petrila, 2003) and Marion County, Indiana (Redlich et al., 2006). Mental health courts are an important development for the study of crime and mental health (Petrila, 2003) and these problem-solving courts have grown significantly in the last 15 years. By 2007 there were 175 mental health courts in the United States (Council of State Governments, 2008). Only two years prior, there had

been 113 mental health courts (National GAINS center, 2006) illustrating firsthand their significant growth during this time.

The therapeutic jurisprudence of mental health courts looks to “break the cycle” that develops when persons with mental illness shuffle in and out of the mental health system and eventually come in contact with the criminal justice system where they do not receive adequate treatment (Erickson & Erickson, 2006). Generally the primary eligibility for inclusion in a mental health court is that the offender has a mental illness that is a significant issue for that person (Casey & Rothman 2003; Goldkamp & Irons-Guynn, 2000). Normally in a mental health court a courtroom workgroup consisting of a judge, probation officers, community treatment providers, attorneys and others work as a team to assist the offenders with treatment, criminal related issues and potentially a host of other problems (unemployment, addiction, education etc.) that may adversely affect the offender’s ability to successfully navigate the criminal justice system (Goldkamp & Irons-Guynn 2000; Wolff, 1998, 2003). Some treatment programs are completed within three months although some last for several years (Goldkamp & Guynn, 2000).

The Council of State Governments (2008) stated that all mental health courts share some common similarities, but diversity of mental health care components varies widely by the specific court. The Council provided a “working definition” of mental health courts, noting that growing pressures exist to establish a national consensus defining what mental health courts currently are and what they should strive to be (see for example, Steadman et al., 2001).



Redlich et al., (2006) explained that there are six primary goals of mental health courts, as evidenced by the research findings of Goldkamp and Irons-Gunn (2000), Redlich (2005) and Steadman, Davidson and Brown (2001). The first is that the mental health court has a separate docket with one judge. As Redlich et al. (2006) continued, another goal is to get the persons with mental illness diverted from the criminal justice system and into court-mandated community mental health treatment. Additionally, mental health courts are to provide ongoing review of each client's progress during court review hearings, offer positive reinforcement for adhering to the program, and exert graduated sanctions over persons with mental illness when noncompliant. A final and essential characteristic is the mental health court be strictly voluntary with the offender choosing whether or not they participate and having the option to be sanctioned in a non-specialty court (Redlich et al., 2006).

As mental health courts have become mainstream over the last decade and a half, scholars have begun to examine and evaluate these courts, with many supporting their effectiveness. For example, Boothroyd et al. (2003) found that defendants engaged in the Broward County (Florida) mental health court were more likely to receive treatment. The primary variables of interest though, recidivism and impact on the offender's mental health, largely had no effects. Other studies examining single sites have found empirical evidence of the success of mental health courts in lowering recidivism rates and improved psychological functioning (Cosden et al., 2005; Hiday, Moore, Lamoureaux & Magistri, 2005; McNiel & Binder, 2007; Ridgeley et al., 2007; Trupin & Richards, 2003).

Finally, some evidence has supported the cost saving benefits to the criminal justice system that mental health courts may provide (Ridgeley et al., 2007).

### **Net Widening in the Criminal Justice System**

Problem-solving courts are now a popular part of the court system in the United States and continue to grow. Individuals being coerced into a guilty plea to join the mental health court, the widening of the court's social control over a person with mental illness, and accountability problems of mental health treatment are each important to consider in the debate of the true effectiveness of mental health and other problem solving courts. Cohen (1985) examined in detail the "net widening effect," arguing that the reach of social control has spread from outside the institution into the community, increasing the amount of social control but also potentially decreasing the visibility of that control by housing it under things like rehabilitative counseling, mandated treatment, and restitution. Cohen suggested that in the contemporary criminal justice system, which is housed largely in the community, the boundaries are no longer clear and the "nets" between the social welfare system and the criminal justice system are inextricably entangled. Likewise, Goffman (1961) suggested that parole was just another way for total institutions to expand control over an individual beyond the reformatory/asylum. Piscotta (1994) also addressed the topic of extended social control in the community when discussing the multitudes of popular treatment modalities and therapeutic programs that continue to grow as basic prison programs also remain within the correctional facilities. Piscotta (1994) hypothesized, "These programs and more recent innovations

share a common end: transforming America's dangerous classes into law-abiding and socially and economically productive working class citizens" (p. 154). Cohen (1985) suggested that this is accomplished by moving the "experts" that were once in the institution to the community where they can oversee the accomplishment of this end.

Control has also shifted in the way that offenders are classified within the criminal justice system. Moving away from largely sociological factors leading to crime, actuarial risks/needs assessments are frequently used within the criminal justice system to target specific "types" of offenders for increased control. Andrews and Bonta (1998) have championed the concept of looking at individuals within different groups; coining this notion of "Psychology of Criminal Conduct" (see also Andrew, Bonta & Hoge, 1990; Andrew, Bonta, & Wormith, 2006). Cullen and Gendreau (2000) discussed the "guiding interventions" of these risks/needs assessments noting the importance of first targeting the "known predictors of crime and recidivism for change" (p. 145). By directing focus on static (i.e. criminal history) and dynamic (i.e. antisocial beliefs) this psychology of criminal conduct centers on: (1) the "risk principle" or which offenders should be targeted for greater intervention; (2) the "need principle" focused on areas that lead to recidivism; (3) and the "responsivity principle" examining how specific offenders will respond to specific types of treatment (Andrews et al., 1990).

One such risks/needs assessment reviewed in detail by Andrews and Bonta (1998) is the *Level of Service Inventory – Revised* (LSI-R). The authors noted that the assessment is made of 54 questions across 10 subcomponents that can assess for

recidivism risk and treatment need and responsivity. With the development of assessments like this, specifically within the context of community corrections, social control has become more targeted and increases substantially for some offenders, while easing significantly the control of lower risk offenders. The other problem with these risks/needs assessments is the concern with how representative they are for all offenders. Andrews and Bonta (1998, p. 232) pointed to over 20 articles noting that the “LSI-R scores predict a range of outcomes with varying offender populations and in different settings” and also that these predictions were as accurate as, or more than, other assessment instruments of this nature. One concern, however, is how precise these assessments are regarding gender. For instance, scholars have voiced worries over the accuracy for these tools to be generalizable to women offenders among others (e.g. see Brennan, 1998; Holtfreter & Cupp, 2007; Reisig, Holtfreter & Morash, 2006; Silver & Miller, 2002). As noted by Holtfreter & Cupp (2007) “such erroneous judgment contributes to increased and unnecessary social control of women” (p. 368)

Aside from potential concerns with over control in risks/needs assessments for women, early evaluative research on specialty courts (mental health courts, specifically) has echoed some of the assertions of the above scholarship regarding net widening and questions about general accuracy and effectiveness. Dorf & Fagan (2003) posited that innovations often occur in response to things widely viewed as alarming (in this case the overabundance of persons with mental illness in the criminal justice system) and that innovation will become institutionalized without full evaluation or quality control being

properly measured. These scholars suggested proceeding with caution on problem-solving courts, as the methods used in the evaluations of mental health courts and others specialty courts has been flawed and the results have not been conclusive (Dorn & Fagan, 2003). Multiple studies have discussed concerns with problem-solving courts and certain aspects of mental health courts (e.g. Bazelon, 2003; Dorf & Fagan, 2003; Keele, 2002). Chief among these concerns are the rights of defendants. Seltzer (2005) advised that mental health courts must be “entirely voluntary.” The author stressed that a defendant should not be coerced into the mental health court at a time when she may have significant anxiety about the criminal justice system or symptomology of her mental health problem. Second, these courts may actually be widening the net as suggested by Cohen (1985) and others. Courts acting as psychiatrists push social welfare to be under the governance of the criminal justice system. If a defendant is pressured into treatment as part of her criminal sentencing after being denied or refusing it in the community, this may be the state enacting a “harm reduction” model (Nolan, 2001). Seltzer (2005) also conveyed that although a majority of courts work with misdemeanants, mental health courts need to be reserved for more serious offenses so that the persons with mental illness arrested for public order types of offenses are not overly criminalized. Another potential shortcoming of mental health courts is their ability to provide quality mental health care in the community (Seltzer, 2005). Courtroom actors have traditionally not been trained in matters of mental illness or psychopathology and are not always

cognizant of the quality of treatment or how this may affect criminal behavior of persons with mental illness.

Effectiveness of these specialty programs within the courts and community corrections have undergone some evaluation over the last two decades with mixed results. As the competing yet coordinated goals of rehabilitation and punishment are now blurred in the form of more social control, at more time points, with increased density over offenders, many questions remain regarding persons with mental illness in the criminal justice system and how this net widening impacts offenders. Greater understanding of this topic is necessary as it remains of paramount importance to establish a balance which focuses on the rights of the person with mental illness and the need for quality treatment involving her illness while at the same time also ensuring the safety of the public (Borzecki & Wormith, 1985; Lamb, Weinberger, & Gross, 2004).

Several evaluations of these specialty programs have been examined, and few have considered specifically the impact of gender, or have asked about the individual impacts/experience of the offender as she navigates this dual system while also still living in the community. For instance, Cohen (1985) touched upon the idea that these forms of benevolent and coercive control may especially affect women. Other scholars have pointed out that women come into contact with the criminal justice system with unique social histories (often filled with abuse and mental health problems) and unique consequences to their criminal justice involvement (primary caregivers of children, etc.).

Considering the scholarship reviewed above I now address the specific topic of women in the criminal justice system.

## **WOMEN OFFENDERS AND THE CRIMINAL JUSTICE SYSTEM**

Two facts about gender and crime have consistently been illustrated in the literature. First, the experience of girls and women have been overlooked in comparison to their male counterparts. This is made clear by Chesney-Lind and Pasko (2004, p. 1) who explained, “Women’s and girls’ experiences with crime, deviance, and victimization were at the periphery of scholarly inquiry; female crime was overlooked almost completely, and female victimization was ignored, minimized, and trivialized.” Second, women commit less crime, come into contact with the criminal justice system less often, and are imprisoned at lower rates than men. Steffensmeier and Allan (1996) wrote, “Women are always and everywhere less likely than men to commit criminal acts” (p. 459). The authors theorized about several areas that “inhibit female crime” (p. 475) including taboos around gendered normative behavior, different moral development by gender, greater social control for females, greater physical strength and aggression for males, and sexual reproduction differences. Covington and Bloom (2003) further highlighted these gender differences as 58 of 100,000 women compared to 896 of 100,000 men were incarcerated in the United States at the time of their study.

Researchers also note, however, that female involvement in the criminal justice system continues to increase, often outpacing male involvement. Multiple researchers

have posited that the “War on Drugs” has been a “War on Women” (Chesney-Lind, 1997; Bush-Baskette, 1998). For instance, Covington and Bloom (2003) pointed to the Bureau of Justice Statistics (2002) and the National Institute of Justice (1998) to illustrate an eightfold increase in the number of women in either state or federal prison. Bush-Baskette (1998) highlighted an 828 percent increase in incarceration for African American women due to drug offenses between 1986 and 1991. Punishment for women offenders has also become harsher. Britton (2000) noted that female incarceration rates were increasing at much greater rates than their arrest rates (146 percent versus 40 percent). Recently, Morash (2010) illustrated the augmented growth for women on probation and parole, remarking that their increases were outpacing those of men in probation and parole. She specified that a 56 percent increase of women under community corrections control had occurred in less than a decade. Glaze and Bonczar (2007) found that in 2006 over 1,000,000 women were on probation. As of 2003, the community corrections arm of the criminal justice system supervised roughly 85 percent of all female offenders (Bloom, Owen & Covington, 2004; Holtfreter & Morash, 2003).

### **The Life-Course Tradition and Criminal Justice Involvement for Women**

Forty years of feminist research in criminology has continually considered the androcentric nature with which criminological theory has been advanced. Scholars have argued that female criminality is often dissimilar to that of male criminality (Belknap, 2006; Chesney-Lind, 1989; Daly & Chesney-Lind, 1988) and that most of the dominant theories in the field have been made for men based on research with men (Leonard, 1982;



Naffine, 1996). Furthermore, mentioned by Daly and Chesney-Lind (1988), in Western thought, both the natures of men and women have been depicted by privileged, White men (p. 499). This is unquestionably true in the fields of psychiatry and criminology. Specific to criminology, Daly & Chesney-Lind (1988) called this the *generalizability problem*. Essentially, this problem questions if theories that were created exclusively examining the lives of boys and men can also be attributed to girls and women.

Empirical analysis examining the gender differences in crime has frequently found that women have unique entries into, experiences during, and exits away from the criminal justice system (e.g., among many Belknap, 2006; Brennan et al., 2012; Daly 1992, 1994, 1998; Gilfus, 1992; Huebner et al., 2010; Reisig et al., 2002, 2006; Richie, 1996, 2001; Miller, 1986; Pettitway, 1987; Salisbury & Van Voorhis, 2009).

Life-course theory in criminology has long posited that one's experiences across the lifespan, especially those occurrences in childhood and adolescence can influence later offending (Loeber, 1996; Sampson & Laub, 1990; Laub & Lauritsen, 1993; Laub & Sampson, 1993). Sampson and Laub (1993) supposed that at the core of life-course theory are *trajectories* and *transitions* (see also, Elder, 1985, 1994; Laub & Sampson, 2003; Sampson & Laub, 1990). To explain, *trajectories* are pathways or patterns across the lifespan that are guided by specific *transitions*. These *transitions*, like entrance into work or marriage, essentially shape and change one's life-course *trajectories*. A third closely related concept is *turning points*. As Elder (1985) highlighted, *turning points* are

more profound changes that result because of *transitions* and significantly affect developmental *trajectories* across time in the life-course (see also Abbott, 1997).

Although researchers have consistently provided support for life-course theory, a major criticism put forth by feminist scholars is that the vast majority of research completed has been with longitudinal datasets of men only (Belknap, 2006). Belknap stated that life-course theory was indeed a “pro-feminist” method despite very little empirical work having been completed with girls and women in the life-course tradition (for an exception see Sommers & Baskin, 1994). Although girls and women have historically been neglected in the life-course literature, Belknap (2006) further stated that research since the late 1970s, “has increasingly used women’s and girls’ voices to determine ‘life-course’ events that place girls (and women) at risk for offending” (p. 61). Now extensively supported with 30 years of empirical analysis, feminist scholars have shown that the process of criminalization (i.e. entry into the criminal justice system) is often gendered. Stated simply, the “constellation of problems” (Gilfus, 1992; Chesney-Lind & Pasko, 2004) that girls and women bring to the criminal justice system is different than that of boys and men.

Extended reviews of feminist pathways research (see Belknap, 2006; Bloom, 2003; Miller & Mullins, 2008; Morash, 2006; Reisig et al., 2006) all considered how gender affected pathways to incarceration. As discussed by Miller & Mullins (2008), Daly (1998, p. 97) stated that these unique pathways for women focused on “biographical elements, life-course trajectories, and developmental sequences.” Gendered pathways

authors have noted that substance use, mental health issues, past physical and sexual abuse, educational opportunities and economic marginalization all lead women to the criminal justice system in ways that differ from those of men. Gender differences regarding entry into the criminal justice system become apparent as early as teenage delinquency. For instance, whereas boys normally engage in delinquent lifestyles, girls' deviance is more often the result of a chaotic or abusive home life (Dembo, Williams & Schmeidler, 1993). These girls and young women often leave home to escape abuse (Chesney-Lind & Shelden, 1992), and as a result become involved with survival crimes on the streets that initially bring them to the attention of the criminal justice system. Girls and young women are more likely to be taken into custody for status offenses that have important influences on the criminality of girls and young women (Chesney-Lind, 1989). Chesney-Lind referred to this as the "criminalization of girl's survival strategies" (p.11).

Victimization is not only a central aspect of girls' offending, but it is often prevalent with women offenders across the life-course (Browne, Miller, & Maguin, 1999; Gilfus, 1992). Victimization has been shown to be more serious and more frequent for girls and women than to boys and men. Dehart (2008) referred to the frequent and varied victimization that many women face prior to entering the criminal justice system as a "multiplicity of traumas." Considering that this victimization often overlaps with offending, scholars (e.g., Gilfus, 1992; Miller & Mullins, 2008) have suggested that the concept of "blurred boundaries" exists between female offending and female victimization. For instance, Silbert and Pines (1981) reported that the majority of women

in their study had been sexually assaulted by the age of 16. Similarly, in biographical interviews with women incarcerated in Hawaii, Chesney-Lind and Rodriguez (1983) found that the backgrounds of women in their sample were littered with violence and sexual victimization that normally originated at a very early age. Additionally the women interviewed were economically marginalized which also led to their entry into the criminal justice system.

Gilfus (1992) conducted similar life history interviews with women in the criminal justice system and found that the majority left home at a very early age. Often, their biographies consisted of multiple types of victimization at the hands of family and boyfriends. Increased and persistent exposure to violence as children and adults left many women vulnerable to future abuse. Gilfus (1992) found that many of the women in her sample were re-victimized after leaving home to escape abuse. Moreover, many of their coping mechanisms for the abuse (e.g., running away, prostitution, drug abuse) were criminal offenses. The “struggle to survive on the streets” (Steffensmeier & Allan, 1996, p. 470) often led to other crime (Chesney-Lind, 1989; English, 1993; Gilfus, 1992). This only further blurred the boundaries between victim and offender for these women.

During this time the dominant pathway for entry into the criminal justice system for women was that of “Streetwoman.” Originating in the foundational ethnography *Streetwoman* by Miller (1986), these women were significantly victimized as children. As a result of abuse and exposure to trauma, they left home at an early age and worked on the streets to support themselves. Miller found that drug addiction, petty thefts and

prostitution resulted in continual contact with the criminal justice system. These women normally had quite lengthy criminal records throughout adulthood as they cycled between the street life and incarceration for survival type crimes, offenses due to drug addiction, and criminal involvement with men.

Building from the *Streetwoman* pathway developed by Miller (1986), Daly (1992, 1994) put forth one of the most influential studies of gendered pathways to date. Daly analyzed a “Deep Sample” of presentence investigations for 40 women in felony court in New Haven Connecticut. Daly (1992, 1994) found that female offenders had difficult familial circumstances growing up, often lacked adequate education and had significant substance abuse problems. As well, these women often suffered from mental health problems. Daly examined prior research on girls and women who had entered the criminal justice system, and compared those findings to the biographies of women in her study. She constructed unique pathways to each woman’s law-breaking for her deep sample and identified five distinct multi-dimensional pathways.

Borrowing the name in part from Miller (1986), Daly (1992, 1994) identified 10 women in her sample who were in the *Street Woman* pathway. As previous research had described, these women escaped abusive homes at an earlier age to live on the street. They normally had extensive arrest histories that revolved around survival crimes and drug use/sales. Daly found that the most prevalent pathway to criminal court was not the *Street Woman*, but instead a *Harmed-and-Harming Woman* pathway. Fifteen women comprised this group. Like the *Street Woman* pathway, women in the *Harmed-and-*

*Harming Woman* pathway experienced childhoods filled with victimization and trauma. However, these women normally committed crimes of violence or acted out in anger. Several women in this group also had psychological problems. Another pathway constructed by Daly (1992, 1994) consisted of five individuals who were labeled the *Battered Woman* pathway. These women entered felony court only as a result of being in relationships with abusive men. An additional group of six women made up the *Drug Connected Woman* pathway. These women entered felony court for using and/or selling drugs. Daly (1992, 1994) noted that in each of these cases the drug use and/or sells were completed with boyfriends or other male family. The final group of four women Daly (1992, 1994) referred to as the *Other* pathway, as these women committed crimes only for economic reasons and had none of the other risks such as histories of abuse or substance addiction. The *Other* pathway subsequently was renamed *Economically Motivated* (see Morash & Schram, 2002; Holtfreter & Morash, 2003; Reisig et al., 2006).

Following the life history interview technique of previous pathways researchers, Richie (1996) interviewed incarcerated women in New York. She developed six paths to the criminal justice system for these women. Richie's work furthered the gendered pathways perspective as she identified some pathways differed between African American and White women. Her theory of *Gender Entrapment* supposed that African American battered women attempted to continually repair abusive relationships with violent men. These women felt disenfranchised by their marginalized status in society. Richie (1996) also hypothesized that the one universal pathway that occurred for African

American and White battered women as well as African American non-battered women, was through addiction.

Traditionally, gendered pathways to the criminal justice system have been constructed using qualitative data – most frequently life history interviews. However, more recent quantitative research has empirically tested the gendered pathways perspective. For instance, Reisig and colleagues (2006) used Daly’s (1992, 1994) prior framework to construct pathways for over 200 women using information from the Level of Supervision Inventory- Revised (LSI-R) actuarial tool. In replicating the gendered pathways framework of Daly (1992, 1994), Reisig et al. (2006) concluded that the perspective was, “a useful way of capturing heterogeneity in women offenders’ prior experiences” (p. 401). Salisbury and Van Voorhis (2009) also used quantitative pathway analysis with a sample of women probationers. They developed three unique pathways to the criminal justice for women. These paths included a childhood victimization pathway, a relational pathway, and a social/human capital pathway. Salisbury and Van Voorhis found support for each of their three quantitative path models, reinforcing the work of earlier qualitative gendered pathways researchers. Other more recent empirical tests of the gendered pathways perspective with samples of jailed women (Simpson, Yahner & Dugan, 2008) and women about to be released from prison (Brennan, 2008; Brennan et al., 2012) have provided additional quantitative support for the gendered pathways perspective.

## **Further Considerations**

Beyond the growing body of research confirming the gendered pathways perspective, other scholars have considered the unique experience of women in the criminal justice system. Based on the psychological relational theories of Gilligan (1982) and Miller (1976) criminologists have highlighted the importance of relationships for women in the criminal justice system (e.g. Covington, 1998; Covington & Surrey, 1997). Relationships potentially affect women's entry into and away from crime in ways that are dissimilar to those of men. For instance, scholars have found that romantic relationships often do not offer the same positive desistance effects for women as they have in men (Griffin & Armstrong, 2003; Leverentz, 2006). Similarly, researchers have demonstrated that men and women are influenced differently by friendships in regards to criminal behavior (Giordano, Cernkovich & Holland, 2003).

Poverty is also a key consideration for women in the criminal justice system. Holtfreter, Reisig and Morash (2004) showed the devastating consequences that living in poverty had in regards to supervision violations and recidivism for a sample of women offenders. The scholars also illustrated, however, that proper services to meet the needs of these women reduced recidivism. In earlier research, Reisig, Holtfreter and Morash (2002) also found that educational deficiencies were associated with network size for a group of women offenders. Women with less education had smaller social networks and social support. Likewise, women who had smaller legal incomes (under \$8,000) also had smaller social networks. The authors hypothesized that deficiencies in social capital



would impact human capital (e.g., employment skills), which reasonably would increase chances for future criminal behavior.

In sum, women have gender specific needs important to consider within the context of the criminal justice system to reduce recidivism (e.g. Scroggins & Malley, 2010; Wright, Van Voorhis, Salisbury & Bauman, 2012). These needs involve past trauma, mental health issues, economic marginalization, relationship considerations, parental concerns, and addiction issues. Multiple scholars have demonstrated that these issues can be gender specific and are important as women reenter the community from the criminal justice (Huebner et al., 2010; Richie, 2001). These needs are sometimes different for women and men (e.g., Giordano, Cernkovich & Rudolph, 2002).

## **SUMMARY**

The goal of this literature review was to overview the historical aspects of formalized social control for persons with mental illness. More specifically, special attention was paid to the expansive nature with which women have been focused on historically by psychiatry and asylums, while being largely ignored in the criminal justice system. Some hypothesize that the criminal justice system has filled the role of psychiatric institutions since the deinstitutionalization movement. As well, the advent of problem-solving courts and other net widening programs have shifted the way formalized control is exerted onto individuals who deviate from societal norms. Specifically, where

women were once seen at “mad over bad” in the eyes of the state, it is very possible some women now carry both labels.

As the exertion of formalized social control has shifted, women now enter the criminal justice system in greater numbers than at any other time. The research has illustrated that these women come to the criminal justice system with unique biographies and gender-specific needs. Little empirical work to date has investigated the lives of women in the criminal justice system that are simultaneously under the control of the mental health system. Accordingly, the remainder of the dissertation explores the experiences of women who are deemed both mentally disordered and criminal.

## **CHAPTER 3**

### **STUDY SETTING AND METHODOLOGY**

#### **CHAPTER OVERVIEW**

This chapter describes the data and methods used in the dissertation research to examine the experience of women on SMI probation in Maricopa County Arizona. As previously discussed, the purpose of this dissertation research is to explore pathways to the criminal justice and mental health system, provide examples of social control while in the system, and to examine characteristics that are predictive of women who do and do not successfully complete SMI probation. This project centers on the entry into, experience during, and exit from SMI probation for a group of women under the control of both the behavioral health and criminal justice systems. First, the pathways into these two systems (behavioral health and criminal justice) are explored for a subset of 65 women on SMI probation, considering specifically the impact that mental illness had on each woman's trajectory into the criminal justice system. Building on earlier research regarding gendered pathways, this group of 65 women is referred to as the "deep sample" (see Daly 1992, 1994). Second, utilizing interviews with the deep sample, as well as 10 months of field notes from the mental health problem solving court in Maricopa County, aspects of social control are analyzed for women navigating the criminal justice and mental health systems simultaneously. Third, 5.5 years of quantitative outcome data for offenders on the SMI probation caseload is examined to empirically test individual characteristics that are related to completion and failure on SMI probation for women, as

well as similarities and differences between women and men regarding SMI probation completion.

As illustrated in Appendix A, multiple data points were drawn on to complete this dissertation research. The project design included qualitative semi-structured interviews with women on the SMI caseload (n = 65) for deep sample analysis, ethnographic field notes from 10 months of observations in Maricopa County Mental Health Court (approximately 100 hours), and over five years of quantitative intake and risk assessment files for individuals placed on the SMI caseload (n = 2813); referred to as the “wide sample” (Daly 1994). Appendix A highlights these different forms of data collection as well as the timeline for data collection. Ultimately, this dissertation was designed to be broad in focus in order to more fully explore the world of a woman on the SMI caseload by learning about her individualized experience in her own words, to be exposed to her experience in the eyes of probation, the courts, and mental health professionals, and to draw upon multiple methods of research (semi-structured interviews, archival review, ethnographic observation, and quantitative analysis). Although far from a complete picture of “the experience” of SMI women on probation, it is hoped that analyzing each of these data sources will gain added academic insight to multiple experiences of a sample of women on SMI probation.

## LOCATION OF STUDY

Established in 1972, the Maricopa County Adult Probation Department (MCAPD) operates in the fourth most populated county in the United States with a population of 3,942,169 residents in 2012 according to the United States Census Bureau. MCAPD currently has over 1,000 employees serving 18 offices with an average monthly probation population of over 31,000 individuals (Maricopa County Adult Probation, 2011). The department has several specialty units including (but not limited to) a drug court, veteran court, DUI court, a domestic violence unit, a sex offenders unit, intensive probation unit, and severely mentally ill (SMI) caseload and court. The SMI unit's primary goal is to improve the probationer's chances at success by "close supervision, timely case management, education, and training, advocacy, and effective collaboration with community agencies" (Maricopa County Adult Probation, 2011, p. 19).

The SMI unit officially began in 1995 at MCAPD with one supervisor and a handful of officers. Before this time, specific "mental health" officers staffed these types of probation cases informally. Since 1995, the SMI unit has grown substantially. Highlighted in the 2011 annual report, the SMI unit had an average daily population of 680 individuals split between 17 SMI officers and two supervisors. The average daily caseload during 2011 was 1:37 (capped at 1:40)<sup>3</sup> with an annual program budget of \$1,356,135 dollars. SMI probation officers normally request to be assigned to the SMI

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<sup>3</sup> Standard officers normally have a caseload that is closer to 1:80.

caseload, and are selected by the SMI supervisors when positions become available.<sup>4</sup>

Selected SMI probation officers undergo unique training to assist in working with SMI offenders. The MCAPD SMI unit is well known, recognized statewide and nationally for their innovative model of supervision.

The SMI unit has its own mental health court to assist in the supervision of offenders on probation. The mental health court is a fully functional problem solving court with two commissioners overseeing one and one-half dockets each week. There are two morning dockets on Wednesday that begin at 8:30 a.m. and normally end around 12 p.m. One docket is a petition to revoke (PTR) court for more serious sanctions, and a second morning court is used for less punitive concerns. A second afternoon court docket begins at 1:00 p.m. This is also made up of non-PTR cases. Although the range in the number of cases per docket varies substantially from week to week, during the time of this study, a low of five cases to a high of 16 in a single court session was observed. The probationers who are mandated to the mental health court are normally chosen at the discretion of probation officers. Probation officers, probation supervisors, case managers, a community treatment liaison, a commissioner, and defense attorneys meet before each court session to review the cases of the day and to discuss a course of action prior to the

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<sup>4</sup> In discussions with SMI probation officers and supervisors, it was noted that sometimes officers are “recruited” to work on the SMI unit. For instance, the officer may have a significant background working with individuals with mental illness in social services or be seen as having a particularly good personality type or supervision style for the SMI unit (normally focused more on case management and service utilization aspects of probation over strict law enforcement). In these instances particular officers might be asked to submit their names to be an SMI officer when openings become available.

public court proceedings. A short recess is taken between case staffings and then the official court proceedings begin. These proceedings are attended by offenders in addition to the members of the courtroom work group explained above. The court serves several purposes including: to obtain service use or residential placement for a probationer, to bring the group together to discuss difficult cases, and to provide positive reinforcement and praise for the offender. The court also has the discretion to sanction probationers who are not doing well to a set number of days in jail (up to 120 days total across the span of one's probation) without having to revoke the offender's probation.

## **SMI PROBATIONERS**

During the entirety of the current project, the SMI caseload was capped at 680 probationers divided among 17 probation officers spread across eight field offices in Maricopa County. Probationers were placed on the SMI caseload in two distinct ways.<sup>5</sup> First, roughly 20 percent of probationers were referred to the SMI caseload by the sentencing judge. At the time of initial contact with the probation department, a presentence officer administers the Offender Screening Tool (OST) risk assessment.

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<sup>5</sup> For many of the processes involving how SMI offenders are screened and placed on the SMI caseload, there is no written or official procedure. As a consequence, much of the process has been pieced together by review of training manuals, interviews with supervisors, and discussions with SMI officers. These decisions are often highly discretionary.

There were two specific questions regarding an offender's mental health status.<sup>6</sup> If the judge determined there was significant concern as a result of this person's mental health history and current mental health status, he/she may mark that the offender has mental health terms as a part of his/her probation. These terms stated that the individual would be screened for mental health court and would actively participate in treatment, take medications as prescribed, submit to urinalysis when requested, and may serve up to 120 days in Maricopa County Jail as mental health days if not compliant. At the time of the study there were roughly 2,000 probationers on any given day in MCAPD who had mental health terms within their case files. At the time of sentencing the judge noted these terms, and if the judge also believed there was potential functional impairment on the part of the probationer, the judge would order the probationer to undergo an SMI caseload determination that is conducted by a SMI officer.

The second and more common way that a probationer was placed on the SMI caseload was through a referral from another departmental officer (normally, a standard caseload officer). If a non-SMI probation officer believed that an individual might be appropriate for the SMI caseload, the officer consulted an SMI officer about the probationer and requested a screening with the SMI unit.<sup>7 8</sup> A screening document was

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<sup>6</sup> The official questions asked to establish "mental health terms" on the pre-sentence investigation consist of the history of mental illness for a probationer and the state of current mental health functioning.

<sup>7</sup> Although the SMI caseload is primarily designed to deal with major mental illness, the unit also occasionally takes probationers with dementia, profound cognitive impairment and/or development disability.



used to determine if probationers were appropriate for the SMI unit. The document considered the probationer's mental health diagnoses, past mental health history, medication prescriptions and use, and functional impairment. Functional impairment was an important consideration for admittance into the SMI caseload. Probation officers noted that there were many individuals with significant mental health problems on probation who were not appropriate for the SMI caseload because they were not functionally impaired. Indicators of functional impairment addressed were whether a probationer had an IQ of 70 or less; had a history of suicide attempts, crisis interventions or psychiatric hospitalizations; had undergone Rule-11 proceedings<sup>9</sup>; had poor independent living skills; received specific types of disability benefits; or had a legal payee who controlled money and/or a legal guardian.

The decision to place the probationer into the SMI unit ultimately was a discretionary one completed by the screening SMI officer. The census changed weekly and at times of lower caseloads, the SMI probation officers reported some leniency, allowing individuals with lesser functional impairment onto the caseload. A probationer was never rejected from the caseload because of a full census, but there were historical

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<sup>8</sup> Referrals to the SMI unit by probation officers can vary widely. SMI officers reported that the most common problem was referrals to the SMI unit, which were the result of substance abuse or addiction with no mental health concern coupled with functional impairment when those individuals were not abusing substances.

<sup>9</sup> In the state of Arizona, a Court Ordered Evaluation or (COE) was completed to determine competency. Two doctors completed psychiatric evaluations and determined if the defendant was competent. If deemed incompetent, and in custody the defendant would undergo "competency restoration" in jail or in the community as long as they were considered "restorable to competency." Information on the Rule 11 process can be found online at <http://www.superiorcourt.maricopa.gov/superiorcourt/probateandmentalhealth/rule11.asp>

instances of probationers being waitlisted. No official numbers existed for those probationers who were screened and deemed inappropriate for the caseload. SMI probation officers reported, however, that they spent a considerable amount of time coaching other officers in their respective field offices about the types of probationers appropriate for the SMI caseload. As a result, rejection to the caseload is uncommon. The two primary reasons a probationer might be rejected for the SMI caseload was if their mental health symptomology was primarily a result of substance use, or the probationer did not have a DSM-IV diagnosable disorder and determined to be malingering. As stated, the important and determining qualifications for the SMI caseload were not only current mental illness (but probation has no statistics for the number of individuals on probation who also have been diagnosed with a mental health disorder), but also marked functional impairment. Screening officers considered carefully if the probationer had specific unmet needs, often as a result of a major mental illness.

It should be noted that the SMI caseload is designed to include the most psychiatrically acute probationers in Maricopa County. Likewise, the women on the SMI caseload were specifically chosen for dissertation research because of this fact. These women represented a group that historically would have been placed in long term institutionalized psychiatric care. In the contemporary system with “multiple nets” the women who made up the sample were juggled between the criminal justice and mental health systems while still living in the community.

## **STUDY APPROVAL**

Due to the potential vulnerability of criminally involved individuals living with mental illness, being granted access to probationers and obtaining project approval continued for a considerable amount of time. Beginning in the fall of 2010, I had multiple meetings with my dissertation chair to discuss the feasibility of completing a research project with individuals with mental illness in the criminal justice system. I also met with the chief of probation, the head of research for MCAPD, the deputy officer for the department and the deputy officer in charge of the SMI caseload to discuss potential working relationships. I then met with the supervisors of the SMI caseload and SMI probation officers to discuss their interest in working on the project and the different avenues available to access data. In January of 2012 I submitted an official application to conduct the study to the Director of Research at MCAPD and the Chief of Maricopa Probation; the application detailed study design, proposed project time frames and interview instrumentation. The application to collect data was officially approved in April 2012 with a letter of agreement provided by probation. As highlighted earlier, the study time line is illustrated as part of Appendix A.

Admittedly, study approval was a challenging and painstaking process. Because of the nature of the proposed study's participants- offenders with mental illness and functional impairment- it took approximately six months to gain approval from the Arizona State University Institutional Review Board (IRB). The lengthy process included three separate submissions to the Arizona State University IRB for full board

review over concerns about the vulnerability of the population and my clinical background. At the urging of the IRB, the initial application was eventually split into two separate parts: Tract 1 focused on archival, quantitative data and interviews with probation officers; and Tract 2, focused only on qualitative interviews with individuals on the SMI caseload. The research team and the Arizona State University IRB liaison were in frequent contact from January to May of 2012 with addendums to the initial proposal. These addendums focused on adding additional safeguards for the individuals who would be interviewed, modifications of certain questions, and to provide specific details about my past work as a clinician and clinical interviewer of persons with pervasive mental illness. In late May of 2012 official approval was granted to commence with data collection for the full study.

## **STUDY DATA POINTS**

### **Mixed Methods Research Design**

This dissertation project employed a mixed methods research design. Qualitative interviews, archival record review, ethnographic field notes/observation, and quantitative intake and risks/needs offender data were all used to examine the experience of women on SMI probation. Although mixed methods research has become popular in the social sciences recently, “the approach remains underappreciated and under-utilized in contemporary criminological research” (Maruna 2011, p. 123). Maruna noted that although mixed methodology often took considerably more time and was more complex,

it had been criticized by both qualitative and quantitative researchers. Maruna (2011), highlighting the work of Greene et al. (1989), identified the multiple ways that mixed methods research is particularly beneficial to answer research questions. Included in these are *triangulation* in order to provide “convergence and corroboration” between methods and *Expansion* to increase “the range or breadth of the research” (p. 127)

By using both qualitative and quantitative data, this study was able to more systematically analyze data, drawing from multiple viewpoints (the women on SMI probation, probation officers, and other members of the courtroom work group). Due to time constraints in completing the dissertation, funding limitations, and access and privacy issues, I was unable to complete a longitudinal project with multiple interviews with the deep sample of women on SMI probation. Therefore the project was unable to establish how each woman left SMI probation and either successfully reintegrated into the community, terminated her probation to return to prison, went to long-term psychiatric hospitalization, or recidivated and returned to incarceration.<sup>10</sup> Although the project was unable to glean that information for the deep sample, because there was access to five years of quantitative data from SMI probation, the project was able to empirically examine factors associated with completion and non-completion of SMI probation over a longer time frame. Additionally, although interviews with men on the

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<sup>10</sup> Although the research design only allowed completion of a single interview with each participant in the deep sample, I was able to learn (at least partially) what occurred with probation completion/termination for several of the women I interviewed. By completing case file reviews after the interview and sitting in mental health court for 10 months after many interviews were completed, I sometimes learned follow-up outcome information about particular women.

SMI caseload were not a part of research for my dissertation, the quantitative data allowed for comparative analysis by gender. Finally, as shown in Table 1, having a multi-year quantitative data set provided an opportunity to conduct side-by-side comparisons between the deep and wide samples of women on the SMI caseload. This comparison is discussed in more detail below. Overall, by using multiple qualitative methods, with additional quantitative analysis, more fully triangulated results were possible. Likewise, the ability to expand significantly and in greater complexity on the scope of my primary research question was possible due to employing multiple research methods.

### **Quantitative Intake Data**

The quantitative analysis and construction of variables is discussed in detail in Chapter 6, but to provide an overview of each of the study data points, the data are also overviewed here. The quantitative dataset encompassed 5.5 years of SMI intake data from January 1<sup>st</sup> 2007 to July 1<sup>st</sup> 2012; the point when data collection for the project officially began. This yielded a sample of 2,813 participants. However, the current Offender Screening Tool (OST), which incorporated many of the life event measures used in quantitative analysis was not adopted and implemented until mid 2008. As a result, these early cases were dropped in the subsequent quantitative results leaving a final sample of 2,262 participants of whom 758 were women.

In addition to demographic information, criminal justice conviction history, and current and past probation sentence details and outcome, the quantitative data files

included Offender Screening Tool (OST) intake assessment scores by question. The OST is a validated Evidenced Based Practice (EBP) intake instrument used by all 15 counties in the state of Arizona. The OST is completed by a presentence officer at the initial meeting between probation and the offender (Ferguson, 2011) and is included as part of the presentence investigation report. It gauges functioning of the offender on 10 specific domains that are summed up and averaged to provide an overall criminogenic need and risk of reoffending score for the individual probationer. The 42-item assessment combines an interview format between the presentence officer and the probationer, review of the probationer's file, as well as individual clinical judgment made by the presentence officer on some level of functioning questions (Ferguson, 2011). The 10 domains consist of physical/medical health, vocation/finance, education, family and social relationships, residence and neighborhood, alcohol, drug abuse, mental health, attitude and criminal behavior. All officers undergo training to properly administer the OST. The quantitative data were used to provide summary statistics for a large sample of offenders on the SMI caseload; to make bivariate comparisons between women and men and between minority and non-minority women; and to conduct multivariate analysis on factors related to program completion or recidivism and termination from probation.

This analysis is examined and reviewed in detail in Chapter 6.

### **Qualitative Interview and Ethnographic Data Points**

To conduct the qualitative analysis, I used a triangulation technique (e.g. see Yin, 2011, p. 81) to examine the experience of an SMI offender. I did so using multiple data

points. First, I analyzed 10 months of mental health court observations (roughly 100 hours). Second, I conducted in-depth interviews with 65 SMI female probationers. I also completed a full review of each woman's case file after her interview.

As mentioned above, MCAPD has its own mental health court that runs 1.5 dockets each week - split between two commissioners. During the data collection period, the two morning sessions, (i.e. one petition to revoke probation docket and one less punitive docket aimed more at problem solving) operated next door to each other. Each Wednesday afternoon a second less punitive docket also occurred. Before court proceedings each week, the SMI courtroom workgroup staffed each of the cases that would be on the docket for the week. In these meetings the courtroom workgroup discussed the best course of action for the offender and provided suggestions and opinions for the judge.

The discussions among probation officers, the lawyers and the judges, and the interactions between probation officers with other officers, with their SMI probationers, and with the clinical team were all observed. I compiled field notes on these different activities using the techniques of Emerson, Fretz and Shaw (1995), which focus on the details of "social and interactional processes" engaged in by members of the courtroom work group (p. 11). These observations enabled me to provide additional "thick description" (Geertz, 1973) about the actual experience of probationers in court and while on probation. This ethnographic research provided a better understanding with regard to probation officers perceptions of and attitudes toward specific clients as well as the



working relationships of the courtroom workgroup (that may influence what happened to a probationer during court and after). SMI court observations also allowed me the opportunity to talk with probation officers in their natural environment, to ask questions, and to discuss the types of cases appearing before the judge that day. Importantly, the SMI courtroom observations also provided me access to the offenders, allowing on a few occasions opportunities for informal conversations and introductions to the research project. Emerson et al. (1995) explained that this building of relationships with and discussions between the researcher and the individuals they are observing can, “Provide clues to understanding the more subtle, implicit underlying assumptions that are often not readily accessible through observation or interview methods alone” (p. 11).

The final qualitative data point is the central endeavor of the dissertation. To better understand the experience of a woman on the SMI caseload, in addition to the probation officer working with her, I conducted in-depth semi-structured interviews with 65 women on the SMI caseload. The demographics of the 65 women on the SMI caseload interviews are discussed in detail in the next chapter and the characteristics of this deep sample are illustrated in Table 1.

### **The Sample and Conducting Qualitative Interviews**

After initially obtaining approval to complete the dissertation project, I met on multiple occasions with the supervisors of the mental health caseload. Together we discussed ways to invite women on the SMI caseload to participate in the research study. Additionally, we brainstormed on the best course of action to exclude individuals who

were not competent to complete the interviews or probation officers who did not want to participate in the research project. SMI probation supervisors each reviewed the interview instrumentation too, noting any questions that might not be best stated for women on SMI probation to fully comprehend. This also provided an opportunity to discuss concerns about the research design, question clarity, and to troubleshoot with the SMI supervisors. Each of the SMI supervisors had a substantial amount of expertise working with SMI offenders, and both had over five years supervisory experience on this specific caseload. Discussed in detail later in this chapter, I initially was worried that women on SMI probation with significant histories of trauma would not feel comfortable enough to open up about these experiences to a male interviewer.<sup>11</sup> For instances like this, the SMI supervisors were able to provide suggestions based on their many years working with SMI offenders. During this phase of the project I also was able to pilot test

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<sup>11</sup> In the initial research design, I had multiple conversations with my dissertation chair about the feasibility of having female interviewers complete interviews. The final decision was made that I would conduct all interviews after the Arizona State University IRB voiced concerns over having interviewers without significant clinical expertise on the population. The project did not possess the funds to hire clinically trained and licensed female interviewers. Additionally, and importantly, research has also discussed reliability concerns that exist when female interview other females (e.g. see Belknap 2006; Morash, 2010) where issues of social class and race also play a factor. Miller (2012) has also examined the important insights that “social similarities and differences” between interviewer and interviewee can provide. Finally, probation supervisors were quite confident that women on the SMI caseload would be willing to discuss private matters with a male interviewer given their general (perceived at least) openness with their male SMI probation officers, case managers and mental health treatment providers about their history. That being said, it is assumed that some women would undoubtedly feel more comfortable discussing these most private matters with another female. Others might have problems or be unwilling to discuss these matters with anyone, regardless of gender.

my interview questionnaire. Two probationers and one probation officer were given the interview as pilot participants so that I could practice timing and transitions, length, and any concerns with insight or understanding of questions. As a result, minor transition and clarification revisions were made to the interview guides.

After initial meetings with the SMI probation supervisors and modifying the interview guides, I attended an SMI probation officer meeting to introduce myself and the research project. At this meeting questions about the project were answered and study goals explained. At the time of the meeting all officers were asked to write down their contact information and they were each later emailed to set up a time to discuss the project. In the following weeks each of the probation officers was contacted to answer any follow-up questions and to ask if they would be willing to let me introduce the research project to women on their caseload. Each probation officer was given the choice on whether or not to assist in the project. Every officer on the unit during the data collection period agreed to assist in the research project (n = 24).

After initial phone contact, I met with each probation officer individually. At these interviews I was normally provided a tour of the particular field office that would serve as extremely helpful in the months after so I would know my way around the different offices. Additionally, this meeting allowed an opportunity for me to once again discuss the aims of the project and what was the best way to interview women on the SMI caseload at each field location. At this meeting each officer printed a copy of their current probation caseload and eliminated any potential women on their caseload who

would not be able to complete an interview because she was not legally competent, or currently inaccessible because of inpatient treatment. At this point in the research process the importance of conducting interviews with as many variations as possible from each officer's caseload was explained. I told officers I was interested in interviewing women with varying psychological disorders, criminal backgrounds, familial situations, and some women who were and were not successfully progressing through probation.

Over time, the probation officers became invaluable assets for recruitment of participants, answering questions, and answering questions based on case file reviews. With some officers, I had up to 15 follow-up and informal conversations about specific aspects of their work. The officers often provided more specific explanations of unique situations that would occur in their collaboration with the court and/or the mental health system. These conversations normally occurred during breaks in their office days, or during breaks in their work on days they were in court. I often took notes on these conversations while they were occurring, and I always added field notes on important topics to my journals after they occurred. These "gatekeepers" (Noaks & Wincup, 2004, p. 56) were paramount in the successful access to the field offices and getting through security, assisting in securing interviews with women on SMI probation, and providing detailed explanations of the nuances (often informal and not in writing) of their work and the mental health court.

## **Interviews with Women on SMI probation**

On any given day, women make up approximately 30% (200 at the beginning of data collection) of the SMI caseload at MCAPD. Because of the wide variability of participants (several were hospitalized and/or deemed legally incompetent), the goal of sampling was to conduct interviews with approximately one-third of the women on the SMI caseload. The final sample of 65 represents women on the caseload at the time of data collection from July of 2012 to May of 2013.

As noted, the participants interviewed were not randomly selected; rather the sample was purposive in nature. As quoted in Yin (2011:88) Kuzel (1992:37) stated that the goal in purposive samples is to, “obtain the broadest range of information and perspectives on the subject of study.” Every effort was made to produce a sample of SMI women on probation that would be representative of a woman offender on the SMI caseload in general. The goal was to complete interviews with ethnically diverse women with variation in age, attitudes about probation, psychological need, criminal offense, and geographic locale within the Phoenix metro region. Each of the SMI probation officers had supervised at least two of the women interviewed as part of the study. Any probationer who had a developmental or cognitive disability or was functionally impaired to the point that she could not consent for herself, had a legal guardian, *guardian ad litem*, or had been deemed legally incompetent at the time of the interview was excluded from participation.

Potential participants became aware of the study when the probation officer presented potential participants with a flyer or explained the interview when meeting with them during regular office visits. If the probationer was interested in participating, the probation officer would then introduce the probationer to me, and I would explain the project in detail to each woman inviting her to participate in the project. Participants were also provided a detailed information letter. Primarily, interviews occurred on the office days when probationers regularly reported to their probation officer on a monthly basis. The interviews took place in a private interview room at each field office in order to ensure privacy and confidentiality of each participant. The interviews were completed across eight probation offices during probation officers scheduled office days. From August 2012 to April 2013 I attended each officer's probation office days (where they meet with their probationers) in order to interview women (ranging from 2 to 6 independent visits per officer and depending on the number of eligible women each officer had on his/her caseload who might be interested in being interviewed). As a thank you for participating, the probationers were given a \$20 gift card to a local retail store or restaurant. All interviews were audio recorded with the permission of the participant and all participants were guaranteed confidentiality.

### **Comparison of “Deep” and “Wide” Sample**

The project research design did not allow for random sampling. After completion of interviews with the sample of 65 women on SMI probation, Table 1 was constructed to compare the “deep” qualitative sample (n = 65) and the “wide” quantitative sample (n =

785) on several demographic characteristics. Overall, the two samples are quite similar. Approximately two-thirds of both samples are White (66.2 percent versus 66.8 percent) while a little less than one-fifth of both samples are African American (18.5 percent versus 17.8 percent). The deep sample has fewer Hispanic women as opposed to the wide sample (7.7 percent versus 12.7). Relationship status for divorced/separated and single women was also quite similar, although married women were a little more prominent in the deep sample (16.9 percent versus 11.7 percent). Offense type for each group was also similar, with violent crimes being a little more prevalent in the deep sample (27.7 percent versus 23.6 percent), non-violent property being somewhat less prevalent in the deep sample (26.1 percent versus 29.4 percent) as were substance-related offenses (33.9 percent versus 38.2 percent). As also shown in Table 2, the two samples were generally consistent in a number of additional characteristics.

## **INTERVIEW DESIGN**

The SMI probationer interview guide is provided in Appendix D. The SMI probationer interview was approximately 45 minutes to one hour in length. The interviews were initially designed to be longer, but the pilot testing revealed that some women would not be able to complete extremely detailed life history style interviews. Due to the nature of their disorder, coping abilities, or medication/drug side effects some women had problems remembering specific and detailed moments of their past and discussing such matters had the potential to trigger memories of profound trauma. As a

result, questions involving the daily specifics of drug use, trauma, medication and psychiatric care were eliminated in favor of more global discussions of key areas of interest.<sup>12</sup> Daily routines, childhood risk factors, relationships (romantic, with the criminal justice system, with the behavioral health system, and with social service agencies), psychological history and treatment, substance abuse history and treatment, criminal justice history, specific economic situation, and past and present feelings about each were discussed in general terms during the interviews. Adopting a similar interview style to Websdale (1993), I normally allowed the participants to lead the conversation as we discussed each of the central content areas I wished to address. Although each of the central topics was addressed in each interview, due to the conversational style used during interviews, some women chose to focus in greater detail on specific aspects of their lives. For instance, whereas some women spent the most amount of time talking about relationships with others, other women spent more interview time addressing mental health history, trauma experiences, or problems with the criminal justice system.

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<sup>12</sup> One example of a way an interview became more generalized or “evolved” over time would be discussions about psychiatric medication. Some women were unable to specifically provide the names for each of the medications she took, how long she had been prescribed each, and the specific side effects of each medication. As a result, I began to ask participants to provide more generally the “types” of psychiatric medications they were currently prescribed and in what ways these medications might be helpful and/or harmful. Another example would be asking women to talk about multiple psychiatric hospitalizations from their youth. Often not being able to recall specific details from each hospitalization, but remembering the experience generally, I would ask the participant to describe her experiences with psychiatric hospitalization generally. (When women were able to provide specific detail of each, that information was recorded).



Information missed during the interview was filled in when I reviewed each participant's probation case file review discussed below.

In examining the make-up of the interview domains, the questions follow no known previous interview guide specifically, but instead were inspired by multiple different qualitative research projects and publications on the topic. The interview questions and follow-up probes (as well as material reviewed in files) were heavily influenced by the work of Daly (1992,1994). Although she did not complete interviews with offenders, but instead reviewed detailed pre-sentence reports, many of her areas of concentration focused on the topics of abuse and neglect, family circumstance growing up, schooling, economic situation, employment record, children, prior criminal record, suicidal behavior, and psychological problems (including institutionalization and contact with mental health professionals). Each of the topical areas informed the interview questions in this project.

Morash's (2010) text regarding community programs and services for women in community corrections was also particularly helpful in conceptualizing interview questions for both probationers and probation officers. This work significantly informed this dissertation because it centered on women in community corrections and compared a group of women undergoing gender responsive programs on probation in comparison to those in a more traditional probation program. Morash (2010) surveyed both probation officers and probationers. Importantly, many of her domain areas addressing probationer income and work, children, school, mental health, criminal history, substance abuse, and

social networks were similar inquiry areas to those described here. These same ways of establishing pathways had been identified in earlier work (e.g. Daly, 1992,1994; Reisig et al., 2006).

Studies focused on samples of women (and some studies with both women and men) who were in the criminal justice system were also helpful in my formation and completion of qualitative interviews. Books employing qualitative methodology like Wright & Decker (1994) provided consideration of questions in relation to the specific experience and viewpoint of the offender. Likewise, Owen (1998) and her ethnographical account of Central California Women's Facility assisted in understanding of feminist methods in ethnography. In addition to Owen (1998), the foundational work of Miller (1986) and her interviews with "Street Women" in Milwaukee allowed for the formulation of fuller questions for women surrounding their pathways and experiences that led each to the criminal justice system (as did the aforementioned [Daly, 1994]). Miller's (1986) analytical style also inspired the formation of my own early interview analysis and interviewing technique. Regarding her research study she stated, "Although the same wide topics were introduced during each interview, many of my questions changed over time. Initial tape interviews were played again and again after being recorded. Tentative hypotheses and emergent behavior categories arose out of the hours of listening" (Miller, 1986, p. 26). Similarly, I adopted a style of tweaking interview questions based on listening to each interview recording numerous times.

Richie's (1996) text on the gender entrapment of black women was also considered extensively. Conducted at Riker's Island Correctional Facility in New York, Richie drew upon her prior research and interview experience to help inform her interview and research design. Before beginning my terminal degree program, I worked for a few years as part of a research project investigating the psychiatric needs and public health disparities of formally detained youth in Chicago. As part of a team of researchers tasked with designing and conducting interviews about substance use/abuse, psychiatric need, and risky sexual behavior, this endeavor helped inform my dissertation research questions about similar subject matter with marginalized participants. As Richie described of her own experience conducting life history interviews, "My interview schedule and the research design were thus informed by firsthand knowledge of the population and the setting, as well as my past experience in the field and my subsequent interpretation of the broader social context of the study" (Richie, 1996, p. 25).

In designing and conducting interviews, perhaps no book was more helpful than Websdale's (1993) ethnography *Rural Woman Battering and the Justice System*. Every attempt was made to frame interview questions in the same non-threatening manner as Websdale and to address each of the interview's general topic areas with participants, as opposed to asking every question verbatim on the interview guide during each interview. Like Websdale, I am a white man completing a research project with significantly disenfranchised women who are under the social control of the criminal justice system. Our social locations (mine and the women being interviewed) were considerably different

and our “experiential incongruence” and “cultural incongruence” (Websdale, 1993, p. 223) varied substantially. Furthermore, many of these women have long histories of violence and abuse at the hands of men, and some are living with Post-Traumatic Stress Disorder (PTSD) as a result of this victimization. Because potential “gender incongruences” between interviewer and respondent existed, I relied heavily on my clinical training to provide participants a safe and respectful environment in which to discuss their experience and aspects of their life histories. During interviews I worked to be constantly aware of my spacing from the respondent, where I sat in the room, and I was cognizant of my body language and tone as well as the respondent’s tone, body language, and demeanor. For example, when talking with participants in interview rooms at probation offices, I would make a point to take a seat where the probationer normally is located, allowing the participant to have the chair and side of the interview table that was normally reserved for the probation officer. In most offices this also allowed the woman being interviewed the ability to see anyone walking past through the interview room window (perhaps aiding in her comfort). Additionally, I always let the participant decide if she wanted the door opened or closed in an attempt to provide her the utmost privacy and also to make her feel as comfortable as possible (with the door fully closed or fully open if she preferred). During one interview a woman discussed at length her abuse at the hands of men followed by a conversation about her PTSD symptoms. She mentioned that she hated people walking behind her and even though the room was enclosed and the door was closed, her back was facing the door. Upon my suggestion,

we moved the desk and location of the chairs so she could feel most at ease. She thanked me and then discussed her experience in the mental health and criminal justice system for over 45 minutes without incident.

While interviewing participants I attempted to make the women feel as relaxed as possible and reminded them of their rights as a participant in a research study. Each participant was provided with a detailed information letter about the research study and explained the goals of the study, my dissertation work, and that I was not affiliated with the probation department or the criminal justice system in any way. I pointed out multiple times to each participant that she was free to decline to answer any question she wished, and I would immediately move on to the next topic area. There were only three instances (twice around sexual abuse and once regarding a specific psychiatric hospitalization) where the participant declined to discuss a topic. Case file reviews in these instances provided missing details regarding the situation. In the end I am not fully certain how much being a majority male interviewing marginalized women, or incongruent social statuses, influenced interview dynamics.<sup>13</sup> However, based upon completing follow-up case file reviews with each participant, the narratives were overwhelmingly consistent between the participant's account and the reports that professionals provided in the file.

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<sup>13</sup> In a chapter about qualitative interview research and the analysis of gender and crime, Miller (2012) discussed at length the concept of "social distance" (p.59) between interviewer and participant. She suggested there are notable merits to having diverse teams of interviewers to analyze the valuable and disparate narratives that can occur based on social distance between interviewer and participant. Despite devoting considerable attention to this topic, in the end I am unable to know in what ways the interviews might have changed with multiple interviewers and different social distances.

Aside from interviewer/interviewee dynamics as well as reliability of data concerns, precautions were also taken to insure each participant's competence at the time of the interview. Interviewing a vulnerable group of women with significant mental health problems required that I pay close attention to clarity of response and any potential decisional impairment (inability to respond fully because of cognitive deficit or psychological concern) during the interview. I labored carefully with each probation officer to screen out any probationer who might be decisionally impaired, which might prevent her from adequately being able to consent to an interview. At each interview I conducted a simple mini-mental assessment that made sure the participant was oriented to person, place, and time. Because of close monitoring by the probation officer and their intimate knowledge of their probationers' decisional impairment needs, as well as the initial screening before any interview began, all 65 participants were able to complete the interview without incident and all data were able to be analyzed.

## **INTERVIEW NOTES AND CASE FILE REVIEWS**

After each interview was completed, detailed notes about the interview, any important information that was conveyed when the audio recorder was not running, the demeanor of the participant, personal thoughts and feelings about the interview, and any other relevant information were all recorded. If multiple interviews were completed in a single day, I would audio record these notes after the completion of the interview and transcribe that evening so that different aspects of particular interviews would not be

mixed up. Each evening after completing an interview the audio recording was reviewed and notes about the circumstances of the interview were recorded. At this time I also began to hypothesize about emergent themes as well as noting new hypotheses. This process was especially helpful when returning to probation to complete a case file review on every woman on SMI probation. Listening to the audio recording before completing those case file reviews provided the opportunity to note any information that needed to be clarified in the case file, any inconsistencies to be reviewed, and importantly - any target information that had not been inquired about during the interview.

Case file reviews varied based on my interviewing schedule as well as the availability of the probation officer. Whenever possible, they were assessed within one month of the initial interview. The file was reviewed first to assess for overall reliability between criminal justice and probationer reports. All past psychological information in the chart was reviewed as well as the pre-sentence investigation report, the police report, any probation officer notes pertinent to the case, and all past criminal history information. Notes that added any clarifying or additional information to the interview were included at the end of each individual's interview. Detailed notes on the information provided in each case file review were later transcribed.

## **TRANSCRIPTION, FACT-CHECKING & CODING ANALYSIS**

Each audio file for the 24 probation officer interviews and 65 probationer interviews was transcribed and then reviewed in detail, matching the audio and

transcription files. Initially I completed all transcriptions. Although an extremely lengthy task, it also proved to be a substantially valuable one, helping me to be closely critical of my interviewing style, to recognize points where I cut off a respondent when I should not have, and opportunities I missed to probe further with follow-up questions. Due to time limitations and to pivot to other work on the project, a transcriptionist completed the word processing of later interviews.

After the transcriptions of each interview were complete, I fact checked the interview by completing a full review of each transcription against the audio recording to clear up grammatical and spelling mistakes and to add in any missing words or sentences. This was a slow yet important task due to the amount of acronyms and language specific to probation, medications and psychiatric illness, and Arizona social service systems with which the transcriptionist was not familiar. This also allowed me to begin to think about first level codes, and to consider early theme development utilizing constant comparative analysis (Glaser & Strauss, 1967; Lofland & Lofland, 1984; Silverman, 2011; Yin, 2011 among many others).

After completing a full fact check of the 65 qualitative interviews completed in the study, higher level coding began by first “compiling” (Yin, 2011) all of my research data. At the start of the project I had significantly underestimated the difficulty involved with this task. For several weeks I matched the unique identifier for each interview with her case file review notes, interview field notes, and reviewed all my ethnographic court notes for instances when this individual may have been in court. Using NVIVO 10



software, I compiled all my research data into a single working project partitioned by specific participant.

Following the analytic phases of Yin (2011) data was then dissembled by reviewing each case several times to develop a pathway to the criminal justice system for that individual. Discussed for the entirety of Chapter 4, all qualitative data were subsequently “disassembled” and “reassembled” multiple times to develop pathways to the criminal justice and mental health systems for each of the 65 probationers. For this process I constructed biographies for each of the women in the deep sample in a manner similar to prior gendered pathways scholars (e.g. See Daly, 1992, 1994; Morash, 2010; Reisig et al., 2006). For each of the women I categorized a dominant pathway based on her past substance abuse, history of victimization and trauma, psychological symptomology, history of criminal justice involvement, and relationship quality. These pathways are explored in Chapter 4. Additionally, all pieces of the qualitative dataset were coded to investigate aspects of social control in multiple ways. These aspects of social control are the topic of Chapter 5.

## **THE REFLECTIVE SELF AND DATA COLLECTION CHALLENGES**

### **The Reflective Self**

Qualitative methodologists have considered at length the fact that we come to a research project and to an analysis with our own worldviews (what some refer to as bias). Creswell (1994) has suggested that presenting our biases upfront will help strengthen the

internal validity of our findings. Similarly Yin (2011) stated that it is important as a researcher to reveal your “reflective self” so that the audience can make their own judgments about your research. Other researchers consider the term “reflexive triangulation” (Hammersely & Atkinson, 1995; Noaks & Wincup, 2004) whereby scholars reflect on the notion that, “They are part of the social world they are examining” (Noaks & Wincup, 2004, p. 9).

I have discussed in the preceding pages aspects of my own “reflective self” (Yin, 2011, p. 270). Among these are that I come from a position of power based on my race, gender, and educational status interviewing disenfranchised women with mental health diagnoses who are in the criminal justice system. Also, my training and my experience have influenced my own worldview. I am trained in clinical psychology and worked as a mental health counselor on a locked psychiatric unit with children and adolescents for nearly two years. I have attended countless case staffings as psychiatrists, psychiatric nurses, and social workers discussed specific individuals. Additionally, my graduate internship training was as an inpatient substance abuse detoxification specialist conducting clinical assessments, individual and group counseling sessions, and case management services. These experiences have undoubtedly shaped my research and my research lens. That being said, I have made every attempt while conducting interviews to be mindful of my own views of matters regarding diagnoses, medication management, and formal social control (among others). I believe my experience also served as a strength for my research by providing me with an additional skill set to conduct difficult

interviews in a limited amount of time. Also, my lens provided me an intimate understanding of many of the processes the women on SMI probation discussed involving psychiatric care, trauma and addiction.

### **Data Collection Challenges**

In much the same way that it is important to highlight my own inherent bias in the study, it is also important to highlight challenges I encountered during the data collection process. Although I was initially worried I would be unable to find anyone to agree to be interviewed, the opposite was true. I interviewed eight women within the first two weeks of data collection, and began to feel overwhelmed with managing all phases of data collection. At the suggestion of a dissertation committee member, I took this opportunity to slow down data collection for a few weeks and immerse myself in the literature, paying closer attention to specific aspects of gendered pathways and gendered social control. Due to the difficult nature of these interviews and the perceived difficulty of securing future interviews, this was a high anxiety endeavor. However, when I returned to the field several weeks later, it was a decision that paid off significantly. I felt that I was a better interviewer after this point, as I had been able to “get my feet wet” interviewing, and then return to the literature and other studies to better inform my future direction while also listening multiple times to my early interviews.

Interview data collection was suspended a second time for a few weeks so that I could concentrate on completing transcriptions and further consider the emerging themes that were developing in the data. Transcribing interviews was often a difficult task; I

occasionally felt like it was time being mismanaged where I might be losing additional opportunities to complete interviews. As discussed by Miller (1986) in her study of *Street Women*, transcribing and reviewing provided me with the opportunity to test tentative hypotheses in later interviews and to be able to clarify thematic questions that would have been lost had I not immersed myself in transcription and fact checking activities. As mentioned, in the interest of time, and to be able to finish the project, at this point in the data collection process I had to abandon transcribing every interview. Each of these breaks is highlighted in Appendix A where the project timeline is described.

Interviews were suspended a final time for a few weeks nearing the end of the project. Overwhelmed by the sheer amount of data that were compiled and needing to begin higher-level analysis, I organized all pieces of information employing Nvivo 10 qualitative analysis software to begin to create a central database.

### **Leaving the Field**

Perhaps the most difficult task involved in my research design and data collection was leaving the field. Once frightened that I would not be able to get any individuals to discuss their experiences, or that I would never become proficient in taking quality field notes during court, I now wholeheartedly enjoyed completing both activities. My informants and gatekeepers had provided access to a plethora of data and terminating from the field made me also fear that I might have missed an additional data point I would later want or need. Noaks and Wincup (2004) discussed leaving the field for qualitative researchers at some length. They wrote, “Leaving the field physically can be

relatively easy but getting away emotionally can prove more challenging” (p. 69). The authors continued, “The analysis process serves as a constant reminder of who researchers have met, the stories they have told and the emotions they displayed when telling their stories” (p. 70). I found this to be very true of my own experience. In the end, these were emotionally exhausting yet extremely interesting interviews to complete and disengaging from the field fully also meant that the laborious task of making sense of the copious amounts of data needed to begin.

### **Overview of Results Chapters**

This chapter focused on the research design of the current dissertation project. The mixed methods research design was explained, as was the entire process of data collection and analysis. I now turn to the results chapters to provide detail on the experiences of women on SMI probation navigating both the criminal justice and mental health system. To do so, first, Chapter 4 examines the pathways to the criminal justice and mental health systems for the deep sample and the impact mental illness has on each woman’s criminal activity. Second, Chapter 5 addresses aspects of expanded social control that occur for women who are on SMI probation by examining interviews with the deep sample of women, case file reviews, and court field notes. Finally, Chapter 6 utilizes the quantitative data to empirically test characteristics that may impact completion and revocation for women on SMI probation when compared to men.

## **CHAPTER 4**

### **PATHWAYS FOR WOMEN ON SMI PROBATION**

#### **CHAPTER OVERVIEW**

The current chapter focuses on the different paths women on SMI probation take to the criminal justice system and how each initially comes into contact with the mental health system. Chapter 2 revealed that in the last few decades gendered pathways research has played an important role in criminology by examining the unique ways that women come to the criminal justice system (e.g. see Belknap, 2006; Brennan et al., 2012; Daly 1992, 1994; Morash, 2006; Huebner et al., 2010; Reisig et al. 2006; Salisbury & Van Voorhis, 2009; Simpson et al., 2008; Richie, 1996). These scholars, among many others, have provided examples of specific life-course events prevalent among women who enter the criminal justice system; history of abuse and neglect, substance use and abuse, domestically volatile adult relationships, educational issues and economic marginalization. Social scientists have also reported on the importance that mental health problems contribute to the criminal justice entry of girls and women (Belknap & Holsinger, 2006; Boyd, 2009; Chesney-Lind & Pasko, 2004; Daly, 1992, 1994; Morash, 2010; Richie, 2001). This previous scholarship is used as a model for the current analysis - specifically the foundational work of Daly (1992, 1994), and the subsequent work of Reisig, et al., (2006) and Morash (2010).

In this chapter the demographic characteristics that served as turning points in the life-course for women on SMI probation are first examined. Second, seven ways that

initially led women on the SMI caseload to the mental health system are discussed; family/guardians/friends, being adjudicated delinquent as a minor, adult criminal justice system involvement, school, drug rehabilitation, suicide attempts, and self-referral. Three primary groups of disorder in the sample are reviewed in detail, including *Psychotic Disorders*, *Mood Disorders*, and *Anxiety Disorders*.

After highlighting the ways women enter the mental health system, prior gendered pathways research methods were used to investigate how the “deep sample” (Daly, 1992, 1994) of 65 women labeled “functionally impaired” and “significantly mentally ill” each entered the criminal justice system. I used the prior work of Daly (1992, 1994), Reisig et al., (2006), and Morash (2010) as a guide to construct a pathway for each woman. More specifically, I created a composite biographical sketch by examining the interview content with each of the women in the deep sample. I also conducted a thorough review of each woman’s probation case file. Following Daly (1992, 1994) and Reisig et al., (2006), I coded biographical content in the key areas of childhood upbringing, substance use history, employment, romantic and familial relationships, education, parenting, and criminal justice history. In addition to these factors, I also explored mental health treatment history and diagnosis, as well as aspects surrounding the specific crime that resulted in each woman being placed on the SMI caseload.

Bearing in mind these different factors, I examined the unique content of each of the women’s biographies, eventually separating the deep sample into three distinct categories – *Addiction-Dominated Women*, *Violence-Dominated Women* and *Economics-*

*Dominated Women.* Within those three major categories, six distinct pathways emerged that I describe below. The chapter concludes by contemplating how the symptomology of mental illness may have impacted different pathways for women interviewed on the SMI caseload.

## **DEMOGRAPHIC PROFILE OF THE DEEP SAMPLE**

Table 1 presents a detailed breakdown of the characteristics of the deep sample. Nearly two-thirds of the sample identified their race as White, and nearly one-fifth was Black. Hispanic women were 7.7 percent of women interviewed, and the sample was rounded out with 8.6 percent identifying as Native American or Pacific Islander.

Generally, women in the deep sample had a significant amount of education. Over 15 percent had either a two-year/vocational or four-year college degree. Overwhelmingly, the most popular two-year and four-year degrees were for nursing. Other professional certificates included cosmetology and fashion design. Additional four-year degrees were in business and social services. Although over 30 percent had some college, these classes were often only a viable option when the women were incarcerated. Several women noted that they dropped out of high school, but later prison sentences allowed for the opportunity to complete their high school degree and enroll in college or vocational courses. That being said, nearly one-third of the women interviewed did not complete high school. An additional five women never entered high school. In these instances the women were usually in and out of residential facilities, psychiatric care, and/or living on the streets and not attending school on a regular basis.



Although many women in the deep sample had educational opportunities, employment was a difficult prospect. Only 7.7 percent of the sample was employed at the time of the interview and only two of the women who were interviewed had a full time job. Many of the women were unable to work at a steady job because of their mental health and emotional problems. Others were able to work at least part-time, but had enormous struggles finding work they could manage in an establishment that would also hire someone with a criminal record. The majority of the women were in very difficult financial situations, relying on the help of family and friends (if available) to assist in providing transportation and/or housing. Additionally, many women cycled in and out of homelessness as their financial situations changed. Almost the full sample (94 percent) received at least one form of government financial assistance. Women on the SMI caseload typically received multiple types of assistance including Social Security Disability Insurance (SSDI) for a major emotional or physical health problem that kept them from working outside the home. An overwhelming majority of the women also received state supported medical insurance due to financial need.<sup>14</sup> Many women reported getting monthly food stamps, while others were unable to receive food stamps or lost the services because a felony drug conviction made them ineligible. A few women also discussed receiving different forms of housing assistance that normally helped them significantly.

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<sup>14</sup> In the State of Arizona Medicaid is known as AHCCCS (Arizona Health Care Cost Containment System)

Roughly three-fourths of the women in the deep sample had biological children, although many women had no relationship with their children or were not the primary caretakers for the children. Of those women, 16 (33.3 percent) assisted raising their children or had full custody. Many of these women had lost custody of children at points of incarceration or while in extended psychiatric hospitalizations, but each had at least partial custody at the time of the interview. For the other 32 women with children, 11 (34.4 percent) had children who were over the age of 18. The final 21 women (43.8 percent of those with biological children) had lost custody of them or the children had been adopted. Over 80 percent of the women interviewed were not married at the time of the interview although more than one-third had been married and were divorced or separated. As written about in detail elsewhere (e.g. Gilligan, 1982; Covington, 2008) and discussed at length in Chapter 7 of the dissertation, relational considerations played an important part in the pathways to criminalization and the mental health system for women on the SMI caseload.

## **OFFENDING PROFILE OF THE DEEP SAMPLE**

The women on the SMI caseload in the deep sample were quite varied in their criminal histories and offense classifications. Nearly one-quarter had been convicted of a violent offense. This propensity for violence is somewhat misleading as some of the women's assaults consisted of spitting on police officers or retaliation during a domestic dispute; these offenses that were considered more retaliatory as opposed to predatory. On

the other hand, 10 women (15.4 percent) were also responsible for serious attacks on their loved ones or strangers. One-fourth of the women interviewed on the SMI caseload had committed non-violent property offenses. These were normally the result of trying to obtain goods or cash to support substance abuse habits or living expenses. The most common offense types were substance related, with over one-third of the sample being convicted for this classification of offense. These types of convictions spanned from DUIs, to possession of narcotics or drug paraphernalia charges, to arrests for selling drugs. The final 12 percent of the sample were convicted for child abuse or neglect charges. For multiple women these convictions were a result of living with men who sexually assaulted at least one minor child in the home. Although no women in the deep sample were convicted of directly sexually assaulting a child, there were a few women who had been convicted of direct child neglect or for physically assaulting their children.

Thirteen women (20 percent) had completed at least one prison sentence before their current probation. Four women spent more than three years in prison with the longest consecutive time being seven years. Two of these women had been in prison for three years on two separate occasions. Normally jail sentences were much shorter, though eight women had spent at least one year in jail. One woman reported being in jail for three years while awaiting trial before eventually signing a plea agreement. Regarding arrest history, 18.5 percent had never been convicted in the criminal justice system before their current arrest. However, more than a third (38.5 percent) of the women had between three and five previous arrests.

## **TRAUMA AND SUBSTANCE USE PROFILE OF THE DEEP SAMPLE**

As gendered pathways research has consistently shown (e.g. Belknap, 2006; Chesney-Lind & Rodriguez, 1983; Daly, 1992,1994; Morash, 2010; Salisbury & Van Voorhis 2009; Simpson et al., 2008) past trauma and substance abuse are two common occurrences in the biographies of women in the criminal justice system. This is also undoubtedly the case for the women on the SMI caseload who were interviewed; 58.5 percent of the women had experienced either sexual or physical abuse as a child (often both, and normally for an extended period of time). Women normally considered these events as important precursors to later mental health problems, substance abuse, and poor intimate relationships as adults. An additional 16.9 percent who did not endorse any sexual or physical abuse discussed significant periods of neglect in their childhoods where they were left alone for extended periods as a very small child, or forced to find their own meals, shelter and other life necessities at quite a young age. Often this was a result of their caretaker's substance abuse or own mental health problems. A smaller number of the women (6.9 percent) discussed being an active witness to their parents or caretakers' regular episodes of physical abuse towards each other, although they were not directly abused or neglected. The women with these experiences also discussed intense fear for their own wellbeing when the adults in their homes of origin would fight.

Substance abuse and addiction problems (after diagnosed mental disorder which was the prerequisite for inclusion in this sample) were perhaps the most common connector in the biographies of the women interviewed. Only a little over one-quarter

(27.7 percent) of the women had never abused drugs or alcohol at some point in their lives. Even then, many of the non-addicted women experimented with substances but stopped using them before problematic use became common. More than 30 percent of the sample was still actively using drugs or alcohol. Actively using was operationalized to be any woman who had used in the last year. For the majority of the active users, however, their most recent use had come within the previous few months. One-fifth of the sample had not used for one to three years; an amount of time that was coded as “long term sobriety.” Additionally, a little over one-fifth of the women (21.5 percent) had been addicts at some point in their lives but had maintained sobriety for at least three years. These women’s intense relationships with drugs and alcohol are more fully considered below as a major pathway to criminalization.

Having provided an overview of the women in the deep sample by illustrating biographical pieces of their demographic, criminal, trauma, and substance abuse histories, the pathways to the mental health and criminal justice systems for the group are now discussed. Each of the women interviewed had been diagnosed with a DSM-IV Axis I major mental disorder.<sup>15</sup> Furthermore, most of the women had significant histories of mental health problems that impacted their pathways to criminalization in unique ways.

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<sup>15</sup> At the time of writing this dissertation, the DSM-V was implemented as an update to the DSM-IV that was used as the system for diagnosing mental health disorders. Because almost the entirety of the sample’s records and psychiatric diagnoses were given using the DSM-IV, it is the classification system used here.

## ENTRY TO THE MENTAL HEALTH SYSTEM

Because each woman in the deep sample had been diagnosed with a major mental disorder, the types of disorder that each was classified with are examined first.<sup>16</sup>

Although several women endorsed being diagnosed with an Axis II personality disorder, which are often controversial, these disorders were not considered when examining specific pathways. Instead, Axis I disorders or “major mental disorder” were classified into three primary groups consisting of psychotic disorders, mood disorders, and anxiety disorders. Because each woman in the current study was diagnosed with a mental illness, and had functional impairment, pathways could not be replicated in the exact way that previous researchers had constructed (i.e. Daly, 1992, 1994; Reisig et al., 2006). For instance, Daly (1992, 1994) had placed most women with mental disorder into her *Harmed-and-Harming Pathway*.

### **Psychotic disorders**

Psychotic disorders included schizophrenia, schizoaffective disorder, and delusional disorder. As described in the DSM-IV, Schizophrenia disorders are often marked by hallucinations, delusions, extremely disorganized behavior or a catatonic state, that occur over a significant portion of time (6 months) and are not substance induced

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<sup>16</sup> Many women endorsed having multiple disorders across their lifespan. In these instances I went with the most recent as the “current” disorder that was coded. For a few women who had been diagnosed with multiple disorders currently, the disorder that caused the most problem and had been most pronounced across the lifespan was the primary disorder that was coded. In these instances I consulted with the woman and later her case file to determine the primary disorder. Additionally, the DSM-IV arranges types of disorder and function on an Axis system. Axis I disorders are reserved for “major” mental illness while Axis II disorders are for personality type disorders. Axis II disorders including Antisocial Personality Disorder, Borderline Personality Disorder etc. are not a focus of this analysis.

(American Psychiatric Association, 2000). Schizoaffective disorder shares the symptoms of schizophrenia while also having at least one major depressive or manic episode in addition to the aforementioned symptoms (American Psychiatric Association, 2000). The DSM-IV explains delusional disorder in similar symptomology but focused on “non-bizarre delusions” or delusions about everyday occurrences (e.g. disease, being followed, romantic involvement etc.)

The primary diagnosis for 18 women (27.7 percent) of the sample was a psychotic type disorder. Of these, the vast majority was diagnosed with this disorder before adulthood with 15 (78.9 percent) of those women with psychotic disorders first being diagnosed as a child or teenager. For example, Gina S., a 48-year-old White woman, first noticed symptoms of schizophrenia as a teenager after she began having persistent auditory hallucinations. Her experience was comparable to most of the other women in the sample with childhood or adolescent onset for psychotic disorders. Gina stated, “I started hearing voices and I wasn’t right there with reality. And I just started having all kinds of anxiety and things just started up and I don’t know what caused it really.” Normally these women entered the mental health system in one of two ways. First, their family or guardians referred them as teenagers to talk to a therapist or entered them into residential placement when they could not control the mental health problems in the home. Additionally, (a topic returned to later in the chapter) several of the women with psychotic disorders were first diagnosed after coming into contact with the police and criminal justice system.

Of the four women (21.1 percent) who were first diagnosed with a psychotic disorder during adulthood, each was able to pinpoint a specific moment for the onset of their symptoms. Carol T., a 42-year-old White woman diagnosed with paranoid schizophrenia related her experience to having a religious conversion. At age 31 she was driving down the highway when:

The radio started asking me if I was Jesus Christ or not, and then I would follow what this guy said – “I can choose Jesus Christ or perish or be punished,” and I passed out or something like that I don’t know it was just things I would go through.

Carol initially thought this was her friends playing an elaborate hoax on her through the radio. Later she considered whether these voices might actually be a religious calling. It was only after repeated delusions involving her ex-boyfriend being brutally raped that Carol entered the mental health system and received her first diagnosis. Each of the women with adult onset psychotic disorder came into contact with the mental health system after referring themselves to get help or after coming into contact with the criminal justice system.

### **Mood Disorders**

The most common type of disorder for the women interviewed for this project was some type of mood disorder. Forty women (61.5 percent) were diagnosed with bipolar disorder. Bipolar disorder is classified in the DSM-IV by depressive and manic episodes that occur over an extended period of time and can cause considerable impairment in one’s life functioning in areas like school, work, and relationships (American Psychiatric Association, 2000). Although mood disorders include clinical



depression without manic episodes, each of the women interviewed with mood disorders had been primarily diagnosed with bipolar disorder - experiencing both manic and depressive episodes.

Onset in childhood or adolescence was the most common for women with mood disorders. However, it was not as prevalent as those diagnosed with psychotic disorders highlighted above. One half of women diagnosed with mood disorders entered the mental health system before adulthood. Family and delinquency/ juvenile criminal justice system were each important ways that these women were first in contact with the mental health system. However, unlike with psychotic disorders, school and suicide attempts were also common areas where women with bipolar disorder were referred to the mental health system. Several women reported that they were first told that they had “a problem” while in school. They were often labeled with attention disorders and placed in classes for behaviorally challenged students or remedial learning. This is where some women were first introduced to school psychologists, social workers and other human service professionals. Suicidal behavior and ideation was an additional pathway for entry into the mental health system. These particular women were placed in psychiatric care after attempting suicide, calling a suicide hotline, or telling someone that they were having strong urges to harm themselves. Libby S., a 46-year-old White woman who was first diagnosed with bipolar disorder at age 16, explained her symptomology:

I was either really happy or I was really pissed off, really pissed off, no happy medium, no just being okay. Yeah, yeah, I'd sleep for weeks. My mom couldn't figure out what's wrong, she's say “you've been in bed for like two weeks”, and I'd be like, “yeah, so?”

After Libby's school continued to complain about her grades and lack of effort, she was moved to a behavioral classroom as part of her school's special education department. Libby's mother, not knowing what else to do, took her to see a psychiatrist where she was diagnosed with bipolar disorder.

Twenty of the other women (50 percent) who had been diagnosed with mood disorders first entered the mental health system as adults. Interestingly, the most common way these particular women entered the mental health system (50 percent) was through the criminal justice system. Billie B., a 36-year-old Native American described her first entrance to the mental health system through the criminal justice system:

<Discussing her auditory hallucinations during a manic episode> Um, they were like yelling, screaming, malicious things, you know. Like, ah, "pray to him", and they were just being obnoxious, so I was like, "ohhhhh!", and I ran down the street and ended up in jail and I didn't know what was wrong with me, you know. I was standing downtown (laughs). I ran down to the, to the um, downtown to the <name of sports arena>. I was standing there, there was a statue there and I was standing on top of it yelling. I ended up in jail again. The only times I would go to jail is when I was having mental breakdowns like that and I start hearing voices, that's when I end up in jail. I always end up in jail...So in jail I was fighting with the detention officers and they were like, "You need medications."

This was the first time that Billie had been told she might have a mental health disorder. Although Billie had been having significant manic episodes for years, it was not until officers in a local jail observed her behavior and suggested treatment, that it was first considered. For many of the women like Billie, the criminal justice system was the initial catalyst for their entry into the mental health system. Other women diagnosed with mood disorders as adults followed pathways to the mental health system through

family/friends/significant others referring them, or some women referring themselves after recognizing their abnormal behavior. A few women also endorsed inpatient or outpatient drug rehab as their initial entry into the mental health system. For these women, only when they were seeking help for addictions was it first suggested that they may have a mental health problem, at which time they discussed mental health concerns with a professional.

### **Anxiety Disorders**

Although several women suffered from significant anxiety problems in tandem with their more pronounced problems, for six women (9.2 percent of the sample) an anxiety disorder was their primary diagnosis. In the DSM-IV anxiety disorders are marked by persistent fear or extreme panic for an extended time and encompass a wide range of disorders from specific phobias, panic disorder, obsessive-compulsive disorder, general anxiety disorder and posttraumatic stress disorder (PTSD) among others (American Psychiatric Association, 2000). Five of the six women with anxiety disorders first entered the mental health system before adulthood. Some had quite traumatic experiences that influenced their disorders. For these women rape and sexual assault were significant traumas that later led to a PTSD diagnosis.<sup>17</sup> For instance, Reva H., a 34-year-old Hispanic woman diagnosed with PTSD had been raped at 15 and had a child

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<sup>17</sup> PTSD symptoms were quite common in many of the women on the SMI caseload who were interviewed as part of the research project. Although PTSD may not have been their “primary” diagnosis, or meeting all the requirements for the specific diagnosis according to the DSM-IV, it was clear that anxiety and fear associated with earlier trauma had a significant impact on many of the women’s lives who were interviewed.

as the result of the rape. She explained her anxiety during the interview that eventually led to her entering the mental health system:

I feel like I became, I became a mother at fifteen and being a mom at that young age and my son being a rape baby, was hard for me to deal with but I couldn't give him up. I decided to raise him and to take care of him, and doing all of that and trying to go to school, you know...I went to a regular school with my child and just the way people were looking at me and judging me, you know, hey she's got a baby you know, stuff like that you know just things like that would really...I always was thinking what are they thinking about me, what are they thinking who I am because I have a baby and I'm still coming to school and it was hard cause you know cause my mom watched my baby, you know, while I went to school. I come home and have a baby to take care of plus stacks of homework to get done. I wouldn't get to bed sometimes until about three then I'd get back up at like five, six o'clock so it was like yeah....and I said mom can you watch him, I'd got to take, I was going to blow a gasket because I was like everything all at once just caught up, and I knew it was a bad thing you know, cause at that time I started getting to where I was throwing things, I was pissed- I was cussing at people who didn't really need to be cussed at and it was horrible.

Even though Reva had been raped as a young teenager, became a mother at 15, was having real problems with her schoolwork, and significant outbursts of anger (undoubtedly as a result of everything that had happened to her) only when she was later found delinquent did she enter the mental health system and talk to a professional about all the different stressors impacting her wellbeing.

Although half of the women with anxiety disorders suffered from significant histories of abuse and were diagnosed with PTSD, the other half of women with anxiety disorders had relatively stable middle class childhoods with no reports of physical or sexual abuse. For these women generalized anxiety disorder or obsessive-compulsive disorder was intertwined with substance use. The families of these women normally encouraged or demanded that they seek help for their mental health issues. Georgia S., a

25-year-old White woman diagnosed with obsessive-compulsive disorder described her symptomology that eventually led to her involvement in the mental health system:

I think I started experimenting going to parties till my parents thought there was something wrong and they started taking me to doctors...I have obsessive and intrusive thoughts and um, those kind of, if it's not treated they turn into more obsessive; I guess actions, like I'll do things excessively, so...Um, I'll get stuck organizing a cupboard and I can't get away from it. It sounds really weird. I have to have somebody come like remove me. If I'm not on my medication or something, yeah just can't stop doing some things.

One-half of the women who were primarily diagnosed with an anxiety disorder initially entered the mental health system upon referral from the criminal justice system.

Additionally, one-third entered the mental health system with the help of family, and a final referral came from school.

The majority of women interviewed entered the mental health system before the criminal justice system. Forty-six women (70.8 percent) had involvement with mental health professionals and a diagnosis before they were formally processed in the adult criminal justice system. On the other hand, 19 women (29.2 percent) were processed in the criminal justice system before ever seeking mental health treatment. Prior research (Horwitz, 1977) has suggested that women are more likely than men to talk about psychological illness. The same study found that family, friends, other members of their social networks, and professionals were all more aware of the mental health problems of women than men. Therefore a logical conclusion would be that women are also likely to self-refer to the mental health system or enter it with the help of social networks. This is true in this sample, but more formal controls are also an apparent pathway to the mental

health system for this group of women. The most common pathway into the mental health system is through an arm of the criminal justice system; 12 women (18.5 percent) were adjudicated delinquent and entering the mental health system that way, and 14 women (21.5 percent) had their initial referral to the mental health system as a result of being in the adult criminal justice system.

Unfortunately there is no way of knowing how many women funnel through the mental health system and are subsequently diverted from entering the criminal justice as a result. In this sample, however, it would appear that for women in the criminal justice system, the mental health system involvement was not an effective deterrent from eventual criminalization. Although 60 percent sought out mental health treatment before criminal justice involvement, all of the women in the sample eventually were convicted of an adult offense. Also, as discussed, the criminal justice system was a prominent pathway for propelling women into the mental health system. For each of the pathways into mental health treatment, the criminal justice system was the most common, with 25 women (38.5 percent) entering the mental health system through either the juvenile or adult criminal justice system. The second most common pathway was through family, friends or significant others. Twenty two women (33.8 percent) entered the mental health system this way. Additionally six women (9.2 percent) were self-referred, five women (7.7 percent) entered through their school, and seven women (10.7 percent) entered the mental health system while undergoing drug rehabilitation or attempting to commit suicide. These findings suggest that both informal and formal social controls are

important pathways to the mental health system and that the adult criminal justice system is an essential catchment area for individuals with mental illness and functional impairment as prior research has suggested (James & Glaze, 2006; Mauer, 2002). Ultimately, the mental health system is a place where future offenders frequently sought service in the same way that the criminal justice system often served as the catalyst for SMI offenders to first receive any mental health treatment.

The preceding paragraphs reviewed the types of disorders with which this sample was diagnosed with, as well as reviewing participants' pathways to the mental health system were reviewed. By disaggregating the experience of women on the SMI caseload and their pathway to the mental health system, it was determined that the majority of women were classified with a mood disorder although psychotic and anxiety types disorders were also present and important. Interviews with women on the SMI caseload further indicated that criminal justice involvement was often an important predecessor to mental health service and diagnosis. Similarly, the mental health system was a frequent catchment area for future offenders with mental illness before they were criminalized. The symbiotic relationship between these two systems is an important consideration that is discussed in more detail in Chapter 7.

## **PATHWAYS TO SMI PROBATION**

As discussed earlier in the chapter, I explored several aspects of the women's biographies and created a composite sketch for each. I analyzed the biographies with

NVIVO 10 qualitative software by comparing and contrasting different biographical components among offenders. These components included crime history, substance use, psychological disorder, history of victimization, violence history, and economic marginalization. For this emergent analysis I found three distinct categories that encapsulated the previous experiences of women leading to the criminal justice system. I label these the *Addiction-Dominated Category*, the *Violence-Dominated Category*, and the *Economics-Dominated Category*.

### **ADDICTION-DOMINATED CATEGORY**

Like Morash (2010) the current study found that the majority of women in the deep sample had lives centered on substance use and abuse and obtaining these substances. Thirty-nine (60 percent) of the women interviewed had criminal histories as either a direct or indirect result of substance use. Because the few women who exclusively abused alcohol did not differ from those addicted to drugs in the ways they came to the criminal justice system, they were combined into an *Addiction-Dominated* category. This is quite similar to Morash (2010) whose *Substance Centered* women probationers made 65.3 percent of her overall sample. In the current sample, the *Addiction-Dominated* category was either the direct result of attempting to use alcohol/drugs, or to obtain money in order to buy these substances. Each of these *Addiction-Dominated* women had many of the hallmarks that gendered pathways research has shown lead women to the criminal justice system - including childhood



trauma, instability in adult relationships and economic marginalization (I discuss an exception to this later). As Daly (1992, 1994) illustrated in one of her gendered pathways (i.e. *Drug Connected* women) many *Addiction-Dominated* women in the current sample were first introduced to drugs by men with whom they had a relationship (romantic or non-romantic). However, this was not true for all *Addiction-Dominated* women as had been true for Daly's *Drug-Connected* group. These relationships were normally a significant factor in initial substance use or criminal involvement as a result of substance use. For instance, Jenny P., a 46-year-old White woman, provided an example of a common pathway for the *Addiction-Dominated* category. She discussed that she first started using at age 21 when her husband introduced her to methamphetamines:

We would do it for weekends cause this was a sex drug. You know what I mean, that's why we did it. And then it progressed and progressed and progressed. It was every week, and then it was every four days and then it's every day and you need that. It seemed like you need it, cause you liked it, I like speed but I like uppers, I don't like downers.

Jenny explained that eventually the use of the drug led to many fights in their relationship and both she and her husband began to use with other people. After both had sexual relationships with others they were using with, Jenny and her husband divorced.

Although Jenny's ex-husband had little involvement with her later criminal activity, he was the one who repeatedly suggested experimenting with drugs early in their marriage. A string of arrests (approximately 10) followed, consisting of drug possession, theft, or other related crimes that she committed in order to obtain methamphetamines. Examples like Jenny's illustrate the important connection between substance abuse and

relationships for *Addiction-Dominated* women on the SMI caseload. Her use was a result of trying to strengthen a relationship with her husband who had initially introduced the methamphetamines that Jenny quickly became addicted to. For almost all the women in the *Addiction-Dominated* category, the relationship with a man eventually failed as a result of the substance use, but the addiction lived on.

The 39 women on the SMI caseload like Jenny had lives dominated by substance abuse. Although each had significant problems with drugs or alcohol, not all were arrested for specific drug offenses. For many, their pathway to the criminal justice system was a result of property crime to support a drug habit or more violent crimes as a result of using drugs. Therefore, not all *Addiction-Dominated Women* in the deep sample were criminalized the same way, although substance use/abuse was the cornerstone to entry into the criminalization process for each. Analyzing this group of women on the SMI caseload in greater detail resulted in three distinct pathways of *Addiction-Dominated Women* in the deep sample emerging.

### **Street Women (Addiction-Dominated) Pathway**

Morash (2010) noted that her sample of *Substance-Centered* women closely resembled those of Daly's (1992, 1994) *Street Women*. In discussing how these *Substance-Centered* and *Street Women* were similar, Morash (2010) stated, "Women who are regular users of drugs...also forge checks, use stolen credit cards, engage in prostitution, and make and sell drugs. These women use illegal means to generate income for basic living expenses and to purchase drugs" (p. 29). Under the *Addiction-*

*Dominated* category in the current project, there were several women who followed the *Street Woman* type of pathway to the criminal justice system. Jenny, discussed above, is a common example of a *Street Woman* as was Betty R., a 52-year-old African American woman who had been arrested several times in her life for drug related offenses. Betty's most recent arrest occurred when she was high on crack and left her purse at a local gas station. When she returned to retrieve it, the police had been called after employees discovered drugs in the purse. Betty had been to prison multiple times before for drug use and sales. She reported that she had been addicted to drugs most of her adult life. Eventually to pay for her addiction, she had to shuffle back and forth between using and selling. In her own words Betty described behavior that eventually led her to the criminal justice system:

Oh god, I would go- man, I even sold it, so I did em' both to keep my habit. I went through a lot, I went through a lot, I can't even give you a price, probably a \$1000 a day. Sold a little bit, smoked a little bit. It's what you do. Sold enough to just get some more, to pay for some more, and then you would break it down and like they profit, there wasn't no profit, it was me, that was keeping me going. Gonna have a little bit more to take back, to make money, and then go do it again. And that's what carried on, by the time I go to bed, and the time I get up. First thing [when] I get up. Certain people drink coffee, a cup of coffee, I look for that [crack], and that's what I did, it kept me going. Five or six days until my body couldn't take any more of staying up and I just passed out. Slept for like three or four days, you know, you know when you wake up you ask what time is it, what time of day is it, or what day it is. And you do the same thing all over again. And that was, that was my way of getting by.

Of the overall category of *Addiction-Dominated Women*, 27 (69.2 percent) were best categorized in the *Street Woman* pathway. One woman in this group was diagnosed with

an anxiety disorder, 17 (63.0 percent) were on the SMI caseload with mood disorders, and 9 (33.3 percent) were diagnosed with psychotic disorders.

### **Domestically Violent (Addiction-Dominated) Pathway**

Within the *Addiction-Dominated* category, a second pathway to women's criminal system involvement not only centered on substance abuse, but also domestically violent encounters that resulted because of substance use.<sup>18</sup> For these seven women (17.9 percent) in the *Addiction-Dominated* category, criminal involvement across the life-course varied but was generally less than for *Street Women*. However, the arresting offenses were often more serious. Peg L., a 49-year-old White woman, had struggled with addiction most of her adult life. When she would use methamphetamines, she and her husband (not addicted to drugs) would often have physical altercations in front of their three children that would result in the police being called. The family had been in and out of homeless shelters for several years, which also put enormous stress on their relationship. Normally these fights would start after Peg's husband would unhook the starter from the family's only car so Peg would not leave in the middle of the night. Peg's husband justified disabling the family car so he could get to work in the morning. When Peg tried to leave with two of her children and discovered the car would not start, she attacked her husband and he called the police. Peg noted:

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<sup>18</sup> The prevalence of domestic violence is an important consideration for this sample as the majority of women on the SMI caseload that were interviewed had at least one domestically violent relationship as an adult. For this specific pathway of women on the SMI caseload however, domestically violent encounters coupled with substance use formed the foundation for why these particular women eventually entered the criminal justice system.

Um, I was using and I was seeing things and hearing voices and um, I thought I needed to leave my husband. I tried to leave him and um it backfired and I ended up hitting him and going to jail for domestic violence.

Although Peg's husband was not a regular drug user, most *Addiction-Dominated* women who were domestically violent and on the SMI caseload had frequent fights with their significant other when they were using together. For instance, Bennie P., a 43-year-old White woman described in detail the mutually violent relationship she and her husband had while they were both using methamphetamines. She described the relationship as "poisonous" while discussing the tumultuous history of substance use and domestic violence between the two:

Because we're just, we are just, we butt heads all the time, ok, we fist fight, ok I mean, knock down drag out fights, I mean, holes in the wall, you know, I mean punching each other, you know, cause I can take it, and I demand to take it like a man if I'm gonna hit you, you can hit me, you know. Um for years and years and years I mean we would just fight, the police came out and actually put us back in [the house] and they would say, "we'll come back when you're both dead..."

For Peg and Bennie, substance abuse and domestically violent relationships created huge stressors on their lives that were compounded by significant mental health issues. Both women had been convicted of different drug offenses but mostly came to the attention of the criminal justice system because of their domestic disputes. Both women had been diagnosed with bipolar disorder and it was difficult for the women to decipher how their mental disorder compounded other significant problems that eventually led them to the criminal justice system. Benny considered her unending cycle of domestic disputes and addiction to be fueled by her bipolar disorder and her frequent

panic attacks, “I’m fighting myself inside all the time, you know, with the bipolar and the panic and anxiety attacks I have many a day, you know.”

Although some *Addiction-Dominated Women* were unable to express the impact that mental illness had on their pathway to criminalization, Marly Y. felt that her schizophrenia mixed with her substance use played an important role in her arrest and conviction. A 49-year-old African American woman arrested for aggravated assault with a deadly weapon, Marly had not taken her psychiatric medication for two weeks at the time of her offense. Marly and her boyfriend were both intoxicated when her boyfriend became quite upset because his friends had stolen things from the house and took his anger out on Marly. She stated:

He took his frustrations out on me and punched me in the face and pushed me on the ground. I got up and went into the kitchen and grabbed a small knife and stabbed him in the shoulder.

Marly explained that she was already actively having auditory hallucinations due to taking herself off her psychiatric medication. As an alcoholic, Marly had been drinking to try and “numb” the voices in her head. When her boyfriend assaulted her, she retaliated by stabbing him with a kitchen knife. The boyfriend called the police and Marly received her first felony conviction.

In each of these previous examples for *Addiction-Dominated* domestically violent women, the assault had been enacted upon a romantic partner, but for some domestically violent women, the violence could also be directed at others (as a result of domestic violence situations). For instance, Olive J., a 48-year-old White woman had a long

history of the police coming to her house because of domestic disputes with her husband spanning nearly two decades. Both substance abusers, Olive would often fight with her husband over relationship matters when they were using and the arguments would escalate into violence. Multiple times the police reported that Olive had attempted to assault them when they were called to the house by neighbors because of the fighting. Olive explained the offense that resulted in her being incarcerated for over a year.

Heavily intoxicated after a big fight she had blacked out:

I was mad this time because my husband hadn't come home and I woke up and my big screen television was gone and a lot of other things were missing including him <usually a sure sign that he was using again> and I called the police and they came to my apartment and he <police officer> disrespected me, and I spit and said, "see how does it feel?" And he put the handcuffs on me and said "how does this feel?"

A series of these types of assaults quickly added up for Olive. Diagnosed with bipolar disorder, she explained that her extreme mood fluctuations along with the anger over her husband using drugs impacted her overall functioning. When he would only come home sporadically for long periods, or not at all for several days at a time, the strain eventually would lead eventually to her own alcohol use. Olive's husband normally became physically assaultive with her in these instances. During these disputes when the police were called, Olive had attempted to assault the officers on multiple occasions which resulted in her eventual incarceration.

### **The Addiction-Dominated Category Reconsidered**

To this point in the chapter variations in the dominant category of offenders in the sample, The *Addiction-Dominated* group, have been highlighted. The majority of the

women in this overarching category closely mirrored the *Street Women* pathway originally introduced by Miller (1986) and later made popular in the gendered pathways literature by others (Daly, 1992, 1994; Holtfreter & Morash, 2003; Reisig et al., 2006). Morash (2010) noted that women in her own *Substance-Centered* group (who resembled Daly's *Street Woman*), "were especially likely to experience problems early in life, with negative ramifications that limit their resources and opportunities for many years" (p. 39). This was true of the majority of women diagnosed with serious mental illness and on probation in my sample. A second pathway of *Addiction-Dominated* women also emerged. For this group, substance abuse and addiction was also at the forefront of their involvement in the criminal justice system. However, the vast majority of the *Addiction-Dominated Women* who were in the *Street Woman* or *Domestically Violent Woman* pathways came from chaotic upbringings with significant family histories of abuse and neglect, familial substance abuse and economic marginalization. Interestingly, and contrary to the above groups, a smaller third sub-category of women who were *Addiction-Dominated* in the deep sample did not have the fundamental hallmarks of the *Street Woman (Addiction-Dominated)* or *Domestically Violent Woman (Addiction-Dominated)*.

### **Mad/Bad (Addiction-Dominated) Pathway**

Five women (12.8 percent) in the *Addiction-Dominated* group had biographies strikingly different from other women in this category. None of these five women had experienced notable abuse or neglect as a child. Additionally, these women were not as



economically marginalized as other *Addiction-Dominated Women*. Women in this sub-category were generally younger than many of the other *Addiction-Dominated Women* as their ages ranged from mid 20's to mid 30's. This group also had more formal educational experiences where four of the five had attended at least some college. Interestingly, each of these women identified their racial category as White and three of the five women had been diagnosed with specific anxiety disorders. This is notable as it is 50 percent of the women overall in the deep sample whose primary diagnosis was an anxiety disorder.

Examining criminal offenses for this group showed that four of the five women had been placed on SMI probation after having drug related charges only, and no histories of petty theft, prostitution, or economic crimes occurred with this group as was apparent for other women in the *Addiction-Dominated* group of offenders. Finally, three of the five women were on probation for their first conviction and the other two women had previous drug related arrests, but had mostly avoided adult convictions.

This pathway was labeled *Mad/Bad* because the women's process of criminalization was unique. Although all women in the *Addiction-Dominated* group had lives that revolved around the core element of substance use, these particular women were first considered "mad" and entered drug treatment or therapy before being considered "bad" and being put on probation. Each of the five women described trips to rehab facilities or therapy that their families had referred them to (or they referred themselves to at the insistence of their families) as a result of using substances. Their

families were normally extremely concerned and upset and could not understand what might be wrong with each of the women. The families searched for “causes” as to why these particular women would engage in drug abuse and break the law. Generally, these women had more privileged upbringings than the majority of the women who were interviewed. They also normally had greater support from family. For instance, Marika L., a 34-year-old White Woman, described her first experience in rehab with an “overly protective” mother:

Yeah, rehab- that I was not into and I signed myself out and I flew home and my mom sent me to a place in Houston when she found out I smoked one joint of marijuana, she I mean, to her smoking marijuana is the same thing as injecting heroin in yourself. She doesn't know anything in between...You know, I didn't really, I wasn't into it...was not my thing, but she found that out <about using marijuana> and sent me immediately to the most expensive most well- known place there is and I just, you know, felt I didn't belong there and I took my credit card and I had miles on there and I just went right back.

Private drug rehab was a common experience (prior to criminalization) for this group as were experiences in therapy. Gail J., a 33-year-old White woman recounts being sent to multiple therapists as a teenager to find out what was “wrong” with her. After bouts with depression she began to experiment with drugs. Her mother sent her to a therapist shortly after:

When I was 14...my mom took me to some therapy, 13ish, my mom took me to some therapist cause I was depressed, I don't know what was going on actually. I can't really recall whether I was depressed or not. But she took me in and they put me on Prozac and they put me on some other medications really early on. Um, I know I've always had insomnia and so that was one of the things that I was medicated for was sleep, you know I was put on sleep medications. But the Prozac and other things, you know, I can't literally recall if there was anything really wrong.

This initial experience spiraled for Gail as she stated that the Prozac caused her to become suicidal. Having suicidal ideation, she began to experiment with a couple of drugs made available by friends. Gail believed her depression at the time was a somewhat normal life-course occurrence, and she resented being sent to treatment implying that something might be “wrong” with her.

For each of these five women, it was only when multiple drug rehabilitations or mental health treatments failed that they were then eventually processed through the criminal justice system for their substance use/abuse. Perhaps because they were White and less economically marginalized these women were able to avoid criminalization and considered “bad” rather than “mad” only when drug and psychological rehabilitation was not successful. It is also conceivable that because of their race coupled with their biographies (lack of childhood trauma, economic marginalization) this group of women were more likely to be considered “mad” by probation officers to help rationalize why there were in the criminal justice system at all. Regardless of the reasons behind entry into the criminal justice system, it is clear that this group of women shared the primary path to the criminal justice system with other *Addiction-Dominated Women* – through drugs and alcohol. However, they also lacked many of the antecedents that the literature has commonly attributed to this type of pathway (i.e. extensive childhood trauma, running away from home, multiple arrests for petty crimes and profound economic marginalization).

## **Addiction-Dominated Women and Mental Health Disorder**

Overall the *Addiction-Dominated* category had a complex relationship with drugs and alcohol coupled with profound mental health symptomology. Prior research (Evans, Forwyth & Gauthier, 2002; Inciardi, Lockwood & Pottieger, 1993) has commonly supported the hypothesis that many women use substances in order to mask or alleviate symptoms of mental illness. Likewise, co-occurring disorder is quite common for women in the criminal justice system (Milin, Halikas, Meller & Mores, 1991). Each of these *Addiction-Dominated Women* would be most likely considered co-occurring; being diagnosed with a mental illness and having a substance abuse disorder.<sup>19</sup> Many of the *Addiction-Dominated Women* described going on “drug binges” when in manic episodes. However, at other times they were not able to get out of bed for days when bouts of depression set in. Importantly, as the cycle of addiction progressed, some women became unable to decipher to what point their mental health symptoms might cause drug use and how drug use might cause or exacerbate mental health symptoms. A few women even began to see their drug use and mental disorder as a single entity. To explain, sometimes drug addiction caused mental health symptoms that were alleviated (or escalated) by continued drug use, and other times mental disorder caused drug cravings and an individual would self-medicate with illegal substances as a result.

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<sup>19</sup> Although the DSM-IV has several substance abuse disorders in the Axis I category, these were not coded as part of the research as my main focus was on non-substance related Axis I category types of psychotic disorders, mood disorders, or anxiety disorders. A substance abuse disorder without an additional Axis I disorder made one ineligible for the SMI caseload. That being said, it is naturally assumed (and often noted in the case file reviews) that each of the *Substance-Involved Women* in the deep sample would have also been diagnosed with a substance use disorder at some point in the life-course.

The focus in the research (Evans et al., 2002; Inciardi et al., 1993) has been on women using drugs as “self-medication” for mental health problems. This is certainly true in the deep sample of women. Many women believed that their initial and continued drug use was a way to manage difficult mental illness symptomology like auditory hallucinations, delusions, and both manic and depressive episodes. Discussed less in the literature, however, some women in the deep sample believed their diagnosed mental disorder was mostly a result of their drug use. For instance, Marnie J., a 28-year-old White woman believed that her symptoms of mental disorder were only a manifestation of her drug use. She stated:

I don't hear voices. I mean, I have been up for 5 days before but like – there is some bad dope out there right now. I never used to have these problems. I never used to have these problems. And then the drugs started getting different and they started making people crazier. I mean like they came out with bath salts and they put bath salts in there. People do weird shit on them.

Marnie, like some other *Addiction-Dominated Women* was adamant that her substance addiction predated any mental health symptoms or diagnosis. Only after a significant amount of drug use, did she begin to have noteworthy bouts of paranoia and would stay up for multiple days at a time while using. Jenny P., described earlier in the chapter, also believed that years of substance use was what eventually led to her psychological diagnosis. Jenny had originally used drugs with her husband in her early 20s to heighten sexual experiences, which eventually led to everyday use of methamphetamines. She was not diagnosed with bipolar disorder until age 30. In

discussions of her earliest memories of episodes of mania and depression Jennie always referenced her substance use as predating her psychological problems:

You know, I think it <original psychological symptoms> really came from the drugs. I think the drug, it kills the brain cells and you don't get them back. Now, I understand that's how I got my face twitches, I get stuck... I'll stick my tongue out when I don't know. So, I know when I was using, you don't think about that, you know... You just go up and you go down. Go up and go down.

Overall, 39 women on the SMI caseload that I interviewed as part of the deep sample were classified in the *Addiction-Dominated* group. The women who made up this group had biographically complex relationships with their substance use. The most common pathway in the *Addiction-Dominated* group was that of the *Street Woman*. These women normally had traumatic childhoods filled with abuse and neglect. They left home at early ages and had long and varied criminal histories centered on their obtaining and using substances. A second pathway of the *Addiction-Dominated* category shared similar biographical components as the *Street Women* but entered the criminal justice system due to violent acts as a result of domestic disputes with loved ones. Substance use always was the catalyst for the violent episode for which they were arrested. A final pathway of offenders had dissimilar biographies with the *Street Woman* and *Domestically Violent Woman* pathways. The only true similarity was that their entry into the criminal justice system was the result of leading *Addiction-Dominated* lives. For this group, being White, less economically marginalized, having influential familial support, and being younger had provided them with opportunities for diversion from the criminal justice system at early ages. It was only when treatment in other institutions (drug and

psychological treatment) did not successfully end their substance abuse that they were eventually criminalized. Importantly 60 percent of the deep sample had a pathway to criminalization that centered on substance use or obtainment. However, it was not the only path to the criminal justice system that women on the SMI caseload took.

## **VIOLENCE-DOMINATED WOMEN**

A second group of offenders came to the criminal justice through lives that were centered in violence. However, unlike the *Domestically Violent (Addiction-Dominated)* women, this group did not have substance abuse as the primary concern in their biographies. Although some had used substances in the past, these histories were quite small in comparison to the *Addiction-Dominated* group. Furthermore, none of these women committed crime while using or attempting to obtain drugs/alcohol. A further distinguishing characteristic was that *Violence-Dominated* women were not criminalized as a result of survival type crimes as *Street Women (Addiction-Dominated)* often were. Generally the *Addiction-Dominated* and *Violence-Dominated* categories shared biographies of traumatic childhoods filled with violence, abuse and economical marginalization. The major difference between the *Violence-Dominated* group and the *Addiction-Dominated* was that the *Violence-Dominated* were all abused or neglected as children, all acted out violently in their lives, and each was criminalized as the result of violent acts that were not the direct result of substance use. Where *Addiction-Dominated Women* were criminalized as a result of obtaining substances or use, the *Violence-*

*Dominated* group of women was all criminalized because of their anger and violence or association with anger and violence.

This *Violence-Dominated* group is different from the *Harmed-and-Harming Woman* pathway described by Daly (1992, 1994), but they do share some similarities. Daly (1992, 1994) described the *Harmed-and-Harming Woman* pathway as being abused or neglected as children with significant histories of trauma. They were often considered problematic children and as adults would become violent when using drugs or alcohol. She also described the *Harmed-and-Harming Woman* pathway as having a difficult time controlling their emotions. Additionally, in Daly's sample the *Harmed-and-Harming Woman* pathway was the most likely to have psychological problems or be living with significant mental disorder. As a result of their harmful and violent biographies, as adults these women had, "diverse and complex ways in which these experiences are reproduced in the women's harming behavior towards others" (Daly 1992, p. 29). In her own work, Morash (2010) described her "violence involved" group of women as similar to that of the *Harmed and Harming* pathway first put forth by Daly (1992, 1994). The *Violence-Dominated* group in the current study shared several similarities but also had key differences. For instance, for some of the women in the current study, mental illness played a more significant role in their entry into the criminal justice system than was apparent in Daly's group of *Harmed-and-Harming Woman* group. Also, the current group was divided by the distinctive ways that crimes against children and crimes against



adults occurred. No distinction of this type has been made by previous pathways researchers.

Seventeen women (26.2 percent of the overall sample) were in the *Violence-Dominated* group of offenders. Each of these women were criminalized because of violent acts (either their own or those of an intimate partner) that were not the direct result of substance use. Eight women in this particular category (47.1 percent) were diagnosed with a psychotic disorder and an additional eight had (47.1 percent) a mood disorder. A final woman's primary diagnosis was PTSD – in the anxiety disorder classification. It is important to also note that these 17 women were the most likely to have a direct link between symptomology of mental disorder and criminalization. Many of the women in this group suffered from significant clinical symptoms at the time of their actual entry into the criminal justice system, and most had less significant involvement in the past with the criminal justice system than the *Addiction-Dominated* group. For instance, Joan D. a 54-year-old White woman had no prior adult felony arrest history before the current offense.<sup>20</sup> Actively hallucinating at the time of her crime, she was arrested for an assault against her son and roommate that left her on the psychiatric ward of the local jail for an extended time. Joan described the situation that led to her current arrest for child endangerment and assault:

I ended up in jail because I ended up hallucinating again and I attacked my son. I was hallucinating that there was demons inside of him so I took a, a knife sharpener and just pressed it on his chest...cause I had to get those demons out

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<sup>20</sup> Of the 17 women in the *Violence-Dominated* pathway to criminalization, a majority of nearly two-thirds (64.7 percent) had no prior history of adult felony convictions before their current probation sentence.

and I pulled him off the bed, you know, and he wakes up “mom, mom!?!” and then my housemate at the time comes to the door and I’m thinking the same thing about him, “Oh god he has demons”. So I have this knife sharpener, my intention was not to kill either one of them, just to get the demons away. In my mind, okay, my hallucinations. So when I left the room I jabbed at em, “get away from me, get away from me”, so I didn’t really attack him, in my mind I was protecting myself, you know, so as a result I have two felonies.

Joan’s experience was common for the *Violence-Dominated* group of women in that her criminalization was the direct result of her clinical symptomology. Ten of 17 women in this group (58.8 percent) endorsed having active hallucinations or delusions when completing the crime for which they were currently serving a probation sentence. An additional six women (35.3 percent) in this group could partially attribute their mental health problems to the offense for which they were currently on probation. The *Violence-Dominated* group was similar to the *Addiction-Dominated* group in that different pathways to the criminal justice system emerged in each.

### **Child Centered (Violence-Dominated) Pathway**

At the forefront of the *Violence-Dominated* group were violent acts. The first pathway for the *Violence-Dominated* group occurred because of violent acts that involved children. Eight women (47.1 percent of the *Violence-Dominated* category) fell into this pathway. Three of the women were living in a home where their boyfriends were sexually assaulting a child in the home, three additional women were physically assaultive with their children, and two women had criminally neglected their minor children.

For the three women who were involved in the sexual abuse of a minor, each woman's boyfriend had been responsible for the abuse. All three of the women had been arrested and convicted for not reporting the offenses to the police. Although one of the women eventually notified the police about the assaults taking place that she was sometimes forced to partake in, because she waited a few weeks to do so, she was also charged in the offense. Another woman, Vera R. a 34-year-old Hispanic, discussed how clinically ill she had been at the time the assaults were taking place in her home. Although she was aware that her boyfriend had become friends with a young girl in the apartment complex, she did not have the mental coherence at the time of the incidents to fully understand what was going on. She stated that she knew that her boyfriend was a sex offender in another state, but she did not know that he had absconded and stated that she did not understand that it was against the law for him to have any contact with children. She described the situation:

Yeah, a little girl was visiting him in the mornings and he wasn't family or anything and we didn't have any kids, kind of odd you know, he's use to tell her "go home in the morning come back in the afternoon" and she would. She'd come over every day. Sometimes he'd stick her on the computer you know, or she'd just sit there and talk to him not me, you know, I didn't...

**INT: How old was she?**

Seven, and he had child molestation charges. So for me, for me, you know, letting that all happen, It's child abuse on my behalf.

**INT: Did you ever question his relationship with this child or other children?**

No, I kept breaking up with him because I didn't want the little girl over every day. I did it twice and both times I was telling him we have to break up right in front of her, she'd go home and tell her mother and then the cops would come

over. I don't know what she was telling her mom but the cops are coming for some reason and they weren't saying why. They didn't tell me what was going on.

In this particular example, even when the police were coming over to question her boyfriend, Vera was unable to recognize what might be happening. Although she wanted to break-up with her then boyfriend over his relationship with the young neighbor, and often would act out in anger towards him, Vera admitted that it was a result of her being jealous of the attention her boyfriend paid to the young girl and not because she suspected that he was molesting the child. So focused on her own psychiatric symptomology and delusions when these offenses were occurring, Vera swore that she never saw her boyfriend do anything with the child other than visit. After serving several months in jail awaiting trial, Vera eventually signed a plea deal that gave her time served and lifetime probation.

The women in the *Child Centered (Violence-Involved)* pathway also had problems in multiple welfare systems. For instance, Pat C. a 39-year-old White woman entered the criminal justice system for the first time after being arrested for multiple charges that stemmed from a fight with Child Protective Services (CPS). Pat had been actively delusional for a significant amount of time and neglectful of her young son as a result. When a CPS worker came to put her son in emergency foster care, Pat fought with the CPS worker and blocked the worker from leaving. When the police were called, Pat punched the police officer in the face and threatened to shoot him with his gun. Her escalation and assault eventually resulted in her arrest.

In each of the case examples for the *Child Centered* pathway, active mental illness symptomology coupled with anger or violence played a significant role in the criminalization. These women also had all experienced sexual assault or significant abuse and neglect as children. Additionally, the women in this pathway had very negligible criminal histories. Although two women in this group had three previous arrests, for the rest their current probation sentence was for their first or second offense. Any chivalry that might exist in the system for female offenders did not appear to carry over when sentencing child-centered offenses. Four of the eight women in this pathway were on lifetime probation. One hypothesis to consider in this sample is that women were bound by the same traditional gender stereotypes (i.e. woman as nurturer) in the eyes of criminal justice professionals and when they do not adhere to those preordained gender roles, they may be punished more harshly than women who commit other types of offenses. This is a hypothesis that is considered in detail in Chapter 5.

#### **Adult Centered (Violence-Dominated) Pathway**

The second pathway for the *Violence-Dominated* group was for those women on the SMI caseload who acted out violently against another adult (that was not substance induced intimate partner violence). Nine women (52.8 percent of the *Violence-Dominated* category) followed this path to the criminal justice system. Like the *Child Centered Violence-Dominated* group, the women involved with adult violence were criminalized as a result of their anger and violence. Seven of the nine women in this category also used a weapon in their violent acts. Whereas five of these women acted out

violently against someone they had relationships with (i.e., sibling, acquaintance), four women were violent with strangers. As was the case with the women involved in child-centered crimes, the women in this pathway were more likely to have active symptomology of a mental illness at the time of their offense. Six of nine women reported active hallucinations or delusions at the time their crimes were committed.

The *Violence-Dominated* women on the SMI caseload who were violent with individuals they knew attacked a family member or boyfriend. May D., a 45-year-old White woman nearly killed her boyfriend at the time when she found out that he had stolen things from her house and had sexually assaulted her teenage daughter. She recounted the story:

My daughter was cramped in a closet when I got home and she was crying and her underwear were ripped and she was bleeding vaginally and two nights later I found him where he was hiding at and I hit him in the face with a bar a couple of times and then there was a baseball bat in the corner that I saw and when he hit the ground I just kept hitting him in the head. I'd say about at least 100 to 120 times. He was, head split open and then he went into the hospital and he was in a comma and when he woke up and he said my name so they did a grand jury hearing and I got arrested.

At the time of incident May was experiencing a manic episode and had not slept for close to five days. When she found her boyfriend she was already enraged, and after they began to argue and her boyfriend hit her in the face, she could not control her anger. She recalled that as she hit him repeatedly voices in her just kept saying, "Kill him. Kill him. Kill him." May's violence was enacted against a boyfriend, but unlike the *Domestically Violent (Addiction-Dominated)* group, her violence was a single occurrence and unrelated to substance abuse. She believed that her violence was a direct result of

her anger and clinical symptomology at the time. May's example is similar to other women who acted with violence in this pathway because the violence was normally in response to a specific episode where the woman was particularly vulnerable due to her mental health decompensating (becoming clinically worse) and not due to repeated intimate partner violence.

For some women who acted violently, the assault began over a much more mundane occurrence than in the May's situation. To explain, a few women stated, "something snapped" or "came over" them or they could not control their anger. In these situations small disagreements or arguments would explode into complicated and dangerous encounters - normally in households already filled with stress and difficult familial relationships. Hilda M., a 30-year-old Hispanic woman, described a situation like this in her own pathway to the criminal justice system. Diagnosed with a mood disorder, Hilda stated that it was often very difficult to control her emotions and that she would become angry at very small things. One such instance became violent and her mother and sister called the police to assuage the situation. Although they did not press charges against Hilda, the state did. Hilda explained in the interview:

I got in a fight with my sister, um, she was, we were at my mom's house. She was yelling at me and just something came over me where I felt like I just got too upset with her and I'm the one who kind of initiated the fight and then I actually grabbed a knife and threatened her with it. So that's why I think they charged me with assault.

**INT: What was the fight about?**

Um, I was on the phone with my boyfriend...and she was just getting angry, she was like, "You've been on the phone too long, I need to make a call" and I asked

her if she could wait and she was saying, “No I’m not going to wait” so I got upset with her and um, got up and we started arguing and then I, she says I hit her first. I don’t know if it really happened that way, but I know I just started you know, fighting and then they called the police. My mom and sister.

In some instances where the *Adult Centered (Violence-Dominated)* women acted out, it was the result of very minor disagreements reaching a tipping point. In this example Hilda described having a difficult conversation with her boyfriend who was living in the psychiatric facility that she had left, was having a challenging time emotionally, was stressed because of her current living situation, and was having severe fluctuations in mood. She believed that each of these smaller things combined had caused her to instantaneously become unreasonably violent with her sister in that moment.

For some women in the *Violence-Dominated* category, their violence was directed not at someone they knew, but at a complete stranger. In these instances it was normally the case that the woman’s mental health had decompensated significantly over time eventually leading to the incident. For Raina A., a 28-year-old White woman with no criminal history, her mental health crisis occurred in a local grocery store. Raina’s mother reported that Raina became increasingly paranoid over several months, thinking that people were saying terrible things about her on social media sites. Raina also was hearing voices continually saying that her mother had been killed. She lost her job and was spending most of her day in a delusional state searching online for things individuals might be saying about her. While shopping at a local grocery store and actively delusional, Raina punched another customer in the face three or four times when they



both reached for the same bottle. After running from the grocery store and to her car, Raina almost struck a pedestrian leaving the parking lot, drove through the closed security gate, and eventually hit a parked car on the street; she was subsequently arrested. With no prior experience in the criminal justice system, and no prior mental health problems or treatment, Raina had no understanding of what was going on in the build up to the incident, or why she was behaving the way she was.

To this point each of the *Violence-Dominated* women described episodic violent outbursts that were the main cause for their entry into the criminal justice system. For some of the women an episode of violence was instantaneous and for others it was a gradual escalation that led to criminalization. There was one notable exception in the *Adult Centered (Violence-Dominated)* group. Heidi A., a 20-year-old White woman, had no adult criminal history at the time of her offense. Heidi developed deep romantic feelings for a man she met when she was a teenager. By all accounts the man had never been interested in Heidi romantically but had been nice to her, and despite multiple romantic advances by Heidi, he had declined to be anything more than a friend. Distraught and delusional, Heidi broke into the young man's family home multiple times to try and convince him to become romantic with her. When these attempts were unsuccessful, Heidi decided to go to the young man's house and kill herself "like Romeo and Juliet." She went to the young man's home and when his father would not open the door the situation escalated:

Well, I had a knife and I cut my arm right here <shows large scar on wrist> to show his dad who answered the door what I wanted, and that was to die with

<young man> and personally by my side, I thought that that's nice versus mean, you know, kind of "I want you so bad." But you know...to take on a person whose broken into their house with a knife, so its, some stranger is - and just you know it's like me against a million eyes. Um, so the police came, they called the police, they felt unsafe with the knife. And then the police tasered me because I ignored their command to get down and drop the knife.

Heidi refused to leave the property after the young man's father denied her entry to the house. She then broke into the house and planned to kill herself in front of the family.

Heidi was not able to realize that the young man did not return her romantic feelings. He was invested in Heidi seeking professional help as opposed to harming herself, which Heidi misinterpreted this behavior as romantic interest. As a result Heidi discussed in detail how she had planned to kill herself in front of the man as an "ultimate act" of love. Of all the violent crimes committed in anger by women in the *Violence-Dominated* pathway, Heidi's was the only one where significant planning was involved and was not a spontaneous act of violence.

### **Violence-Dominated Women and Mental Disorder**

As can be seen by the case examples presented for *Violence-Dominated* women, mental disorder was an important contributor to the criminalization of these women. For a few women who did not directly commit an offense but were living with a man who was sexually assaulting a child, their own active mental illness often kept them from fully recognizing the severity of the situation they were in. As well, for the majority of women who acted out violently or in anger against another person, their acute symptomology involving mental health problems aided mightily in their criminalization.

Comparing the *Violence-Dominated* category with *Addiction-Dominated* category the two groups shared similar biographical experiences of profound childhood trauma and economic marginalization, but their histories differed by the fact that *Violence-Dominated* women were less drug/alcohol involved. As well, substance use was not the primary reason for their criminalization as it was for the *Addiction-Dominated Women*. Of the 17 women in the *Violence-Dominated* category only three were active drug users (17.6 percent) and nine (52.9 percent) had never used drugs or had only used them recreationally at some point in their lives. Additionally, these women differed markedly from most *Addiction-Dominated Women* in their criminal histories. The majority of *Violence-Dominated* group had little to no experience in the adult criminal justice system prior to their current offense. For this deep sample of SMI women on probation, it appeared that mental illness played an indirect role through substance abuse/addiction for the *Addiction-Dominated Women* and had a more direct role in the criminalization for women in the *Violence-Dominated* category.

## **ECONOMICS-DOMINATED WOMEN**

The final category in the deep sample of women on the SMI caseload was through involvement in crimes for economic reasons. The women in this category shared some similar characteristics to those in the *Violence-Dominated and Addiction-Dominated* groups. Their lives were filled with trauma, poor adult relationships, and many were economically marginalized. However, for the most part this group of offenders did not

have the significant histories of substance addiction that the *Addiction-Dominated* group did. Seven of the women who were economically motivated (77.8 percent) either had never used drugs or only recreationally in the past. The two exceptions to this had both achieved long-term sobriety. These women engaged in petty theft, identity theft, or fraud that was ultimately responsible for each woman's criminalization.

This group of women is markedly different from other economic offenders found in past gendered pathways research. Daly (1992, 1994) in her original work in gendered pathways had no *Economic* group but instead an "other category." Morash & Scharm (2002), Reisig et al., (2006) and others later labeled this type of offender as economically motivated and it has been a commonly considered pathway to criminalization for women offenders since. Women in the current study almost universally had significant histories of victimization, mental illness, relationship difficulties and other risk factors for entry into the criminal justice system. This would most likely exclude any purely *Economically Motivated* offenders in the traditional gendered pathways sense from being on the SMI caseload. As a result it is important to note that the biographies of *Economic-Dominated Women* in the current study differ substantially from previous gendered pathways examinations, except that each of the women in this category committed economic offenses. All but two of these women were economically marginalized, all were diagnosed with mental health disorder, and almost all had histories of trauma.

The *Economic-Dominated* category of women entered the criminal justice by attempting to achieve economic gain in a fraudulent manner. Three of these women

committed crimes out of desperation feeling that they had no choice. These women were placed into the *Trapped (Economic-Dominated)* pathway. Six other women were repeat offenders. They were often impulsive and normally committed retail theft or fraud when they were experiencing manic episodes. This pathway was labeled *Impulsive (Economics-Dominated)*.

### **Trapped (Economic-Dominated) Offenders**

The three women in the *Trapped (Economic-Dominated)* pathway had specific life circumstances at the time of their offense that contributed to their decision to break the law. Beth A., a 35-year-old White woman was in dire need of transportation for herself and her children when she bought a car from a man she did not know. When that car turned out to be stolen, Beth was arrested. She explained:

Well, this guy came by and he was a friend of a friend and he's like you know I heard that you're looking for a car. "Me and my lady split up, I bought the car for her so I took it and I don't need two cars you know, would you like to buy it? I'll sell it to you for \$1500 bucks." I was like "okay." You know, I drove it and like okay I'll get it and it was like, I don't know it was like a little SUV type thing and he's like uhh, well I don't have the title right now. He said you can pay part of it right now he said because I'm moving cause we split up and he said the title's put away. I was like, "okay that's fine I'll give you some money down on it right now and then when you bring the title and I'll pay the rest." I don't know how long I had the car, maybe a month and the next thing I know police are knocking at my door, saying, "Who owns that car?" And I'm like, "I do." Why am I going to lie? As far as I know I own the car. And I take them out and they're looking at it, you know, they look it over and they tell me, or they punch it up on the computer and the car and they tell me this car is stolen...And, you know, I told them the whole story about how I got the car.

This incident was what initially led Beth into the criminal justice system and probation.

In the months after her offense her clinical depression became so severe she could not get

out of bed and missed multiple mandatory appointments with her probation officer. When the police came to her house she was arrested on a weapons charge during a search of the property. Although Beth admitted to being frustrated with herself for being so naïve in the situation, she also maintained that she did not understand the car had been stolen or she would have never purchased it. Hoping to relieve her enormous stress at the time by having transportation for herself and her children, her clinical depression significantly worsened as a result of her arrest and conviction.

Betty C. a 40-year old Black woman was also in a tremendous financial bind at the time of her economic offense. Under stress at her job and living with profound depression, Betty had just been released from a hospital stay after a suicide attempt. Needing financial assistance and feeling that she had no other choice, Betty fraudulently created an identity and cashed checks at the payday advance loans branch where she worked. In her interview Betty recalled the incident:

Cause I had attempted suicide, I couldn't take it anymore there, they were just working my nerves, I had never done anything like that, but long story short...I was losing everything, and they wouldn't help me out, I couldn't get another, I couldn't get a pay day loan from anybody else cause I worked at a pay day loan store, so I had, I just felt like I had no other resource, I didn't have any family to ask, so I used my own checks, and put three loans in the system, made up a person that we used, that we denied, I used their information, like switched it around but used their name, not their real social, nothing else was real but their name. Like I said the other person was made up completely, um, and then the third person was one of my customers. I knew he wasn't gonna be coming back anytime soon, but, his loan that I put in the system I had already started paying back on. It wasn't like I was trying to steal from them, but I know what I did was wrong so...

**INT: You eventually got caught?**

Well yeah, um, cause I couldn't, I couldn't pay the loan back, and um, I had people, there's people in there that worked there that was gonna take the payments for me, so it was, that wasn't the issue, the issue was I didn't have the money to pay it, so eventually, they started, you know they all started coming to date, and they started calling people, they started researching it, then they called the police. And when they came to my door I was just so relieved, that's what the detective said even in the report. He said I was so forthcoming.

Each of these *Trapped (Economic-Dominated)* women had significant problems with her living situation that only complicated her criminalization after the initial offense. In the examples of Beth and Betty, the guilt and embarrassment over their offenses compounded their clinical depression. They missed required meetings with their probation officers and violated their probation. This resulted in more punitive actions in the criminal justice system.

### **Impulsive (Economics-Dominated) Offenders**

The six women who were in the *Impulsive (Economic-Dominated)* pathway were all most likely to commit economic offenses when experiencing prolonged manic episodes. Like the one-time economic offenders, the majority of women in the *Impulsive (Economic-Dominated)* category committed crime out of necessity, but their crimes were more likely to result from impulse and necessity over extreme need only. For instance, Raquel I., a 26-year-old Black woman described that she would often cash bad checks during episodes where she was manic and not thinking clearly. During one of these particular episodes a man Raquel did not know approached her to help him cash a check. She explained during the interview:

Somebody just asked me you know, I didn't have a job and someone saying you know, are you trying to make some extra money, you know I can put the check in

your name and all I had to do was cash it and you can keep the rest of the dollars, so I did it cause I needed some money.

**INT: How much was the check worth?**

It was \$1100 and I only got \$300 out of it. It was a single check but then there was one time you have like you know, how you have a bank account and you get your checks? There's people who made those checks and I just went to stores and used them.

Some *Impulsive (Economic-Dominated)* women only committed crimes with strangers and never against someone they knew. Others, however, committed crimes against loved ones too. Fay J., a 34-year-old White woman committed several economic offenses against her mother, defrauding her of an estimated 250,000 dollars over several years. However, she did not enter the criminal justice system though until she was caught with a group of other women who ran an operation that stole the identities of several people. Fay admitted that she was easily influenced by others and was initially introduced to the defrauding scheme by a female friend.

*Impulsive (Economic-Dominated)* women were somewhat unique in that some did not necessarily only steal out of necessity. For instance, Martha K., a 57-year-old White woman was living a perfectly comfortable middle class life with a full time job when she stole several thousand dollars worth of possessions from a family member. Martha noted that the family member owed her the possessions for Martha's assistance, but the family member stated that Martha had been taking things from the family since she was a young adult. Similarly, Faith T., a 20-year-old Black woman had been criminalized as the result of several thefts. Although Faith often stole from local department stores to assist with



her living needs and those of her small child, she also reported taking things in extremely hyper states when she had mixed up her medications and was particularly agitated. Faith recalls one of the incidents during her interview:

It was honestly just baby clothes. Stuff like that. Onetime I had accidentally taken the wrong medication. My psych medication. I thought I was taking my anxiety medication and it ended up being my other medication and I was like so out of my mind, I went into to Wal-Mart and stole candle holders and a whole bunch of stuff like that. I don't even know why. I don't need no damn candles, I have lights. So – Its - yeah?!?

Faith seemed perplexed by her own decision to steal items she did not need. Although she was not caught for that particular shoplifting offense, she was for later ones where she was taking things for survival needs and also for more frivolous reasons.

### **Economic-Dominated Offenders and Mental Disorder**

As highlighted in the case examples above, economic offenders in the deep sample were impacted by their mental health problems when committing their offenses. Eight of the nine women in the *Economic-Dominated* pathway were diagnosed with bipolar disorder and the ninth woman listed it as a secondary diagnosis. It appears that for these women extreme symptomology (either in depressed or manic states) aided in their pathway to the criminal justice system. For the women in the *Trapped* pathway, a profound sense of hopelessness and clinical depression was apparent at the time of their offense. For most of the *Impulsive* pathway woman, symptoms of mania and spontaneity were evident at the time of their offenses. This perhaps indicates that *Trapped* (*Economic-Dominated*) group came to the criminal justice system after committing an act

of desperation in a depressive state, and that manic episodes may trigger the continual offenses of *Impulsive (Economic-Dominated)* offenders.

### **PATHWAYS OF THE WOMEN ON THE SMI CASELOAD REVIEWED**

This sample of 65 women all diagnosed with a serious mental illness had been placed on the SMI probation caseload. As discussed, the women shared similar biographical experiences that have also been consistently highlighted as important in the pathways literature. For instance, as children and young adults, almost all of the women had been victims of sexual abuse, physical abuse, or profound neglect. A few women who had not been the direct victim of this abuse or neglect had witnessed repeated abuse in their homes, and they discussed the impact of that experience during interviews. Patterns with chaotic and abusive relationships followed these women to adulthood where they were often in unhealthy and abusive relationships. The dysfunction surrounding these relationships often enabled initial substance addiction and criminal activity and then compounded into further addiction and criminal activity.

Many of the women ran away or left home at an early age and spent most of their lives cycling between the streets, the mental health system and the criminal justice system. Others were forced to leave their homes to live in psychiatric institutions or to spend extended periods at residential homes for problem youth in drug rehabilitation facilities. At the time of the interview over three-fourths of the sample had spent time in

a psychiatric hospital (not counting drug rehabilitation) at some point in their lives with over one-third of the women having multiple intakes to psychiatric hospitals.

The majority of the women I interviewed also were economically marginalized. Most of the women (though there are noted exceptions discussed throughout the chapter) lived in poverty for the majority of their lives. Many of the deep sample cycled in and out of homelessness and some had lived without stable housing throughout adulthood. Due to their extreme mental health needs and other physical ailments, very few of the women were able to find employment and predominantly survived on financial assistance from the state and from personal relationships. These women on the SMI caseload also had significant and complex relationships with drugs and alcohol. This was apparent in that 80 percent of the women had drugs or alcohol abuse problems at one point in their lives. Additionally, 30.8 percent were struggling with an active addiction having not maintained sobriety for at least a year.

The women in the deep sample entered the mental health system through both informal and formal channels. Although many first talked with a professional about their mental health problems because of the concern of loved ones, many women also entered the mental health system through the criminal justice system. Mental health symptomology in school and drug rehabilitation also provided the catalyst for some women to initially enter mental health treatment. It is important to consider the degree to which the different systems were at least partially responsible for the pathway into the other system. To explain, the majority of the women in the deep sample were initially in

the mental health system before ever entering the criminal justice system. In the end any treatment received was not entirely effective given each eventually entered the criminal justice system. Likewise, the most prominent entryway to the mental health system for the deep sample of women came through delinquency as a juvenile or an adult conviction. For many, help for their significant mental illness and functional impairment was not ever addressed until they already had a criminal offense. This raises important policy considerations for the mental health and criminal justice systems further considered in Chapter 7.

When addressing the overarching paths to the criminal justice system for this sample, three principal categories emerged. These classifications were the *Addiction-Dominated* category, the *Violence-Dominated* category, and the *Economics-Dominated* category. Within each of these three major classifications, pathways were created to better understand a specific route to criminalization. It is unclear to what extent mental illness *caused* the crimes to occur in any of the scenarios. Like Daly (1992, 1994) discussed in her work, the intention here was to examine the pathways to criminalization (how each woman came to the criminal justice system) over actual crime causation.

The first and largest category discussed was the *Addiction-Dominated* group. These women committed crime as a result of their addiction to substances. They followed a *Street Woman* path, a *Domestically Violent* path, or a path where women from more privileged upbringings were considered “bad” only after being labeled “mad” and seeking unsuccessful treatment (labeled as the *Mad/Bad* pathway). For *Addiction-*

*Dominated* women, mental disorder symptomology formed a complex relationship with substance use. Many of the women endorsed using substances to self-medicate and to help alleviate their problems as a result of mental disorder. However, some women also reported that self-medicating behavior often exacerbated their mental health issues. Finally, some women also felt that their drug addiction was what eventually led to their mental health problems. In their opinions years of increased drug use and changes in the quality of drugs on the street were responsible, in the end, for significant symptoms of mental disorder.

The second category was the *Violence-Dominated* group. *Violence-Dominated* women shared similar biographical components to most of the women in the *Addiction-Dominated* pathway, but their criminalization was not a result of obtaining substances or use. These women engaged in, or were accomplices to violent acts. The group was divided into two distinct sub-categories – a *Child Centered* group and an *Adult Centered* group. For *Violence-Dominated* women, mental disorder normally played a significant role in their criminalization. Many women reported experiencing profound auditory or visual hallucinations or delusions when their offenses occurred. Other women were too focused on their own mental health needs to recognize or understand the seriousness of the crimes that were being committed in their homes involving children to which they would be charged as an accomplice to. Still others lived under immense fear and paranoia about what might happen to them if they told anyone about their hallucinations or delusions or about the crimes they were accomplice to. These women acted out with

anger or violence and it was often very difficult for *Violence-Dominated* women to control their emotions.

The final grouping for women on the SMI caseload who were interviewed fell into the *Economics-Dominated* category. Women in this group were criminalized as a result of committing offenses that assisted them financially. The pathway was split into *Trapped Economics-Dominated* offenders and *Impulsive Economics-Dominated* offenders. The *Economics-Dominated* group was almost exclusively made up of women without substance abuse problems who were diagnosed with mood disorders. These women normally committed crimes while they were profoundly clinically depressed or experiencing a manic episode. *Trapped (Economics-Dominated)* women normally committed offenses that led to their criminalization under duress. They felt trapped by their circumstances and believed they had no other choice. *Impulsive (Economics-Dominated)* also normally (but not always) engaged in crime out of circumstance, but were highly impulsive and manic during their offenses.

A final consideration that encompasses each of the pathways to criminalization for women diagnosed with significant mental disorder is that of the role of relationships. As previous research has noted (Covington, 2003) women's relationships are extremely important to entry into the criminal justice system and also important to exit from the criminal justice system. This was glaringly true in this sample of women. In fact, relationships emerged as a paramount consideration for SMI women across pathways. Women in the *Addiction-Dominated* category were often introduced to drugs through

friends or male intimate partners. For the *Domestically Violent* women, all episodes of violence happened because of relationship problems that occurred after using substances. Some women involved with crimes against children were only accomplices to the crimes of their boyfriends. Finally many of the women who acted violently did so with a family member or someone with whom they were romantically involved. Problems in each of these relationships were a common component in the criminalization of women on the SMI caseload. The importance of relationships in understanding the criminalization process and the experience of SMI women in the criminal justice system is another policy consideration discussed in detail in Chapter 7.

## **CONCLUSION**

The goal of this chapter was to examine the pathways to criminalization for women with serious mental disorders. Findings show that women vary in the types of diagnoses, crimes, and biographical experiences they have on the way to the criminal justice system but that specific clusters of experience or “pathways” do emerge. Borrowing from the constructed biography techniques of previous researchers (i.e. Daly, 1992, 1994; Reisig et al., 2006), I was able to classify the deep sample of 65 women who were interviewed based on dominant problem categories and pathways to the criminal justice system. I was also able to illustrate the influence that symptoms of mental illness directly had on one’s entry into the criminal justice system. In the next chapter I examine experiences while in the criminal justice system and the impact that formal social control

has on functionally impaired women diagnosed with serious mental disorder on the SMI specialty caseload.



## CHAPTER 5

### FORMAL SOCIAL CONTROL FOR WOMEN ON SMI PROBATION

#### CHAPTER OVERVIEW

As reviewed in Chapter 2, Liska (1992) defined social control as, “those acts, relationships, processes, and structures that maintain social conformity” (p. 2). All societies have systems of social control in place to respond to deviance. At the heart of formal social control in most Western cultures are the criminal justice and mental health systems. Liska (1992) referred to these as “coercive” and “beneficent” controls, each with the power to exert expanded regulation over any individual. Especially vulnerable to different forms of social control are those who are deemed a social threat in society. As well, theorists have argued that as different formal social controls expand, a “widening of the net” of social control occurs (Austin & Krisberg, 1981; Cohen, 1985; Warren, 1981 See also, Foucault, 1977). Foucault (1977) posited that the expansive reach of the institution sought not only to control more people, but also to increase the control over individuals in new ways. Cohen (1985) argued that as formal social control moved to the community through diversion in the criminal justice system and deinstitutionalization in the mental health system; “deposits of power” (p. 90) from these systems only widened the net of social control into new areas. This net widening frequently blurred the boundaries between systems of social control (such as the mental health and criminal justice systems) and also expanded to the community in unique ways.

There are specific impacts these deposits of power engender for girls and women. Historically women have been considered “mad” over “bad” and their deviance has been pathologized as opposed to criminalized (e.g. see Chan, Chunn & Menzies 2005; Russell, 1995; Smart, 1995). The phenomenon where women’s deviance has been controlled within the confines of the mental health system as opposed to the criminal justice system is sometimes referred to as the *medicalization of female deviance* (Offen, 1986). Furthermore, some scholars have argued that women who violate traditional gendered norms or societal expectations are specifically targeted for expanded social control (Horwitz, 1990; Tittle, 1994) and these women may also be targeted for psychiatric treatment (Thompson, 2010). Building on this dichotomy of women being seen as “mad” or “bad,” the goal of this chapter is to explore examples of expansive social control that exist for a group of women who have been labeled *both* “mad” and “bad” under the dual control of the criminal justice and mental health systems. Kendall (2005) suggested that these women historically presented a “philosophical conundrum” to the different systems of social control as, “Criminality implied responsibility for one’s actions, whilst lunacy suggested a loss of reason and therefore absence of responsibility” (p. 47). Contemporarily, women are also vulnerable to increased regulation by multiple formal social control systems due to their perceived social threat as a result of breaking gendered norms and being labeled both “significantly mentally ill” and “criminal.” To examine these different aspects of formalized social control, I explored mental health court field notes for nearly a year of observations, case file reviews of each of the 65 women in the

deep sample, and informal conversations with members of the courtroom workgroup. Most importantly, I drew upon interviews with 65 women in the deep sample. Aspects of expanded social control for these women are analyzed in several domains. First, examples of the control girls and young women experience in the juvenile justice system are highlighted. Second, the experience of these women is considered through the lens of psychiatric and medical control. The chapter concludes by investigating how these women ultimately felt about the extensive influence the criminal justice system had over multiple aspects of their lives.

While reviewing the expanded formal social control for women on the SMI caseload in the deep sample, two specific aspects of the women's experience are also highlighted at points in the analysis. First, the double-binds (e.g. Becker, 1995) that are common for the women in the deep sample and the SMI caseload in general are considered. In these double binds, no matter the "choice" that a woman makes, it inevitably leads to harm in some way in her life. Second there is evidence that women on the SMI caseload, like all women in the criminal justice system, are subjugated to formal social control in gendered ways. This is also briefly considered using a few examples throughout the chapter.

## **THE EXPANDED SOCIAL CONTROL OF DELINQUENT GIRLS**

Past research (e.g. Chesney-Lind & Pasko, 2004) has placed a spotlight on the relationship between girls/young women, and institutionalization. For instance, the use

of private confinement (most notably psychiatric hospitalization and residential placement) to confine girls in comparison to boys, the lack of significant psychiatric impairment for “severe or acute mental disorders” that girls often display in these facilities, and the extended time spent in these institutions compared to adults have all been noted as concerns (Chesney-Lind & Pasko, 2004, p. 83). The authors felt the expanded social control for girls and young women was especially problematic given the lack of specific intake requirements and the propensity with which abuses happen to females in these institutions.

The women in the deep sample of the SMI caseload discussed similar themes regarding the parallel systems of juvenile justice and social welfare. For many women this formal control began early in their lives and followed them consistently from that point onward. Forty women (61.5 percent) originally entered the “benevolent control” of the mental health system as a child or teenager. Additionally, 24 of the women (36.9 percent) had already entered the “coercive control” of the criminal justice system by the time they reached adulthood. These women discussed memories of institutional confinement and the profound sense of abandonment and frustration they felt as a result of residential placement at a very young age. For instance, Maria F. was sent to a residential facility for the majority of her childhood after she started her parents’ couch on fire. At age five Maria’s parents were undergoing an unpleasant separation and her mother stated at the time of the incident that Maria believed setting the family sofa on fire would bring her father home. Labeled an “unruly child” after the incident, Maria spent

most of her childhood and teenage years living in a residential facility with frequent outbursts of anger.

As previous research has shown (e.g. Chesney-Lind & Pasko, 2004 ; Daly, 1992, 1994), substance abuse, pregnancy, and running away were often responsible for forms of social control that expanded beyond the criminal justice system. In the current study, several women discussed similar experiences with early substance abuse, pregnancy, and running away to escape abuse. Generally, the women looked back quite negatively on these experiences as girls and young women. One woman discussed being the victim of a sexual assault by a male staff member as particularly traumatic. Another woman, although not physically assaulted, felt especially emotionally violated as a result of her experiences within the social services system. Hanna A. described running away from home in response to ritualistic physical abuse at the hands of her stepfather. Hanna went to stay with a friend, and after that friend's mother called the authorities over the situation, Hanna was placed in a residential facility. She explained:

The cops came and saw that I was bruised from head to toe, real dark...So they put me in a detention center and said you have to find a safe home and if you don't find a safe home we have the right to take you to CPS <Child Protective Services> and CPS came and got me because nobody came and got me <from the family>. None of my family wanted me.

Hanna felt specifically betrayed by the "system" after she turned 18 and was classified as a "vulnerable adult" and in need of partial guardianship. Hanna believed that because she started receiving her own social security benefits when she became a legal adult that her family then wanted to take care of her. Hanna stated that her family

this time responded, “‘Oh I want her, I want her, I want her!’ Money. It was a money thing.” Hanna’s feelings of betrayal were a result of not being protected from a lifetime of abuse and neglect until she finally ran away from home and was placed in a long-term residential facility. She felt that social services had further failed her when at the age of 18 she was returned to a family member who was unwilling to take her in when she was not receiving a monthly financial stipend.

Bev R. shared a similar experience regarding the contradictory treatment afforded her by agents of social control. As Bev entered high school her moods began to fluctuate considerably and with little notice. When Bev sought help from her family for her mood problems, she went from not being taken seriously, to giving up her freedom entirely for a summer. Bev recounted:

Um, what happened was my mood started switching...I started getting all emotional, distraught doing crazy things and I knew something was wrong and nobody was listening to me and they were saying, “Oh it’s adolescence stuff. You know hormones, you’re going through puberty you’re fine, you’re just going through a hard time.” So what I had to do to get everyone’s attention was I found the dullest knife I could and brought it to school and said I was going to kill myself. Finally everyone was like oh, there’s something wrong with her and they took me to a psych hospital to get help cause no one would listen to me. I was saying something is wrong, something is wrong. No one would listen so I had to go to drastic. And finally when I went to the psych hospitals, they put me on antipsychotics...So I was in and out, in and out, in and out. Around that time I was in there in and out a total of sixty eight days.”

Hanna and Bev were both presented with uneven and puzzling power over their lives that ultimately created double binds. In each situation despite the course of action they chose, the decision would lead to a negative impact on their lives. For example, both committed minor offenses in order to try and escape their circumstances after not

receiving help they needed. Bev's experience had been particularly gendered, as she explained during the interview that her family and school counselor had considered her behavior not only "adolescent stuff" as highlighted in the above excerpt, but also a consequence of being a young woman. It was naturally assumed that her dramatic behavior was just what teenage girls do. However when Bev and Hanna actually responded to what was occurring with them in a deviant way, both were put in longer-term institutions. Likewise, it was only when each broke culturally approved gender normative behavior (submissiveness, obedience, and passivity for young women) that they not only received a response, but they also experienced an amplified response by multiple systems of social control. These findings support other scholars' work on the experiences of girls and young women in the criminal justice system. For instance, Smart (1976) has suggested that the widely held misconception involving girls' delinquency is that, "Deviancy by a female is a sign of a much deeper pathology than deviance by a male" (p. 133). Dembo et al. (1993) found that girls' delinquency is often different than boys, resulting specifically from a distressing life at home that could lead to increased running away. Where boys may begin crime through associations with others, girls may do so as a result of broken homes. Likewise, Dembo and colleagues (1993) explained that girls were more likely than boys to come in contact with the criminal justice system for status offenses like running away from home. Similarly, in the current sample multiple young women had control placed over them as a result of status offenses or

responding to their circumstances that perhaps were different than those that would have been placed on boys.

### **BENEVOLENT SOCIAL CONTROL OF WOMEN ON SMI PROBATION**

Multiple scholars have reviewed in detail the long history of women's unique involvement with psychiatric institutions (e.g., Chesler, 1972; Russell, 1995; Rogers & Pilgrim, 2010; Ussher, 1992). In the seminal work of Chesler (1972) the author argued that women were considered "psychiatrically impaired" as a result of stereotypical gender roles. Chesler (1972) and others posited that the patriarchal system of psychiatry labeled women as mentally disordered more often than men in ways in which, even today, are unique (Rogers & Pilgrim, 2010). However, the authors have also contended that men who are labeled as mentally disordered and criminal are governed by greater control than similarly situated women. To explain, men have generally been considered to be dangerous and to be treated, "At the 'harsh' end of psychiatry as mentally disordered offenders in secure facilities" (Rogers & Pilgrim, 2010, p. 82). The authors considered this notion to be especially true when bearing in mind those men labeled in both the criminal justice and mental health systems. Examining the current sample of women on the SMI caseload, many of the aspects of expanded social control that have been considered "male" were also evident for these women deemed both criminal and mentally disordered.



Although many women were subject to expanded formal control of the mental health system as teenagers, by adulthood the overwhelming majority of them had experienced a psychiatric confinement for acute mental health symptomology, a suicide attempt, or acting out behavior. Three-fourths (75.3 percent) of the women interviewed had at least one involuntary psychiatric hospitalization during their lifetime. These forced hospitalizations ranged from a few days for some women, to at least four different women being institutionalized for one year or longer at an inpatient facility during a single psychiatric stay.<sup>21</sup> Of the women who had been hospitalized, nearly one-half (49.0 percent) experienced multiple psychiatric hospitalizations. These hospitalizations were rarely if ever completely voluntary and were seldom considered a positive experience in their lives. Heidi A. described her own experience with being “numb” during her inpatient psychiatric care:

It was like I was like frozen like I was being patient beyond reason. I wasn't trying to think I wasn't trying to take it in, I was just trying to wait to get back to my own little nest of life like it was a world of new people, strangers, and consequential decisions. I just wanted to be like left alone, you know what I mean, like I didn't even, I didn't even take it in. I just wanted, I got - it was like the feeling of when you don't have a choice, your body kind of goes into hibernation...

But the hospital...it kind of felt like, it kind of just felt like the anticipated uh, overflow of professional opinions I mean I was fresh bait for them to do what they do, which is you know - judge people's cases and I knew that that's all they were going to do. So I just - it was almost not whether I agreed with them or not...I was like jumping in their pocket.

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<sup>21</sup> The majority of women on the SMI caseload had at least one hospitalization lasting at least one month.

Biding time was a common theme for women in the deep sample as they recounted their experiences with psychiatric hospitalization. In this instance, Heidi referred to it as “hibernation” and being “frozen” or “fresh bait” for the professionals. As well, Heidi and other women romanticized their lives in the community when under the control of the psychiatric institution. These women described the world outside the institution as “warm” or “real” and Heidi herself likened her non-institutionalized life to a “nest.”

Like Heidi, Pat C. felt traumatized by her experience under psychiatric institutionalization. Pat had become well versed in the anti-psychiatry movement as an adult and had read numerous books on the medicalization of mental illness. During her interview she admitted to being highly delusional when she entered the psychiatric hospital for the second time but felt the loss of governance over her own life to be especially troubling:

It was horrible - they just kept making sure I took these pills that made me not have any strength left in my body, I couldn't even open my orange juice. I had to have an old lady open it for me. They took away my strength and they took away my brain, cause they were causing a chemical lobotomy in my brain so I couldn't remember anything or think, I just stared in front of me and just looked- and I forgot what happened...

Importantly, the women who discussed in detail their experiences with psychiatric hospitalization considered this confinement to be more all encompassing and overpowering than their carceral confinement. In jail and prison the respondents felt that they were at least in control of their own cognitions, feelings, and worldviews. This is not to say, however, that many women were not acutely symptomatic when they had been

institutionalized. For example, some were experiencing significant hallucinations about harming themselves or others, while some women also existed in a near catatonic state before their hospitalization. However, for selected women longer-term psychiatric hospitalization created a feeling like they had not only lost their freedom, but perhaps even worse- any sense of personal identity.

### **Medicalization, Mental Disorder and Social Control**

Highlighted in Pat's discussion of her experience in the psychiatric hospital was the mention of a term she returned to more than once during her interview – “chemical lobotomy.” The majority of women interviewed had experienced profound psychiatric symptomology at different points in their lives. As a result, most women had lengthy and complicated relationships with psychotropic medications to help with mental health symptoms. The majority of the women had grown quite accustomed to taking psychotropic medication on a regular basis as part of their court-ordered treatment. Scholars have argued that women are prescribed and use psychotropic medications at far greater rates than men despite their clear ambivalence about doing so (Rogers & Pilgrim, 2010). Notably, when considering gender in prison, psychotropic medication has been utilized up to 10 times more in female than male facilities (Culliver, 1993). Researchers have argued that psychotropic medication is so much more prevalent with women in the correctional system than men as a result of a “historical tradition of ‘treatment’ responses to the behavior of deviant women” (Auerhahn & Leonard, 2000, p. 628).

The personal feelings about medication and its success varied substantially among the women interviewed.<sup>22</sup> Generally, coerced adherence to a medication regime at some point in their lives was nearly universal in the deep sample. Several women had been placed on court-ordered treatment for a year when the judge/courtroom work group deemed it necessary. Some women who were considered unreliable due to their diagnosis and past behavior, or who initially resisted their treatment, were required to have their medication administered via injection. Normally this increased regulation was only implemented when women could not or would not agree to take the medication on their own. Hilda M. described her experience with a compulsory court-ordered medication regimen. She stated:

Well, um, I was at Mental Health Court the second time, I went to the hospital for mental health, um, I was court ordered treatment for a while I had to take an injection of Haldol but now my doctor says I'm doing well so they took me off that shot and I'm just taking the medication. Yeah, but the anxiety is still an issue though for me but it's not all the time, it's just like rare when that happens but it does happen.

**INT: Was there any reason that you had to take your medication via injection?**

Oh, yes, there was a reason, um, I felt like, I felt like I was really upset that I, the doctor diagnosed me with mental illnesses and I felt like I didn't want to take the medication. It was really hard to start taking it because then I would, it was for me, I thought I was, you know, agreeing with the doctor, with what they were saying "okay, you know, I'm mentally ill."

Some women were actively defiant with their court ordered treatment, or initially

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<sup>22</sup> At the time of the interview all but one of the deep sample had been prescribed psychiatric medication and 60 women (89.2 percent) were actively taking psychiatric medication for symptoms of mental illness.

refused to agree with the mental health professionals about their diagnosis. Raina A. shared an experience similar to that recounted by Hilda. After being arrested for assault, Raina was sent to a psychiatric hospital:

I got taken to the hospital and they forced me to take some medicine and then they told me that I might be bipolar and schizoaffective. That was very upsetting for me because they told me that I have to be on meds for the rest of my life... Yeah, eventually I will be allowed to take my meds orally. At first I refused the medicine and that is why they put me on the shots.

For Hilda and Raina, agreeing to take psychiatric medication also meant agreeing with a diagnosis of mental disorder – a label that both were certainly not happy about. At the time of the interview, both were resigned to the fact that to be court compliant, they must also be medication compliant. Both admitted to even seeing some improvement as a result of taking the medication, but each continued to be troubled by the stigma involved with their diagnosis. In one instance if they were not compliant with their psychotropic medication, they were in direct violation of their probation. On the other hand, taking the medication and adhering to the court-ordered treatment felt like an admission that they were “crazy” or even more abnormal. For women like Hilda and Raina, professionals believed an acceptable alternative to voluntary oral administration of psychiatric medication was to have a professional administer periodic injections until these women were more willing to fully comply with their court-ordered treatment.

Beyond refusals to take prescribed psychiatric medication, other women were administered medication via injection because they were transient or had frequent memory lapses. In these cases mental health professionals did not want the women to go

into psychiatric crisis in the community without medication. Dia A. recounted that she had asked her doctor if she could switch from doing injections to taking medication orally. When asked why she received injections she stated:

Cause I'm basically not compliant, I forget I mean. I think that, then I think I take too many. And I think it's my doctor. I don't know, I told him, "I think that I'd rather take pills." He goes, "Oh, we are way past that!" He was kind of joking with me I think, cause I don't even know sometimes the day of the week.

Some women who were not administered injections were still considered unreliable about taking their psychotropic medication. For these women other means were implemented to ensure medication compliance. For instance, Vera R., had been traditionally quite sporadic in her adherence to her psychotropic medication due to occasional memory lapses. She stated that her medication was delivered to her on a nightly basis. Staff members from a local clinic would come to her home in the evenings to personally administer the medication and ensure full compliance.

Medication was considered an enormously important tool by the courtroom to sedate women in the community. The court also felt medication assisted many women with coping and alleviating clinical symptomology. Some women, like Hilda and Raina discussed above, raised several concerns with their court-ordered medication. Referred to by one woman quite unsympathetically as the "cocktail" (the regimen of multiple psychotropic medications in varying doses at different times), psychotropic medications often had unknown or unwanted side effects that could even result in medical complications. Several women also voiced concerns regarding psychotropic medication and the effects on their bodies in gender specific ways. For instance, a few women

discussed being pregnant at different times in their lives while on psychiatric medication, as well as the anxieties they had about the impacts of court ordered treatment on their unborn children. Professionals oversaw their medicine regime and sometimes mandated women to take certain medications during their pregnancy and at other times instructed them to abstain from specific psychotropic medications because of their pregnancies. Numerous women also disliked the swift and substantial weight gain that was a common side effect of many of their medications. Billie B., for example, had been taking multiple psychiatric medications for years. When discussing the most problematic side effects of her medication she noted a common concern:

I hate the way I feel in the mornings. After I take my medicine I just feel like I'm still dead tired, it just, and then I gained 100 pounds after I started taking my...yeah, yeah...I gained bad heavy weight gain and it makes me just feel groggy every morning.

The concerns over being lethargic and gaining significant weight were particularly problematic for some women with substance abuse issues who had used illegal drugs to self-medicate (numb) psychological symptoms and to manage weight in the past. For women like this, psychiatric medication normally did not provide the perceived benefits that illegal substance did (limitless energy and appetite suppression).

Despite women's concerns about the impact of psychotropic medication on their bodies, professionals working with the women on the SMI caseload took medication compliance very seriously. The women in the deep sample were often frustrated that the professionals prescribing the medication would not listen to concerns over problematic side effects. Regardless of these concerns, it was expected that women would adhere to

all aspects of the medication regimen. For those who did not, graduated forms of control were in place. Beyond medication injections already discussed, some women would be brought before the judge and the mental health court when experiencing medication problems. This was the case for May D. who had been required to come before the court a few weeks prior to her interview. May had overdosed on her psychiatric medication and was rushed to the emergency room to have her stomach pumped. May swore that this was an accidental overdose and that she was not suicidal when the accident occurred. Crying and visibly shaken when she went before the mental health court, the courtroom workgroup decided that in the future May's adult daughter who lived with her would be in charge of administering all medication so that May would not be responsible. Prior to court May's probation officer had cleared this plan with her daughter. This solution made the courtroom workgroup feel more comfortable that May could remain in her home while also complying with her medication regime. May, on the other hand, was resentful of the resolution that the court had come to without her input. She admitted that she needed help in managing her medication, but stated in her interview that she also disliked being treated like a child, and having even more regulation placed over her life as the result of an accidental overdose was particularly troublesome to her.

Though some women feared the expanded social control of the criminal justice system when there was a medication problem, others were specifically concerned with the mental health system's control. Some women were occasionally dishonest with the professionals who were prescribing the medication in an attempt to leave inpatient



treatment or a residential placement more quickly. Carol T. discussed this specific type of situation during her interview. When asked why she had been dishonest about the medications working for her, Carol explained:

Cause I was afraid to stay in the hospital longer. I knew the sooner I got this thing decided how many pills, the sooner I was getting out, this was my first time in there and I was scared - because when you get locked up for the first time... I can't tell you how frightening it is for the first time you go in. You don't know when you're getting out. You know that you, you don't know how it is possible they putting you in there. You know you're just trying to hide what was- whatever it is, that you're going through... So nobody keeps you in a mental hospital you know what I mean?

In situations like Carol's, women occasionally described jeopardizing their own health and treatment for the sake of their freedom. In these instances the woman would try to be as compliant as possible and state the medication was working with no problematic side effects in order to be released from their hospitalization more quickly. Tina J. conveyed feelings about adherence to medical control that were similar to those experienced by Carol. She stated that she did not want to be on medication, and wanted to pursue other treatment options, but that she would do whatever necessary to get out of the criminal justice system as quickly as possible. Because of this, she was willing to agree to any suggestion from the court about her medication regimen. She stated:

But I don't think like it's <prescribed psychiatric medication> is good for me. I don't like it but I am going to do whatever she says <doctor> cause I'm here <on probation>. When I get out of here, and I'm not on probation, I'll start listening to the doctor I want to listen to - because I've tried millions of medications, since I have been here...so I don't want all of this stuff she puts me on, but I will stick it out till I'm done here...

Sometimes I don't think it helps at all, I think that putting those pills in my body period is bad. I don't like doing that...Yep I've got to do it - and so I'm going to do whatever I have to do to keep my freedom, because I want it back. So...

Some women initially agreed to take psychiatric medication for their symptomology but often did not expect that the medication would be a permanent fixture for their entire lives. A particularly problematic concern for these women occurred when there were problems or harmful side effects to the medication. In these instances medical professionals would normally change the medication, but rarely attempt to detoxify women from the psychotropic drugs. Many women were frustrated that the only solution ever offered to them was different medication. One example was Gail J., who at the age of 16 had been prescribed anti-depressant medication. After she felt the medication was causing suicidal ideation, her family consulted her treatment team. Gail recounted the experience:

And the Prozac made me suicidal, which you know was a side effect and um...And so I stopped Prozac, <the psychiatrist> put me on some other stuff, and of course then it was just endless, it never stopped, you know. It was something, a different medication, they never gave me just a break from it all to see if I was actually just okay without medications in the first place. So I've been going through that pretty much ever since, but then every couple years I will you know if I get fed up with the medication I'm on I'll just go off of it just to see if I'm okay...I find them completely useless <the medication>, cause they don't do anything; they don't do anything. They make things, actually make me hungrier, more tired, um...you know, things that don't really help, you know. In this day and age when I need to be up and alert and functioning, they kind of numb me and dope me up so I don't, I'm not too, I'm not a big fan of em. So that's why right now I'm on just a couple.

For nearly 20 years Gail had been struggling with her medication regime. While cycling between psychiatric hospitalizations, rehab for substance use, jail, and probation Gail was

never able to feel completely comfortable with her medication regimen although she had been prescribed countless iterations of psychotropic drugs.

For women who were opposed to psychotropic medication, stigma was a common concern. Some women interviewed did not want to have the labels of “crazy” or “mentally ill” that came with psychotropic medication. Additionally, some women were philosophically opposed to taking medication, as they wanted to have a say over their own lives and what they put into their bodies. As previously mentioned, many women voiced legitimate medical concerns about the drugs’ side effects or other medical considerations. A number of women also conveyed practical and situational concerns about adhering to their medication regime. They stated that taking their prescribed medication left them especially vulnerable to victimization because of homelessness and other problems. For instance, Alex C., who was transient at the time of her interview, (and suffering from significant PTSD symptoms dating back to childhood), expressed her concern over taking her nighttime medication:

That’s another thing, the court ordered me to take pills and make this big issue for me to take pills. Well, this last time I decided, ‘Okay! I’m going to take these damn pills.’ I take these pills and the next thing I know, it was horrible because the nighttime pills that they gave me make me sleep way too much. Like I have a fear of sleeping anyways cause if I sleep then people are going to do stuff behind my back, to try to hurt me or something and I don’t know what’s going on around me. I don’t have control on what I allow to happen so when I wake up, you know I’m all flipping out, I’m not thinking this and that and tripping...

Alex believed her extreme fatigue after taking the medication often made her PTSD symptoms worse, and due to her current circumstances left herself and her property quite

vulnerable at a time of day she perhaps needed to be most alert. Alex noted this was a pertinent concern due to past sexual assaults by men while she was living on the streets.

In summary, many women had strong reservations about the control over their lives that psychotropic medication had. These women were also concerned about the effects of a lifetime of pharmaceutical use. Ironically, many of these women had spent significant portions of their lives addicted to illegal substances. Some viewed mandatory court-ordered psychotropic medication as not entirely different from their illegal substance addictions that had sometimes helped mask their symptoms of mental disorder. Nonetheless, most who were prescribed medication reported adhering to their medication regime. Some were motivated by fear, some by apathy, and some by blind faith. Other women reported taking the psychotropic medication because they felt it truly helped alleviate mental health problems.

### **Positive Aspects of Psychotropic Medication**

The women interviewed for this project discussed problems with psychotropic medication due to the loss of control over their lives, as a result of the stigma that being labeled “mentally ill” brought with it, and the potential health dangers as a result of taking these medications. Despite these concerns some women believed that the medication helped them in their lives. For these women, who were plagued by significant and often debilitating clinical symptomology, psychotropic medication improved these symptoms. For instance, Hilda M. had expressed significant frustration with her label of “mentally ill” and succumbed to the system’s coercion to take the

prescribed medication. After some time, she began to see some positive effects of the medication:

But after a while I did realize that the medication would be good for me because when I did start taking it finally - I did a lot of praying - and I realized that I needed to take it because I was getting sicker again, even more sick and I didn't want to end up in the hospital for a third time so I started taking it, and then after a year it really helped me out. So, I continue to take the medication...

Although she had mixed feelings about the medication's overall effects, after a year Hilda finally felt like the medication was helping her hallucinations and delusions.

Additionally, she had been able to remain in the community without another arrest or hospitalization for a third time.

Other women also rejected the stigma involved with taking psychotropic medication and instead argued that it was just like taking any other medication for any ailment. Rona H. felt that her medication helped her stay grounded in reality and leveled her mood. When asked if she resented taking medication for her diagnosis she stated:

No, cause I understand, it's just like using my asthma inhaler, it's something that I need, you know what I mean, it's just what's - SMI I believe is just a chemical imbalance. So that just helps balance us out. So we can be as "normal" - whatever that word is. It <the medication> fits us into society - so.

Multiple women voiced similar feelings to those expressed by Rona. For these women, the medication prevented their moods from fluctuating extensively and it alleviated unwanted hallucinations and delusions that they experienced on a consistent basis. Some relied heavily on their medication to prevent the unwanted behavior that was at least partially to blame for past arrests. For instance, Billie B., who had left her children multiple times in the past to live on the streets while experiencing extreme

symptoms of psychosis, now took her medication religiously as she noticed marked improvement from her psychotic behavior when on the medication. She had first been prescribed psychotropic medication while in jail. After stabilizing on the medication even her children noticed the consistent improvement. They made sure she adhered to her medication regime on a daily basis. Asked if she had any concerns with taking medications, or whether she would prefer not to take them Billie responded:

No I have to take it. My daughter stays on me - sometimes I go to bed without taking my pill and she knows. She's like, "no." You know what she said to me? She says, "You're taking your pill!" She brought me my medicine with my water. She's like "get up. You haven't taken your pill yet, you're taking your medicine." She said "You're gonna act up and you're gonna leave us again."

Billie noted in her interview that without this medication which was originally prescribed to her while in jail, she would most likely be incompetent, would have lost her children, and would be living on the streets. She was thankful for the medication, but also fearful of the power it had over her and perhaps even her daughter as highlighted in the dialog above. Other women described similar experiences to Billie's. Some took their psychotropic medication sporadically or were confident they no longer needed it and stopped taking it all together. Some record indicated that several women decompensated, resulting in hallucinations, manic episodes, or general psychosis that eventually led to psychiatric hospitalization or being rearrested.

A few women wanted to take medication but could not always afford their prescriptions. As a result these women were sometimes presented with double binds because they needed to be medicine compliant as part of their conditions of probation,

but due to situational constraints could not be. For example, Betty C. who was one of the few women in the sample who was able to hold a full-time job, did not qualify for the state's Medicaid coverage and could not afford a prescription for the medication that had helped her in the past:

I can't afford to get it. And I've had it since, you know, < several weeks before interview> and it's \$135. Where am I supposed to get that? How am I supposed to get it? I went to the clinic because I know that I need to be back on my meds. Um, I, found a set of meds that were working good for me in California and then I moved back out here and...Yeah, it's really frustrating to go and tell somebody you need help and this is what they give you <holds up prescription note>, you know, a prescription that costs \$135. You're going to, um, you know, a state funded facility, obviously you don't have insurance, but I'm gonna pay \$135 for one prescription? I only make minimum wage, so, that's what's frustrating to me. And then I have to come in and I have to explain to my probation officer and you know I have goals I have to meet and I have to comply with the judges, you know, stuff and I just get too, too frustrated.

Betty planned to donate plasma after the interview so that she could put together enough money to be able to afford her prescription. Betty was afraid of relapsing from a meth addiction, and believed the medication would stabilize her. She had also been suicidal in the past. Betty worried that being off medication for an extended time might make her suicidal again. Ironically, relapse or a suicide attempt are both behaviors that would force Betty back in institutionalized care where she would receive medication.

### **Considerations for Expanded Social Control by the Mental Health System**

Women interviewed for this project reflected on several paradoxical themes about expanded social control as they pertained to the juvenile and adult mental health systems and psychotropic medication. Some discussed being institutionalized in the mental health system as girls as a result of status offenses. Bounced between these two systems some

young women were even placed back under the control of family members after reaching adulthood. Additionally, the majority of women interviewed experienced medical control. Women also expressed concerns about the effects of psychotropic medication on their bodies and pregnancies. For these women, medication was often met with skepticism, but they felt there was no other option than to comply as not to risk losing custody of their children. Additionally, women who did not adhere to the traditional female gendered roles of passivity and compliance to their psychotropic medication were repeatedly given medication via injection or other forms of expanded control. Finally, many women were presented with considerable double binds as they navigated the control of the mental health system. For instance, some stated that psychotropic medication did not help while they were institutionalized, but they either resigned themselves to the medication regime or openly lied to social service professionals in order to regain more control over their own lives. Some other women wanted medication but were also presented with a double bind when they had no way of paying for medication they would have been happy to take. Ironically these same women who wanted medication but could not afford it were in violation of their court-ordered treatment by not taking prescribed medication.

### **COERCIVE SOCIAL CONTROL OF WOMEN ON SMI PROBATION**

The mental health system exerted ample power over the women on the SMI caseload, but these “beneficent constraints” (Liska, 1992) were only one aspect of a



larger system of control. A second and equally important consideration is the coercive control (Liska, 1992) of state power, most often implemented by the police, courts, and correctional organizations. I now look at aspects of social control for women on the SMI caseload as they relate to the coercive aspects of the criminal justice system.

For women in the deep sample, it appeared that the justice system was most harsh on those who were involved with crimes against children. Eight women (12.3 percent of the sample) had been involved in crimes against children. Six of those eight women spent at least one year incarcerated for the offense, and five of eight were placed on lifetime probation for the offense (with an additional woman having a sentence of ten years). As a result of not fulfilling the gender stereotypes attached to traditional female roles involving motherhood and nurturance, some of the women in this group appeared to be controlled excessively. Past scholars have conveyed that women experience expanded control over them in the legal system as a result of being mothers. For instance, Cahn (2000) has explained that mothers are frequently prosecuted for not preventing abuse of children, or for failing to stop further abuse at the hands of others in the home. The author argued that this is a cultural result of women being identified mostly as mothers. Therefore they are often punished particularly harshly for allegations of child neglect and assault, regardless of their involvement.

Of the eight women involved with crimes against children, three women had physically assaulted a child or had attempted to, and one other woman had left her young children in the home alone for an extended period. The final four women were placed on

lifetime probation (after serving lengthy terms of incarceration) for sexual abuse that was occurring in the home at the hands of their boyfriends. Two women were actively psychotic at the time of their offenses. They reported being aware of little else going on in the home beyond their own direct symptomology. In both instances, the women pled guilty after being incarcerated for several months, as they feared that a longer sentence would follow if their cases went to trial.

Reva H.'s case provided many instances of heightened and gendered control implemented by the criminal justice system. Reva was living with a boyfriend at the time of her offense and he had a long history of being very physically abusive to Reva. At the time of the incident she was the primary caregiver for her children in addition to taking care of two of her boyfriend's children. One night while high on crack, Reva's boyfriend forced her to place her mouth on her infant son's penis and he also placed his own genitalia in the child's mouth. Fearing that her boyfriend would kill her, Reva waited a couple of weeks to notify the authorities of the assault. When she eventually did notify the authorities, her boyfriend was arrested after he admitted to other sexual assaults on children in the home. Reva was also arrested for not reporting the incident to the authorities immediately. In order to strike a plea agreement, Reva's defense team had Reva take a polygraph test (which she passed) stating that she had not been aware of any other abuse going on in the home and that she had not been involved in any other abuse that occurred. Additionally, in a letter to the court, Reva's defense team made specific mention of the fact that in the past Reva "had her tubes tied" in case "the state is

concerned that Reva will simply have more children and mistreat them.” As well, Reva severed all rights to her biological children after a prominent member of the community adopted them. The court eventually ruled that Reva would receive lifetime probation over a prison sentence when it was determined that she had never abused her children prior to the incident, was unaware of other abuse going on in the home, was not an active participant in the assault on her son, had severed her rights to her biological children, and had undergone an operation that would keep her from having any other children.

By all accounts, Reva had been a victim of her boyfriend’s extensive abuse. It is not unreasonable to ponder if Reva’s perceived failures as a mother were at least partially responsible for her sentence by the court. Only when she proved that she was not previously aware of abuse going on in the home, showed the court that she was incapable of having future children, and severed all legal rights to her existing children was she “rewarded” by the court with lifetime probation. Becker (1995) has referred to this as the “Good Mother / Bad Mother Dichotomy” which regulates women with children who come under the control of the criminal justice system as either good or bad.<sup>23</sup>

The court was responsible for many other aspects of governance over the lives of women on the SMI caseload. A majority of women had undergone competency hearings

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<sup>23</sup> Ironically, there was one instance of a mother in the deep sample who was convicted of child neglect as a result of profound mental health symptoms (delusions and hallucinations). Although her husband knew about the wife’s neglect of the children, he continued to let the wife care for their children while he was at work. He was not arrested with the wife and was mandated by the court to have sole custody of their children while his wife underwent several months of treatment after her arrest (and could not live in the home).

at least once. Normally if the court did not rule them competent, these women would return to psychiatric care (often with a heightened medication regimen) within the criminal justice system until they could be ruled legally competent. In addition to the medical control discussed earlier in the chapter, other common mandated regulation (treatment) for women took shape in the form of individual or group counseling, drug or alcohol classes, parenting courses, urinalysis for drug screens, assistance in housing and employment, and case management.

Another example of the expanded coercive control of the criminal just system, the courtroom workgroup spent a substantial amount of time regulating the relationships (both romantic and maternal) of women on the SMI caseload. As illustrated by Reva's example above, some had endured heightened social control, perhaps as a result of breaking gender normative behavior and gendered stereotypes that still exist around motherhood. However, at the opposite extreme, other women were exposed to expanded control by the criminal justice system for adhering to the stereotypical gendered behavior. To explain, multiple women were in exceptionally abusive relationships with men. These men would on occasion force the women to prostitute themselves in order to secure money and drugs. These women were passively resigned to their life circumstances given their exceptional emotional dependence on the men in their lives. The courtroom workgroup often decided that these women would not be allowed to have any contact with a boyfriend while they were on probation if the boyfriend was considered to be a negative influence on the woman. In many instances this paternalism caused the

probationer additional stress. In instances like these, the court mandated women to avoid contact with their only source of social and financial support (regardless of the quality of that support). In certain instances where the court could not regulate the relationship between a woman and her significant other, the probationer was subjected to additional control.

Olive J. provided one pertinent example of this type of court sanctioning. In Olive's case, there was considerable evidence that her husband had physically and emotionally abusive with her for years. Olive's husband, whom she had met in a psychiatric facility, had been her only social and financial support for over a decade. Worried that her husband might one day leave her, Olive stated that she would do anything to keep this from happening. Olive's husband, however, manipulated and exploited her devotion by spending her social security checks without her knowledge and would often abandon Olive for days at a time when using drugs. The police had been called to Olive's home on multiple occasions over the years to resolve domestic disputes between them. Olive's probation officer had worked diligently to remove Olive from the home by trying to get her into a long-term residential facility for her addiction but Olive would refuse and resisted being away from her husband. Because the court wanted to keep her away from the abusive husband and to stop being exploited, they had set up a person to serve as a payee for Olive.<sup>24</sup> As a result, any time Olive wanted to spend

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<sup>24</sup> The payee is an individual designated by the court to govern over the finances of certain probationers that the court decided were unable to govern over their own finances.

money, she would have to consult the payee in order to do so and receive the payee's approval. Additionally, Olive was called before the court on a monthly basis so that the courtroom workgroup could be updated on her progress. The court used this as an opportunity to scrutinize the relationship with her husband each month. During these hearings, the judge would often make statements about Olive's husband, implying that the court would do all it could to protect Olive from her husband if she ever needed it. At the same time the judge would admonish the husband for suspected inappropriate behavior. Ironically, the husband was not in attendance at Olive's hearings. As a result, Olive was left to listen to the judge reprimand her husband for the abuse that was happening to her.

In situations like Olive's, the court, acting in a paternalistic nature, seemed to care about the predicaments women on the SMI caseload were facing, but in doing so also created amplified double binds for women under their control. For Olive, a payee did not necessarily provide her increased independence from her husband who would take her social security money, but presented an additional entity with substantial control over her life. Additionally, by the court actively attempting to get Olive to leave an extremely abusive relationship, they were also creating added problems for Olive. Olive had been with her husband for well over a decade and despite his abuse, she saw him as the only true source of support she had. Olive stated in her interview that the thought of losing her husband was unbearable, and the court potentially exacerbated these feelings of

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This person could range from a family member when one was considered appropriate to an arbitrary third party as assigned by the court.

abandonment and fear, both of which were triggers for Olive's alcoholism. Furthermore, it is unknown how Olive's husband reacted to the court's urging Olive to leave him as well as admonishing him for his behavior. Based on his treatment of Olive over several years, however, it is reasonable to believe that any anger over the situation would be taken out on Olive. In the end, the court had subjected Olive to expanded control for being perceived as weak and dependent for not leaving an abusive relationship, which perhaps made the relationship further untenable for her.

The criminal justice system not only presented women on the SMI caseload with double binds regarding relationships, but it did so in other areas such as employment. Due to the nature of their mental health history, the majority of these women were unable to hold employment. However, for those who were employable, their options were often exceptionally limited. For many younger women, who were especially anxious to complete probation and to pay back owed restitution, one of the easier jobs to obtain was working at strip clubs or as servers at bars. Denied many other forms of employment because of possessing a criminal record, these were normally the easiest two avenues outside of illicit activity, for women to make a substantial income quickly. Marnie J., for example, had multiple drug convictions and had been barred by her probation officer from dancing at a local strip club or being a cocktail waitress at that establishment. The court believed that this was not a positive environment for her to be working in due to the nature of her offenses. As a result, Marnie told her probation officer that she had quit her job at the establishment, while really continuing to work there. Marnie could afford her

school, living expenses, and pay off financial restitution owed to complete her probation. Faced with the “choice” of potentially going to jail for violating probation or potentially losing her apartment and not being able to pay her restitution, Marnie decided that it was best to try and pay off the few thousand dollars she owed. At the time of her interview Marnie was attempting to complete all her financial obligations before the court found out that she was violating her probation.<sup>25</sup>

Like Marnie, Tina J. was able to make enough money to pay bills and her probation restitution while working as a dancer at a local strip club. As described in her interview:

**INT: So what happened when you got out of jail and you were homeless?**

I really had to go to a strip club. I had no choice. I didn't go to the strip club first, I went to a place and they had everyone that I knew Western Union me money cause my parents wouldn't help me at all...So I went to this strip club there, doing whatever on the side, I don't care what anyone tells you they did stuff on the side. It's just how it is...I didn't have a choice, but I really didn't have, but I swear to God I had no - I had to survive. That was my only means of survival was dancing I had no, that's what you do when you can't get a job when you're a felon.

Desperate to find “legitimate” employment, Tina eventually became trapped by the money that dancing provided her to live more comfortably and to pay off her restitution

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<sup>25</sup> As part of a larger project, 46 men on the SMI caseload were also interviewed. In considering the gendered nature of the control of the criminal justice system, it is perhaps noteworthy to mention that the court never barred male drug offenders interviewed were from employment in day labor or construction jobs. Although men often discussed the frequency with which drugs were available at construction positions, no men in the study were kept from working in these environments. However, multiple women interviewed were not allowed to work as dancers or bartenders at strip clubs because of the availability of drugs and alcohol at those jobs.



to the court in order to complete probation. Like several other double binds that women discussed during their interviews, work also presented significant challenges to staying clean and being around illegal drugs. In Tina's case, the work was directly violating her probation. She had to hide all of this from the criminal justice system and eventually began to engage in prostitution in order to pay off lingering debt and her court fines more quickly.

The mandates of the court were not the only form of heightened coercive social control women on the SMI caseload faced. Some women experienced other forms of sanction due to their criminal involvement. During interviews, a few women conveyed being afraid to report their own victimization to the authorities because they were currently on probation and did not want to get their probation revoked. For instance, Wanda S. was in an extremely abusive relationship at the hands of her boyfriend. On multiple occasions, Wanda's boyfriend had nearly killed her during physical assaults, pulling out large chunks of her hair and scalp and forcing her to attempt to overdose on drugs. During her interview, she explained her fear of calling the police at times when her boyfriend would become violent:

**INT: Do the police ever get called when it's violent?**

Um, no because I'm afraid, I'm afraid to call them so I never call them because the police do not help. When you're on probation, you're automatically at fault even when you don't do anything wrong so, as somebody on probation, you have to um, basically you have to take abuse if you're being abused because the system basically says so...

**INT: You're scared that you'll get in trouble if your boyfriend is violent?**

Basically the law says here, even if I never hit him back ever because he would probably, he knows where to hit me not to show bruises and that type of thing.

But when the police come, the law says here that one of us goes to jail, you both go to jail and then as soon as they run my name and find out I'm on probation, it's automatically um, I have to be guilty of something just because I'm on probation, even though I went six years without ever getting in trouble, never doing anything wrong so when I just don't want to deal with the police.

In this example and others like it, women believed that taking the abuse (whether they were an active participant in the domestic altercation or not) was less dangerous than getting involved with the criminal justice system. Some scholars have questioned the role of the state in policies like mandatory arrest for domestic violence (e.g. Carlen & Worrall, 1987; Daly & Chesney-Lind, 1988). They posited that these programs might be seen as a "symbolic victory" (Daly & Chesney-Lind, 1988 p. 522) for feminists generally, but also have disadvantages for women specifically. The double bind discussed by Wanda is one such example. Her boyfriend is one of the few people that Wanda has in her life, yet she regularly fears for her life at his hands. That fear, however, is trumped by the distress Wanda feels at the thought of being totally alone. Furthermore, if she were to call the police when the abuse was too much in order to get a reprieve, she also would risk the chance of being arrested herself. This is a particularly relevant concern considering that Wanda is currently on probation and Arizona is a mandatory arrest state for domestic violence calls.

Beyond the potential of being arrested, each woman on the SMI caseload also carried with her the stigma of not only being labeled criminal but mentally disordered. Because of this, some women also feared police officers as they were not only responsible for jail stays, but often psychiatric stays too. For instance, when asked about

the impetus for her own psychiatric hospitalizations, Ellen B. gave a common response, stating that after she was arrested the cops took her to a psychiatric urgent care facility to stabilize her. She noted, “Well the cops kind of made me go you know. So I had to go. I had no choice.” In several instances the police acted as street level psychiatrists (Bittner, 1967; Teplin & Pruett, 1992) for women on the SMI caseload, removing them from their homes after domestic disturbances or when homeless or committing lesser public order crimes. In these instances women in psychiatric crisis or acting out were not being processed in the criminal justice system, but were being stabilized within the mental health system.

For other women, being on probation while also trying to protect themselves and deal with significant mental health symptoms led to additional coercive control initiated by the police. Beth A. shared such an example during her interview. While on her first probation, Beth had become so clinically depressed that she was unable to shower or even get out of bed for several days. After failing to report for probation, officers went to Beth’s home to search the premises. When the officers asked if she had any weapons in the home, Beth told the officers about a gun she kept as protection from a violent ex-boyfriend who had threatened to kill her. Because having a firearm was a direct violation of Beth’s probation, she was arrested and subsequently sentenced to prison as a result of the probation violation. She described the situation in her interview:

Yeah, I didn’t read it <referring to the conditions of probation>, I signed where she told me to sign, my first probation officer. They come to my house; my son’s father’s is very violent. He abused me and my children, he went to prison for it. I had a gun in my house it was unloaded. It was put up where my kids could never

find it but still I had it for protection. I didn't know I would be in trouble and go to prison for that.

During the interview Beth admitted that she should have read her conditions of probation more carefully and that it was her own fault for absconding and violating her probation. However, Beth also felt that she had a situation that was difficult to successfully navigate. Ironically she noted that if she had not been honest with the officers at the time of the home check, there is little chance they would have discovered the weapon she kept to protect her and the children from her ex-boyfriend.

The coercive control exerted by the criminal justice system was aggravated by net-widening into various aspects of the social service and mental health systems for women on the SMI caseload. The formal control over their lives often extended to relationships and parenting, therapeutic counseling, employment, housing, and other financial matters. This social control often expanded as women on the SMI caseload acquired additional labels such as “child abuser,” “battered wife,” and/or “stripper” along with the labels of “mentally ill” and “criminal” which had already been established. In the final section of the chapter, I turn to explore how the women on the SMI caseload felt about the social control that was often placed over their lives by the criminal justice system.

### **Personal Perceptions about Coercive Control**

As one might imagine, some women in the deep sample objected to the coercive control placed on them by the criminal justice system. For these women, the criminal justice system encroached too far into their lives. They often felt overwhelmed by

attempting to adhere to each of the requirements of probation and their mental health treatment that might include a medication regime, doctor's visits, individual and group therapy, psycho-educational classes, case management, appearances at mental health court, regular drug screens and attending regular meetings with their probation officers.

Some women expressed wishing for less control over their lives. For instance, Olivia H. stated during her interview:

I got so much going on and I'm not sure which one I got to do first. Which one is more important than the other, and um, so <probation officer> says you just constantly saying you need to get housing you need to get... Okay, that is what I was doing, but then he put this six o'clock curfew on me. And then he tells me I got to do UA's and I'm like looking at him like okay, I got all this stuff during the day I had to do them, by the time I get done with it, it's four or five o'clock. I got a stipulation down on this thing. I can't leave the property after six o'clock. Where am I going to get time during the daylight hours to go drop?

When Olivia was asked how she felt about all the regulations she had to adhere to in both the criminal justice and mental health system, she stated:

Overwhelmed, pushed in a corner um, I'm fifty years old. I shouldn't have to be told where I can go, when I can go, how long I can go for and that's what is bugging me the most. Is that my age and then having people controlling what I do. It's really difficult for me to grasp on to the concept of somebody telling me "you *have* to do this."

Other women expressed similar sentiments. May D., was most frustrated by what she felt like was constant surveillance over her life. Beyond her psychiatric troubles and her forced hospitalization after a recent accidental overdose she also noted:

I just don't like to be watched. I wish it would be over with. I can't wait until I don't have to report to anybody any more.

**[Later in Interview talking about the control of the criminal justice system]**

Especially if there is a cop, like you'll be walking and they're like do you have any identification and I'm like 'yeah I do', and you know it's late at night, and it's like where are you going. 'I'm like I's just walking to Circle K', you know, and they'll be like well you shouldn't be out this late or whatever and I'm like 'I'm forty-five years old I can be out this late.... 'Well, it looks here you're on probation', when they pull you up on the computer and I say 'yes, I'm on probation.' Well you know, it just sucks.

May, discouraged by being watched most of the time, equated her entire situation to not being incarcerated per se, but still, "Under their lock and key." Generally these women often felt even when the courts, probation, and social services were trying to help that it was often just too many demands from too many different parties. This ultimately created an inconsistent relationship for some women on the SMI caseload in regard to these formal social controls. On the one hand, they were in the community and "free" but at the same time under the "lock and key" of the criminal justice system. In a similar regard, their mental health problems were not considered significant enough to warrant long-term inpatient psychiatric care sometimes, but other times they were forced to undergo psychiatric stabilization and most were mandated for court-ordered treatment which normally meant a regime of psychotropic medication and therapeutic counseling and/or psycho-educational classes. Under a widening net of social control, and existing somewhere between the criminal justice and mental health systems with markers of neither "prisoner" or "free" or "crazy" or "sane" women on the SMI caseload were left to try and negotiate these aspects of formal social control by themselves. Furthermore, unique aspects of control for these women were sometimes gendered and frequently created double binds.

## **THE POSITIVE IMPACTS OF WIDENING THE NET**

In his influential critical critique of the widening of social control, Cohen (1985) asked, “Whether good or just things could happen in spite of (and even sometimes because of) net widening?” (p.225). Other scholars (e.g., Goodkind & Miller, 2006, p. 67) have specifically considered that statement and concluded that, “In any therapeutic relationship there is a tension between helping and control” one that the authors note is intensified within the criminal justice system and despite potentially being gendered can produce some positive benefits. Although some women were overwhelmed and frustrated with the control that existed over so many aspects of their lives, for many of them not all aspects of these controls were negative.

Each probation officer on the SMI caseload was trained in working with individuals with mental health problems and had requested (as opposed to being assigned) to be an officer on the SMI caseload. For the majority of women on the caseload, this specific agent of formal control was often an extremely helpful and positive force in their lives. In fact, the positive relationships that women built with their probation officers were a force for constructive change. Betty R., for example, spent a good deal of her adult life cycling in and out of the criminal justice system. About to finish her probation term, she stated that she “didn’t know what she would do” without the support that she had been provided. Asked to elaborate, Betty Stated about her probation officer:

Oh my god, she is the BOMB. She is the BOMB, you know. When I was first on standard probation they told me I have to go to mental health probation, I’m not

too good on changes and I don't like changes at all, but when I met her and she's telling me this and I'm like oh my god, I have to get someone to get to know me all over again, I can't do this, I can't do it. And then she sat down and she talked and she told me I want you to go get on [social services], I want you to go do this, I want you to go do that. And I'm like, well I can't, and I would just cry and stuff, and she's the one that got me on track by telling me 'I can do'.

**INT: How was she able to get you on track?**

Just telling me that I can do it, 'just stop, stop, just stop letting people tell you No.' It's always a door that gonna tell you Yes. It was just pushing...I'm like okay, so she kept pushing me, she kept pushing me. And when they denied me [for Social Security Disability Insurance ] she says, why you gonna stop there?

In this example, Betty felt that her probation officer believed in her just enough and pushed her just enough, but was also empathetic to Betty's needs and had been particularly empowering influence. Beyond just surveillance and compliance, the SMI officer had assisted in getting a monthly stipend that would improve her life and also provided her with encouragement and advice while she did. Betty stated she would have never tried to reapply for social services after her initial rejection without the encouragement of her SMI probation officer. Some women discussed during their interview that probation officers gave them the "tough love" they sometimes needed to stay motivated to complete what they needed. For instance, Winnie T., explained during her interview that her probation officer knew just when to start to put more pressure on her and also when to ease off. She mentioned in the interview:

I've seen a lot of her though. I've been blowing off a lot of appointments in the last six, seven months you know and it's like and she knows me better than I know myself sometimes and - but she knows that if I start slacking off she shows up on my door three times a week. She knows I don't like that. That I don't like being surprised, you know, so. And she knows that when she backs off she's kind of giving me the rope like are you going to hang yourself or are you going to keep going? So, it's worked so far, so far so good.



Other women found the unique experience of being under the umbrella of multiple systems helpful because of what their probation officer was able to do for them as a result. For Gail J., having her probation officer aware of everything going on in her treatment assisted her because the probation officer became an “advocate” for her when other members of her treatment team were not following through on her care. She stated:

I would definitely miss [PO] being an advocate for me cause she’s been so helpful. I mean, when anybody on my case management team or when [mental health facility] is falling short she will contact them and be like, she has courts behind her, that’s pretty powerful of course. Um, anytime I’ve had questions that they’re not answering, that you know they do treat me like I’m SMI even though they’ve had experience with me I get treated, I get the dumbed down treatment and um, she will call and clear things up if they’re not telling me what I need to hear, what they’re doing, you know. I really like having her as an advocate and that’s kind of how I feel about her at this point, she’s kind of gone from being my probation officer to now that I’ve created some credibility and I’ve gotten some trust from her, um, I feel like she’s more of an advocate now than she is a probation officer, so it’s good, she’s changed um, our relationship has changed.

[Later in the Interview]

Well because it’s like, there’s a part of me that kind of has this resentment towards the probation thing but then at the same time if I really look back it’s really been of assistance to me more than I would give it credit for. It really has. So, it’s a little bit nerve-racking coming off of somebody as supportive as [PO] cause she’s really been like that.

In addition to helping some women become empowered, relationships with agents of control were important for other women on the SMI caseload because they considered their probation officers some of their most important supporters. Perhaps a testament to how miniscule the social support systems were for some, at least one woman interviewed even referred to her probation officer as her “best friend.” These particular relationships were so important to the women on the SMI caseload because many believed that they

could truly count on their SMI probation officer when they had no one else. Kassie T., a longtime recovering drug addict, stated in her interview that her probation officer would be the first person she would call if she were ever about to relapse and buy or use drugs. One would assume that her probation officer would be the last person that Kassie would want to find out about any substance use. However, during her interview she explained:

Absolutely, I could call him on [location where she buys drugs] - where I cop dope and call him and say I am coping dope right now and I don't want to do it, and [PO] would come get me, and I know that. Just like a backup plan.

Kassie felt that her probation officer was one of the few people in her life who would do what was best for her, even if it meant admitting to him that she broke the law. This level of closeness that the majority of women interviewed felt for their SMI probation officers and the SMI court was quite different from their feelings regarding past experiences with probation and the court system when they were not on the SMI caseload.

For many women in the deep sample, the relationship with their probation officer was so strong that they were most concerned with how the courtroom workgroup would respond to any of their failures personally, as opposed to the fear of having their probation revoked. For instance, Olivia H. was interviewed as she was about to go into custody for four days of jail as a graduated sanction for missing multiple drug screens and eventually testing positive for drugs. Olivia described her relationship with her PO like having another “uncle.” She described the situation when her PO found out that she had been using drugs:

Somebody who I can call up and say, 'hey look I messed up' and I did. I told him, 'You know', I said, 'I'm - I'm probably- I am just going to tell you right now that I am dirty.'

**INT: How did he respond to that?**

He was like really disappointed and I could hear it in his voice and I told him, I started crying and he said, 'I'm sorry' and he goes – 'Why are you crying?' And I said, 'Because I disappointed you and I didn't want to do that' and um, he says, 'Well let's start over.' He just- <pauses a moment> 'Let's start over.'

Even as Olivia was being sentenced by the judge to do a few days in jail as a result of her probation violations, she was visibly affected by what her probation officer said to her. She realized that in many ways her probation officer was the only person that cared enough for her in her life to be disappointed that she had been using, and also the person willing to forgive her. Olivia's major concern was that she had disappointed her probation officer and the disappointment might damage her relationship with her probation officer. Her probation officer helped her get housing when she had nowhere to go, helped her obtain necessary medication, and emotionally supported her. She did not want the relationship to be damaged.

Similarly, Mary P. had grown to depend upon the emotional support and encouragement her probation officer gave. She stated that her probation officer was one of the few people who gave her positive support in her life. Due to learning disabilities she had been teased and bullied throughout adulthood. However, her probation officer had been kind to her, and even helped her secure a spot in a food preparation course that had led to long-term employment. Mary took great joy from the praise that the court and

her probation officer provided her. She stated: “[PO] is really nice. She always has something nice to say about me. She’s proud - she says, ‘you’re the only of my clients that has a job and I am proud of you.’”

Women who were able to establish these positive relationships with their probation officers also considered the relationships they developed as some of the most meaningful in their lives. For instance, Jenna S. had grown to depend on the relationship with her probation officer. During her interview Jenna described how worried she had been after her probation officer “walked away” from her after multiple relapses at one point in her treatment. Above all, she had been most concerned with the damage to what she considered to be the most positive relationship in her life. Once in a long-term residential drug facility and clean for nearly a year, Jenna even invited her probation officer to her birthday party in which the probation officer came and celebrated with Jenna and other women in the facility. She stated during the interview:

She’s a very caring PO, but she’ll sit down and talk to you, you know, you ask questions...I asked her a lot of questions, you know throughout my probation she’s actually helped me. Nobody else has ever stood by me like, like [PO], you know. She doesn’t scare me now...I always called her my mom, I said I never had a mom so now I have one, you know.

I respect her enough because of the simple fact that she’s authority and I’ve never liked authority figures. And I think that has a lot to with another reasons why I backed away from her so much. You know. An authority figure telling me what to do is like - it hurt. But if I lose her when, when I get off probation, when she does get me off probation, it’s gonna be a little hole in my heart for her, you know.

Many women highly valued their relationships with their probation officers and other members of the courtroom workgroup, despite the power that the criminal justice system wielded over these women. Several women even had problems keeping

perspective on the relationships with their probationer officers. For instance, despite despising being on probation, and frustrated with most aspects of her life including her job, her relationship with her girlfriend, her relationship with her children, and her increasing depression, Betty C. still considered the aid and support her probation officer had given her as immensely helpful. When asked about the relationship Betty C. stated:

I love her to death. I try not to, I try not to disappoint her in any way, like when I have to come in here and tell her this crap, I feel like I'm letting her down in a sense.

**INT: How does she respond when you can't make your restitution or pay for your medication?**

I don't know, I mean, this is really, like the first time I've ever had to say anything, and then I had to tell her um, when she came to my house last month, I can't pay the restitution, you know, I haven't been able to pay it. And it's, it's too high, it's high for me. And I don't know what to do, and she's like, 'you know, we'll work something out', and you know, her main thing is she just doesn't want me to be the same, or revert back, or go back to the person I was when she first met me. Um, just crying a lot, lot lot lot lot. Every time you turn around I was boo-hooing. I can honestly say today it's a little bit better, but - but she's wonderful. She's wonderful, and if I had to, change facilities and probation officers...I don't know how I'd handle it or, I know I would go in there with a negative attitude. I know that for sure.

Sometimes my girlfriend has to tell me, 'she's not your friend', you have to remember that, 'She's your probation officer, she's not your friend.' You know, 'You need to respect her and treat her as such.' Sometimes I might say things that, you know, if I was talking to my friend and not my PO. I just, it slips my mind sometimes, she's so, she's so nice that she's just, she makes you feel so comfortable from day one, you know, I was scared to death. I was scared to death to be on probation.

Regardless of probation officers and the court having so much control over women on the SMI caseload in so many areas of their lives, many women still found this to be a helpful experience. In these instances the important relationships the women

forged with the court personnel were a greater benefit in their eyes than the interference the SMI officers, courts, and case managers caused. As previous studies have concluded (i.e. Goodkind & Miller, 2006, p. 68) it may be that strengthening relationships with the court in turn can strengthen the social control of the staff over the offender. On the other hand, it may be possible that, “The two- control and helping- can exist side by side.” This consideration is further examined in a discussion in Chapter 7 on the overall impacts of social control for women on the SMI caseload.

## **CONCLUSION**

In this chapter the ways in which the formal social control of both the mental health and criminal justice system affected women who were on the SMI caseload as part of the deep sample were explored. The chapter focused specifically on illustrating the expansion of formal social control, or net widening behavior, as well examples of the gendered nature of formal social control. Unmistakably, the women on the SMI caseload who were interviewed as part of the deep sample had unique experiences with social control due to taking on the statuses of both “criminal” and “significantly mentally ill.” Several important themes emerged as a result of these dual labels.

First, many of the women experienced increased control from the mental health and criminal justice systems as girls and both systems were quite inconsistent in their governance of the women when they were young. Often both systems either ignored the girls entirely until they would deviate from gendered normative behavior and then

substantial power was placed over them by multiple systems including the criminal justice system, the mental health system, and the child welfare system. Second, the control imposed by psychiatric institutions was almost universally considered a negative experience for the women interviewed. For some, the colossal power of the psychiatric facilities was particularly difficult in ways that often surpassed even jail or prison. Third, the expansion of control of the psychiatric establishment was wide-ranging with almost every woman interviewed being prescribed multiple psychotropic medications across her lifetime outside psychiatric institutions. Although this medical control was frequently resented, and sometimes presented problems that were always gendered (i.e., pregnancy) or culturally gendered to be more negative for women (i.e., the powerful stigma of weight gain and weight control for women), not all women felt similarly about the medical control. Some truly believed that psychotropic medication played a beneficial and important role in their personal welfare.

Moving from the mental health system to the criminal justice system, similar themes developed in the data regarding coercive control. Multiple women experienced expanded control often as a result of what appeared to be not taking on stereotypical gendered roles or not performing well in those gender roles. For instance, it seemed that women in the deep sample often were judged by the criminal justice system on their value as caregivers and mothers in substantial ways. Even when women were so clinically symptomatic that they were not fully coherent or unable to engage in daily life, they were still often held responsible for the abuse of children that occurred in the home.

Other women appeared to be controlled by the criminal justice system in expanded ways for taking on gender social roles too well as they appeared too tolerant and submissive. The system appeared to want the women to be strong and independent in regards to their romantic relationships, often regardless of the circumstances. This sometimes created a duality for women in the deep sample to try and conform to. In this type of deplorable mother / pitiful wife duality, a woman in the deep sample was considered deplorable unless she protected children in the home regardless of circumstance and was punished harshly if not. At the same time, a wife or girlfriend was expected to leave an abusive boyfriend or husband regardless of circumstance and was looked on with pity and paternalism by the court if she did not.

The criminal justice system governed over women on the SMI caseload in what could be considered gendered ways involving employment and legal considerations in domestic violence situations. In some instances women were not allowed to work at positions where the greatest income was available to them because of the proximity to alcohol and drugs. Some women found the expansive control over so much of their lives to be insufferable and wanted nothing more than to be free of so much regulation by multiple entities of control. On the other hand, a majority of women interviewed truly valued the relationship with their probation officer and the court. The bulk of the women felt that despite the many negative aspects of their situation, they were able to build lasting relationships with these professionals who helped secure needed services, provided advocacy to other agencies, and gave moral support. In Chapter 7 the



importance of these relationships is further considered as well as the dual nature of the formal control of the mental health and criminal justice systems.

Having illustrated in Chapter 4 the pathways of the deep sample to the mental health and criminal justice system, as well as explored aspects of the governing control of the mental health and criminal justice system for the women interviewed in the deep sample in Chapter 5, the analyses now turn to the wide sample of quantitative data. In Chapter 6 I will examine SMI probation outcome data for a multi-year period utilizing the data of the wider sample of women on the SMI caseload. Because the qualitative interviews only occurred with the deep sample a single time, analyzing the quantitative data will help to illuminate the characteristics of those women who successfully completed SMI probation as opposed to those not successful over a longer time period.

## CHAPTER 6

### COMPLETION OF SMI PROBATION

#### CHAPTER OVERVIEW

To this point in the dissertation, the pathways that the women on the SMI caseload took to different systems of formal social control as well as the expanded social control they experienced, have been analyzed using qualitative data, including interviews with the deep sample, case file reviews, and field notes from observations of the mental health court. The current chapter shifts focus to explore the unique predictors of completion and non-completion of SMI probation. The chapter seeks to serve a few purposes. First, because of the nature of the study, it was impossible to follow the women in the deep sample over an extended period. In most cases I am not aware of those who did and did not complete SMI probation. Utilizing quantitative data, however, it is possible to examine the characteristics of women who did complete SMI probation by examining a “wide sample” (Daly, 1994) of women’s outcomes on SMI probation over a period of time. Second, as a part of the dissertation, men on the SMI caseload were not included in most of the qualitative analysis. By running bivariate and multivariate analysis comparing women to their male counterparts on the SMI caseload over an extended period, statistical differences between the two groups can be established. Additionally, potentially gendered predictors for successful and unsuccessful completion on the SMI caseload can be examined. Finally, recent research (Huebner, DeJong & Cobbina, 2010) has found that women on parole with specific

problems such as low educational attainment or a history of drug dependence are more likely to be unsuccessful on parole and have increased odds of recidivism. Likewise, Mallik-Kane and Visser (2008) found that women who entered the criminal justice system with mental health and substance abuse disorders had less social support when leaving the criminal justice system, more problems obtaining other services, and higher chances of recidivating. Involvement in a romantic relationship has long been considered an important factor for desistance in men (e.g. Laub & Sampson 2003; Horney, Osgood & Marshall, 1995). Empirical analysis has also found, however, that being involved in a relationship can be a risk factor for recidivism with women (e.g. Griffin & Armstrong, 2003; Huebner et al., 2010; Leverentz, 2006). The current chapter explores the predictive factors for completion of SMI. These same factors are explored regarding unsuccessful outcomes for individuals on the caseload. Utilizing a database encompassing 5.5 years of SMI intake data from January 2007 until the start of the qualitative data collection in July 2012, demographic factors including age and race, as well as contextual factors (e.g., drug and alcohol dependence and relationship status) are examined.

The results of the quantitative analyses are divided into tables divided by demographic, offense, and social characteristics. The results are compared at the bivariate level using a series of chi-squares for SMI female and male offenders. The second section of the chapter illustrates multivariate outcomes employing logistic and ordinal regression models to investigate outcomes for women on the SMI caseload during this five-year span. The male and full samples of offenders are also shown for reference.

## **Review of Quantitative Data**

As reviewed in the methodology of Chapter 3, the quantitative dataset included 5.5 years of intake, demographic, and completion data for individuals on the SMI caseload. The 42 questions of the OST assessment (also detailed in Chapter 3) were relied on heavily in order to control for substance dependence history, vocational history, criminal attitudes, familial history, and relationship questions. After completing the OST, each probationer was given a final recidivism risk score based on their OST score ranging from, Low risk, Low-Med risk, Med-High risk, or High risk.

## **Dependent Variables**

The present study used quantitative intake data and individual responses regarding risk and needs factors to construct four primary binary dependent variables and one ordered categorical dependent variable to examine outcomes for offenders on the SMI caseload. The dependent variables consisted of:

*Completion* (n = 437 women): Coded as a binary variable (1 = yes, 0 = no). This outcome variable was constructed from individuals discharged from probation successfully. This could be due to completing all requirements in the length of the probation grant, or being terminated early. Early termination was normally due to good behavior or earned time credit where offenders were given credit from probation for time served by making all restitution payments and meeting all treatment and probation requirements. This variable was constructed to serve as a proxy for a successful outcome for an offender on probation.

*Early Termination* (n = 157 women): Coded as a binary variable (1 = yes, 0 = no). This variable was a subset of the variable *completion*. Early termination accounts for women who had the most successful outcomes to their SMI probation, because of earned time credit (n = 22 women) or because the probation officer put in for early termination (n = 135 women). Often a highly discretionary decision, this particular variable was created to consider individual differences for the women labeled by probation officers as most successful on SMI probation.

*Unsuccessful Outcome* (n = 124 women): Coded as a binary variable (1 = yes, 0 = no). This variable was constructed by compiling those individuals revoked to prison or jail by their probation officer and/or the court (n = 76 women), who self-terminated their probation in order to serve out their sentence in jail or prison (n = 25 women), were incarcerated for a new charge (n = 8), were placed in long term psychiatric institutionalization (n = 2 women), or absconded and a warrant was issued for their arrest (n = 13 women).

*Revoked* (n = 76 women): Coded as a binary variable (1 = yes, 0 = no). This variable was constructed accounting for the subsection of individuals in the unsuccessful outcome category whose probation was revoked at the discretion of the probation officer and/or the court. This variable aimed to specifically examine instances in which an offender whose grant of probation was terminated at the hands of the probation officer and/or court.

*OST Risk Level:* Coded as an ordinal variable (Low = 1, Low-Medium = 2, Medium-High = 3, High = 4). This variable was constructed using the OST risk level for each offender. At the time of intake, the presentence probation officer administered the OST assessment with the offender. As explained earlier, each offender's OST administration resulted in a composite score based on the 10 subsections of the instrument that calculated an overall risk assessment score of criminogenic need and recidivism for the offender.

### **Independent Variables**

Within the quantitative data, several demographic and life circumstance indicators were used as primary independent and control variables to examine their impact on outcomes to SMI probation for female offenders individually as well as compared to male offenders and the sample as a whole.

*Female:* Coded as a binary variable (1 = yes, 0 = no), gender (34.7 percent female of full SMI sample) was used as a primary predictor to consider gendered differences. At the bivariate level gender differences were compared using chi-square tests.

*Race:* A series of dummy variables was coded as White (referent category), (1 = yes, 0 = no), Black (1 = yes, 0 = no), Hispanic (1 = yes, 0 = no), or other (1 = yes, 0 = no).

*Age at Sentence:* Age of the time of sentencing, a continuous variable, was constructed by subtracting the date of sentencing from the date of birth for each offender.

*Offense Type:* Each case was coded for offense type using their most serious conviction charge. The sample was split into five mutually exclusive types including violent offenses (1 = yes, 0 = no), non-violent property offenses (referent category) (1 = yes, 0 = no), substance related offenses (including DUIs) (1 = yes, 0 = no), public order offenses (1 = yes, 0 = no), and all other offenses (1 = yes, 0 = no).

*Offense Class:* Three dummy variables were constructed for each case by determining if the conviction was a misdemeanor (referent category) (1 = yes, 0 = no), felony (1 = yes, 0 = no), or undesignated class of offense (1 = yes, 0 = no).

*Prior Convictions:* A series of binary variables was created to account for conviction history. Included in these were any prior felony (1 = yes, 0 = no), any prior prison sentence (1 = yes, 0 = no), any prior probation sentence (1 = yes, 0 = no), and any prior revocation (1 = yes, 0 = no) of probation or parole. Juvenile arrest history was also controlled for (1 = yes, 0 = no).

*Probation sentence length:* Three binary variables were constructed to account for length of an offender's probation sentence. These included any probation sentence less than three years (referent category) (1 = yes, 0 = no), a probation sentence between three and five years (1 = yes, 0 = no) and a probation sentence of more than 5 years (1 = yes, 0 = no).

### **Life-Course Characteristic Control Variables**

In addition to core demographic and criminal offense variables, several social and life-course controls were also included in the analyses. A series of binary outcomes was

created to account for *Relationship Status* at the time of intake. These included *never married/single* (referent category) (1 = yes, 0 = no) *married/common law* (1 = yes, 0 = no) or *divorced/widowed and not remarried* (1 = yes, 0 = no).

Although there was no indicator for highest education level achieved, two binary variables were created to use as a proxy for educational impairment. The first was *No High School Attendance* (1 = yes, 0 = no) and the second was *Reads Below Sixth Grade Level* (1 = yes, 0 = no). The presentence officer tested sixth grade reading level at the time of intake when the offender would read a literary passage from the *WRAT* intelligence test designed to determine reading impairment at this threshold.

*Employment/Financially Sound* (1 = yes, 0 = no) was determined at the time of intake by considering if the offender was employed and if not if they had the financial independence through disability/government assistance, family members, or some other way to adequately support their financial needs. Finally, *Residential Instability* (1 = yes, 0 = no) was constructed to account for any offender who had moved at least two times in the last six months at the time of intake.

Substance related concerns were controlled for by constructing two binary variables. *Alcohol Problem* (1 = yes, 0 = no) considered if the offender had any alcohol troubles that interfered with her life in social, legal, or health related ways up to one month before the present offense. *Drug Use/Problem* (1 = yes, 0 = no) was constructed to include any individual who used illegal substances in the past month that may have led to any social, legal or health related problems.



A series of variables were created to account for other childhood risk factors for poor outcomes. These included if the offender *Left Home by Age 16* (1 = yes, 0 = no), brothers, sisters, or parents who were *Criminal Members of Family* (1 = yes, 0 = no), that in childhood the probationer was *Raised by Biological Parent* (at least one) (1 = yes, 0 = no), and during childhood the probationer either witnessed or was the victim of *Domestic Violence* (1 = yes, 0 = no). Each of these was controlled for when taking into account SMI probation outcomes.

Three final control variables were included in the models. The first two involved relationships at the time of intake. If the individual had *Pro-social Friends* (1 = yes, 0 = no) as determined by the presentence officer and if the most significant *Romantic/Companion Relationship* was positive (1 = yes, 0 = no) as endorsed by the offender. Finally the offender's motivation level was assessed by the intake interview and the clinical judgment of the presentence officer resulting in the offender being *Not Motivated to Complete Probation* (1 = yes, 0 = no) at the time of intake.

### **Sample Characteristics / Preliminary Hypothesis Testing**

Table 3 presents the sample demographic and offense characteristics for female and male offenders as well as the bivariate chi square comparisons between female and male offenders. The results reveal that 34.70 percent of the full SMI sample was female (n = 785). Women's ages ranged from 17 to 61 at the time of sentencing with a mean of 36.91 years (*SD* = 10.22). Racial composition for women consisted of 66.84 percent White (n = 525), 17.80 percent African American (n = 140), 12.68 percent Hispanic (n =

99), and Other race 2.68 percent (n = 21). Female offenders were more likely than male offenders to be white. Females were less likely than males to be Hispanic.

[TABLE 3 HERE]

When considering key outcome variables for the sample, 17.20 percent of women were early terminated from SMI probation (n = 135).<sup>26</sup> During the relevant time period 55.67 percent (n = 437) of women completed SMI probation. This result was significantly higher than the completion rate for men at 49.42 percent (n = 730). When considering unsuccessful outcomes during the same time period, women were significantly less likely to be unsuccessful on SMI probation 15.80 percent (n = 124) than men at 21.26 percent (n = 314). Finally, examining only those women whose probation grant was revoked, 9.68 percent (n = 76) had their probation revoked, which was significantly lower than SMI men at 12.46 percent (n = 184). The four categorical OST scores were also compared with 8.03% (n = 63) of SMI women offenders having a Low risk factor score, 31.08 percent (n = 244) having a Low-Med risk factor score, 48.15 percent (n = 378) having a Med-High score, and finally 12.74 percent (n = 100) having a High OST score for criminogenic need and offender recidivism risk. Interestingly, women on the SMI caseload were significantly less likely than men to be scored as High-risk need ( $p < .001$ ), and significantly more likely than men to be scored as Low risk/need and Low-Medium s/need ( $p < .001$ ).

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<sup>26</sup> There was no significant difference between early termination of probation between women and men on the SMI caseload. As a result, multivariate results for early termination were conducted but were not displayed in this chapter.

More than half (58.18 percent) of the females in the sample were arrested for felonies. They were significantly less likely to be arrested for a felony than males (66.53 percent). At the bivariate level, women were significantly less likely to be convicted of felony offense than men on the SMI caseload ( $p < .001$ ) but significantly more likely to be convicted of an undesignated offense ( $p < .001$ ). Considering probation sentence length, 47.01 percent ( $n = 369$ ) of SMI women offenders were sentenced to probation for fewer than three years, 45.10 percent ( $n = 354$ ) were sentenced between three and five years, and only 7.90 percent ( $n = 62$ ) of the female sample received a probation term of more than five years. Women were significantly more likely than men to receive a probation sentence under three years (47.01 percent versus 42.72 percent).

Regarding prior record, SMI women offenders had a substantial history with the criminal justice system but one that was significantly less than SMI men offenders. Nearly one-third of the women probationers, 32.74 percent ( $n = 257$ ) had been convicted of a prior felony. Additionally 18.16 percent ( $n = 143$ ) had a prior prison sentence, 40.79 percent ( $n = 320$ ) had a prior probation sentence, 17.39 percent ( $n = 137$ ) had a probation or parole sentence revoked at some point, and over one-third 36.56 percent ( $n = 287$ ) had been arrested as a juvenile. Women were significantly less likely than men to have a prior felony conviction and a past prison or probation sentence ( $p < .001$ ). Women

offenders were also significantly less likely to have been previously revoked from probation or parole ( $p < .01$ ).<sup>27</sup>

Table 4 presents sample univariate and bivariate relationships between SMI offenders based on gender; focusing specifically on social and life-course characteristics. Regarding relationship status 11.71 percent ( $n = 92$ ) of the female offenders were married/common law, 30.07 percent ( $n = 236$ ) were divorced or separated, 49.30 percent ( $n = 387$ ) were single/never married, and 8.92 percent ( $n = 70$ ) had an unknown/undisclosed relationship status. At the time of intake, 25.61 percent ( $n = 201$ ) described their most significant romantic relationship/companionship as positive and supportive. In comparison to the male sample, SMI women offenders were significantly more likely to be divorced or separated ( $p < .001$ ) and significantly less likely be single/never married ( $p < .001$ ).

Although there is no statistically significant bivariate difference in social characteristics between females and males on the SMI caseload, there are several informative univariate statistics of the wide sample of female offenders. The majority of SMI women offenders attended high school, with only 9.55 percent ( $n = 75$ ) did not attend any high school. Observing reading level, 11.97 percent ( $n = 94$ ) read below a sixth grade level at the time of intake. The majority of women, 54.78 percent ( $n = 430$ )

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<sup>27</sup> Pearson's  $r$  correlations were conducted on all variables to examine the relationship between independent variables used in the analyses. Although many variables are significantly related, the highest is between prior probation and prison ( $r = 0.51$ ,  $p < 0.01$ ) Therefore all variables fall within the traditional maximum cut-off values of 0.70 (Tabachnick & Fidell, 2007).

were employed or received financial assistance in lieu of employment outside the home at intake. However, 18.98 percent (n = 149) of women were considered “residentially unstable” at the time of entering probation as operationalized by two or more moves in the previous six months. Finally, several childhood and time of intake characteristics were evaluated. For instance, 21.66 percent (n = 170) of SMI women offenders left home by age 16, 84.59 percent (n = 664) were raised by at least one biological parent, and 39.87 percent (n = 313) had been the victim of or experienced domestic violence in their childhood home. At the time of intake, 32.48 percent (n = 255) of SMI women offenders had a brother, sister, or parent who had been convicted of a criminal offense. Likewise, 82.68 percent (n = 649) self identified as having pro-social friends, and 90.32 percent (n = 709) of the women sample was motivated to complete probation as judged by the intake probation officer.

[TABLE 4 HERE]

## **MULTIVARIATE MODELS**

Table 5 provides results for three exploratory logistic models that were completed by regressing the SMI probation completion for the female, male, and full samples.<sup>28</sup>

Separate models are presented to consider within group predictors for the women as well

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<sup>28</sup> Model diagnostic tests were completed on each of the multivariate models to look for harmful levels of collinearity between variables. All variance inflation factors (VIF) were below the common threshold of 4.0 considered by some scholars to be problematic (Tabachnick & Fidell, 2007). Due to concerns with collinearity regarding the prior prison, probation, and revocation variables, models were also completed excluding each of these variables. They were no substantial fluctuations in standard errors as a result or significance levels as a result.

as between group comparisons. Recall that the completion variable was constructed by combining individuals who successfully completed their full sentence on probation or were terminated early during the designated time frame. Many significant relationships materialize in the model. First, in the female only model, age at sentencing increases the likelihood of SMI probation completion ( $\text{Exp}(b) = 1.02$   $p < .01$ ). Age appears to be an important predictor of completion for the men and the overall sample as well, suggesting that for SMI offenders in this sample, older individuals are more successful in terms of completion. In the female only model, offenders convicted of public order offenses ( $\text{Exp}(b) = 2.81$   $p < .05$ ) are statistically more likely to complete probation in comparison to the referent group of non-violent property offenders. However, this finding is unique for the SMI women and not found to be true for the male only and full sample models. In relation to misdemeanor offenses SMI women felony offenders ( $\text{Exp}(b) = 0.42$   $p < .001$ ) and undesignated women offenders ( $\text{Exp}(b) = 0.43$   $p < .001$ ) are significantly less likely to complete probation than misdemeanor offenders. Although both of these results are also found in the full model, they only holds for men felony offenders in the male only model and not for undesignated offenses.<sup>29</sup>

When considering additional offender characteristics, as anticipated, Table 5 reveals that SMI women with prior prison sentences ( $\text{Exp}(b) = 0.40$   $p < .01$ ) and prior probation sentences ( $\text{Exp}(b) = 0.49$   $p < .001$ ) are significantly less likely to complete

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<sup>29</sup> The equality of regression coefficients for each of the independent variables that were significant for both females and males were calculated (see Clogg, Petkova & Haritou, 1995; Paternoster, Brame, Mazerolle & Piquero, 1998). Results conclude that effects were significantly more pronounced for females over males in these instances.

probation. These are findings that hold across all models showing that past criminal justice involvement offers considerable risk against completion for current SMI probationers.

Two social/life-course factors emerge as significant in the SMI women model not relevant in the SMI men or full models. First, women who have an alcohol problem at the time of intake onto probation ( $\text{Exp}(b) = 0.60$   $p < .01$ ) have 40 percent lower odds of completing probation as SMI women offenders without alcohol problems. Additionally, SMI women raised by at least one biological parent are significantly more likely to successfully complete probation than those women who were not raised by biological parents ( $\text{Exp}(b) = 1.63$   $p < .05$ ). There are no social/life-course factors that are statistically significant for the SMI male sample. However, Black offenders in relation to White offenders are significantly less like to complete probation in the male and full samples and violent offenders and substance offenders are statistically more likely to complete SMI probation in the male and full samples. Notably, neither of these findings holds for women.<sup>30</sup>

[TABLE 5 HERE]

Table 6 illustrates unsuccessful outcomes of probation. As a reminder, an unsuccessful outcome was operationalized to be any offender who did not complete

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<sup>30</sup> Although no significant difference exists between racial categories of women and completion of probation at the multivariate level, Black women were significantly less likely to be early terminated from probation as opposed to White women. (This model is not shown). This may indicate that probation officers make discretionary decisions that are less favorable to Black women than other races.

probation. This could be because her probation revoked, because she terminated the probation grant and chose instead to serve the remainder of her sentence in jail or prison (normally because she was frustrated with all the conditions of her probation), because she was moved to long term psychiatric care, or because she absconded from probation and a warrant was issued for her arrest. Although gender is not significant in the full model, many factors are noteworthy predictors in the model for SMI women offenders considering unsuccessful outcomes while on the SMI probation. First, Hispanic women ( $\text{Exp}(b) = 0.40, p < .01$ ) are significantly less likely than White women to have a negative outcome on SMI probation. Age at the time of sentencing ( $\text{Exp}(b) = 0.93 p < .001$ ) is also a significant predictor of negative outcome; as age increases odds of unsuccessful outcomes to SMI probation decrease. Age is also a significant predictor in the SMI male and full sample. Criminal offense controls also have significant impacts. For instance, SMI women offenders convicted of a public order crime ( $\text{Exp}(b) = 0.11 p < .05$ ) are less likely to have an unsuccessful outcome as non-violent property offenders. This is also true for the full sample. Likewise, having a prior prison sentence is also a predictor of an unsuccessful outcome for women ( $\text{Exp}(b) = 2.67 p < .05$ ) as well as for the men and the full sample. Offense classification remains important for SMI women offenders as felony offenses ( $\text{Exp}(b) = 4.69 p < .01$ ) and undesignated offenses ( $\text{Exp}(b) = 3.49 p < .01$ ) are both more likely to have an unsuccessful outcome as opposed to misdemeanor offenders. Interestingly, although both these results were also true for the complete



sample, offense classification has no significant impact to unsuccessful outcomes for SMI men offenders.

[TABLE 6 HERE]

Table 7 also highlights a series of important variables significant to the SMI women sample but markedly have no impact on the SMI men sample. For instance, for the women only model, reading impairment ( $\text{Exp}(b) = 2.20$   $p < .01$ ), positive companion/romantic relationship ( $\text{Exp}(b) = 1.95$   $p < .01$ ), being employed/financial sound ( $\text{Exp}(b) = 0.65$   $p < .01$ ), and being raised by biological parents ( $\text{Exp}(b) = 0.45$   $p < .01$ ) each has significant impacts for unsuccessful outcomes for SMI women offenders. Both reading impairment and having a positive companion/romantic relationship increase odds of unsuccessful outcomes for SMI probation. However, being employed or financially sound as well as being raised by a biological parent significantly decreased the odds of having an unsuccessful outcome in the SMI women only model. None of these are significant predictors for the SMI male model, providing evidence for unique considerations for SMI women offenders. Also notable in relation to gender specific considerations is that alcohol users were significantly less likely to have an unsuccessful outcome for SMI men offenders and not being motivated to complete probation was a positive predictor of an unsuccessful outcome. Neither of these factors made a statistically significant difference to unsuccessful outcomes for women.

Table 7, like earlier tables, was split between the three models of women only, men only, and the full sample. The primary purpose of Table 7 is to review a specific

subset of unsuccessful SMI women offenders – those whose probation is revoked by their probation officer and/or the court. Although gender is not a significant predictor in the full model, a few interesting differences emerge between the different gender-based models. For the SMI women only model, age is again a predictive factor ( $\text{Exp}(b) = 0.94$   $p < .001$ ) with younger women more likely to have their probation grant revoked. This is a finding that also is established in the men only and full models. Being convicted of a felony ( $\text{Exp}(b) = 1.86$   $p < .05$ ) for women also accounts for a significantly increased odds of revocation as opposed to be convicted of a misdemeanor. As in the previous women only models, being raised by a biological parent is a significant protective factor ( $\text{Exp}(b) = 0.52$   $p < .05$ ). Those women were significantly less likely to have their probation revoked as women who were not raised by a biological parent. This is a finding consistently significant in the women models with no influence in the men only models. On the other hand, these results in Table 7 illustrate a couple criminogenic factors such as prior prison sentence, and not being motivated to complete probation as predictive of SMI men and full sample revocation but have no impact on the revocation of SMI women. These findings present important considerations for gender and social control discussed in more detail in Chapter 7 of the dissertation.

[TABLE 7 HERE]

The final model, Table 8, examined OST risks/needs factor scores at intake to predict chances of recidivism for individuals on the SMI caseload. Unlike earlier models, this model is focused on intake risks/needs scores instead of completion and failure on

probation. In this model, ordered logistic regression was employed (OST score Low, Low-Med, Med-High and High). Results indicate that SMI women offenders experience significantly lower OST criminogenic need and recidivism risk levels ( $\text{Exp}(b) = 0.34$   $p < .001$ ) than men even when controlling for several other relevant factors. Here the primary exploratory variable of gender is a significant predictor for OST risk level indicating SMI women have significantly less criminogenic needs than their male counterparts. The SMI women also present less risk to overall recidivism as established in the OST. The result is especially salient as the probation department scored female and male offenders category of risk at different levels. To explain, male OST risks/needs scores were divided by Low risk - 0-5, Med-Low - 6-10, Med-High - 11-17, and High risk - 18+. For women Low risk was 0-8, Med-Low - 9-13, Med-High - 14-20, and High - 21+. These results indicate that in comparison to men, women on the SMI caseload have less criminogenic needs and are lower risks for recidivism. However, these women are still subjected to the expanded control of mental health probation in the same ways SMI men are. Multiple scholars have expressed concern over actuarial tools and their ability to accurately assess the risks/needs of female offenders. Holtfreter and Cupp (2007) reviewed several studies that had used the LSI-R actuarial tool. The authors concluded that risks/needs assessments were less successful for predicting recidivism among women who entered the criminal justice system through gendered pathways (see also Belknap & Holsinger, 2006; Reisig et al., 2006; Salisbury, Van Voorhis, & Spiropoulos, 2009; Van Voorhis, Wright, Salisbury & Bauman, 2010). Explored in the

next chapter, the results in these models provide some evidence that within the confines of the criminal justice system women's deviance is seen as more pathological than that of men.

[TABLE 8 HERE]

## **CONCLUSION**

The goal of this chapter was to complement the qualitative findings regarding pathways to systems of social control for women on the SMI caseload and the expanded social control placed on them while on the caseload. By utilizing a wide sample of over five years of quantitative intake data from the SMI caseload, this chapter considered predictors of completion and unsuccessful outcome for a large sample of women on SMI probation. In addition the wide sample provided a snapshot of the make-up of the demographic and social characteristics of women who are on the SMI caseload and compared them to those of men on the SMI caseload. Furthermore, because the quantitative data also included men, the outcome models could be analyzed in a comparative nature by gender. Some important differences emerged by examining the female only models in relation to males who had been on the SMI caseload in the same time frame.

Included within the results was that women in the wide sample on the SMI caseload were significantly more likely to complete SMI probation when they were raised by their biological parents. Being raised by biological parents was also important in regard to unsuccessful outcome, as were romantic relationships. Scholars have long held

that women form relationships differently from men and these relationships are important to life outcomes in ways that unique by gender (e.g. Covington, 2008; Gilligan, 1992, 1993). Likewise, women involved in romantic relationships may not be a protective factor for desistance (Leverentz, 2006; Simons et al., 2002) as research studies have argued are for men. In addition to relationships, quantitative outcome results suggested that some forms of offense classification, as well as prior system involvement significantly negatively impacted female offenders on the SMI caseload in ways they did not men; or at least provide evidence that impact may be more negative for women. For instance, women had nearly five times the odds of having an unsuccessful outcome if they had committed a felony offense as opposed to a misdemeanor. For men, felony offenses had no significant effect on negative outcomes. Finally, as previous research has supported for women in community corrections settings (e.g. Huebner et al., 2010) educational obtainment can impact recidivism rates for female parolees. In the current sample educational obtainment and cognitive ability also appeared to have a significant effect as women who could not read at a sixth grade level had over twice the odds (2.20) of not successfully completing SMI probation. On the other hand, those women who were employed or financially sound were significantly less likely to have an unsuccessful outcome. Both of these were social factors that had no impact on unsuccessful outcomes for men.

The final chapter of the dissertation will explore these results in more detail to consider how they may complement many of the qualitative findings with the deep

sample from Chapter 4 and Chapter 5. As well, Table 8 will be discussed in conjunction with the qualitative findings to examine how women are controlled within the SMI caseload with recidivism risk levels that are lesser than those of men. Chapter 7 will also tie together the importance of relationships for women on the SMI caseload, including the effects they have on pathways into the formal systems of control up until the point that women leave the criminal justice system. Finally, a detailed assessment of how the mental health system and criminal justice system work together to form an all encompassing net over some women on the SMI caseload will be put forth.

## CHAPTER 7

### DISCUSSION AND CONCLUSIONS

The criminal justice and mental health systems are two primary institutions of formalized social control in the United States. Offenders deemed mentally ill frequently cycle between these two systems. As a result of the deinstitutionalization movement (Torrey, 1997), and the subsequent net widening behavior (Cohen, 1985) of these systems of control, some offenders with mental health problems now find themselves under the dual governance of both systems. One particularly unique group affected by this expansive control is female offenders who have been diagnosed as mentally ill. Historically, women and “the female condition” have received substantial scrutiny by psychiatry (Chesler, 1972; Russell, 1995; Showalter, 1987; Ussher, 1991). At the same time, however, women have been traditionally neglected or entirely ignored in criminal justice research (Belknap, 2006). Considered together, scholars have long posited that women’s deviance is pathologized, while men’s deviance is criminalized (Thompson, 2010). Important, yet rarely discussed, are the women under the governance of both the criminal justice and mental health systems that have been labeled simultaneously “mad and bad.”

The main goal of this dissertation was to explore the lives of these women under the benevolent control of the mental health system and the coercive control of the criminal justice system. The project focused on women on SMI probation for several reasons. First, the rates of female involvement in the criminal justice system continue to

increase (Guerino, Harrison, & Sabol, 2011). Second, women in the criminal justice system have a unique set of problems that have influenced their criminalization and affected their chances of success once their criminal justice involvement ends (Belknap, 2006; Reisig et al., 2006; Daly, 1992, 1994, 1998; Morash, 2010). Third, mental health courts have increased dramatically in probation departments across the country over the last two decades (Watson, Hanrahan, Luchins & Lurigio, 2001). Though recent research has generally found mental health caseloads to be more effective than traditional probation caseloads (Skeem & Manchuk, 2010), some scholars express concern about the expanded control that problem-solving courts and specialty caseloads have over offenders. Beyond simple surveillance, individuals on the SMI caseload at MCAPD are mandated to adhere to court ordered treatment that can consist of individual, group, and family therapy, psychotropic medication, substance abuse treatment, parenting classes, case management, social security and disability payments, vocational/educational classes, urinalysis, financial restitution, and attending the mental health court at the discretion of their probation officer. In this way, the criminal justice system works in conjunction with the mental health system to govern over most aspects of these women's lives.

Most important for this dissertation is the fact that women on the SMI caseload at Maricopa County are in a unique position. To explain, they are a group of offenders who reside in the community, but often cycle in and out of forced confinement. Nearly all the women had at least one institutionalized stay in a psychiatric facility. The vast majority of these women were adjudicated incompetent at some point while in the criminal justice



system. Additionally, most had extensive histories of coerced psychiatric treatment including court ordered adherence to psychotropic medication. Some had cycled in and out of the criminal justice system multiple times. Several had inpatient substance abuse treatment. A few more affluent women even had multiple inpatient substance abuse stays before their first conviction. Although these women were often deemed incompetent, they were held criminally responsible for their actions. Ultimately these women were left to negotiate a space “on the brink” between sane versus crazy, free citizen versus incarcerated criminal, and criminally responsible versus legally incompetent. Reviews of the historic treatment of women in the mental health and criminal justice systems in Chapter 2 of this dissertation elucidated why gender is an important topic for consideration. These women are deemed doubly deviant by being under the governance of two primary systems of formalized social control. They had unique entries into these systems and gendered occurrences while under the systems’ governance. A principal goal of this dissertation was to explore the experience of women on SMI probation through their own declarations. This has been a viewpoint that has far too frequently been dismissed in studies of women diagnosed with mental illness. These perspectives are important as practitioners, bureaucrats and academics potentially create policy that is misguided and often ineffective without the offender’s perspective.

To explore the experience of the women on SMI probation, the dissertation employed a mixed-methods approach focused on qualitative interviews with a deep sample of 65 offenders, nearly a year of field observations from the mental health court,

and over five years worth of quantitative intake data for the SMI caseload. Three primary issues were addressed in the results chapters of the dissertation:

- (1) What were the pathways to the criminal justice and mental health system for the deep sample of women on the SMI caseload?
- (2) How was formal social control used in the criminal justice system and mental health system to govern over women on the SMI caseload?
- (3) What demographic characteristics predicted successful completion and unsuccessful outcome for women on the SMI caseload in comparison to men?

Based on these three questions, the results of the research project highlighted several key findings that support or expand upon existent literature. In this chapter I discuss four of these findings in greater depth and consider their policy implications throughout the chapter. These include:

- (1) Women on the SMI caseload followed pathways to criminalization that were apparent and in several ways largely supported the gendered pathways perspective. For some women, symptoms of mental illness played a significant role in their criminalization.
- (2) As primary institutions of formalized social control, both the criminal justice and mental health systems serve as initial catchment areas for each other concerning women on the SMI caseload. The women in the current study existed within two systems that work together to change and control behavior.
- (3) Expanded forms of social control for women on the SMI caseload do exist. From the viewpoint of women who make up the SMI caseload, many aspects of the psychiatric, medical, and coercive control over their lives was unwanted and considered harmful. However, women on the SMI caseload did not form a singular voice in this regard.
- (4) Relationships, as previous theory has suggested, remain important for women's success and failure in the criminal justice system. The quality of relationships for women on the SMI caseload impacted women's entry into, time during, and successful completion of SMI probation.

## Considerations for Gendered Pathways

First, pathways to criminalization for women in the current sample were largely supportive of previous gendered pathways research (e.g. Daly, 1992, 1994; Morash, 2010; Reisig et al., 2006; Salisbury & Van Voorhis, 2009; Simpson et al., 2008). Abuse, neglect, and substance dependence were all frequent problems that appeared throughout the biographies of the deep sample. Research has continually supported the notion that many women in the criminal justice system have histories of victimization that leave them vulnerable to psychological disorder and substance abuse (Battle et al., 2003; Maas-Robinson & Thompson, 2006). As noted by previous research, trauma and substance abuse, coupled with significant mental health problems left many of the women in the current sample *hyper-vulnerable* for entry into the criminal justice system.

Central to pathways to the criminal justice system for the current sample were problems with drugs and alcohol. Sixty percent of the deep sample entered the criminal justice system as a result of illegal substance involvement. Many of the biographies of the *Addiction-Dominated Women* were similar to criminalized women who are not on SMI caseloads (e.g. Daly, 1992, 1994; Morash, 2010; Reisig et al., 2006). Substance abuse/dependence, histories of trauma, and victimization were extremely common. Nearly 60 percent of the deep sample had been victimized (physically or sexually) at least one time as a child. An additional 17 percent (not abused) had experienced significant childhood neglect.

As reported by earlier research (Miller & Mancuso, 2004; Salisbury & Van Voorhis, 2009) some women “self-medicated” with substance to numb the adverse psychological symptoms caused by victimization. Researchers have concluded that women are more likely than men to use substances in order to alleviate psychological symptoms and continue to use those substances to treat psychological symptoms (Evans, Forwyth & Gautheir, 2002; Inciardi, Lockwood & Pottieger, 1993). In the current project biographical analysis of the women supported the notion of complex pathways to the criminal justice system. These pathways appeared to be bidirectional among many risk factors. For instance, some women expressed that they used substances to alleviate symptoms of mental illness. However, other women reported that they experienced no symptoms of mental illness in their lives until they had become substance dependent over time. Although some women on the SMI caseload commonly endorsed self-medication for alleviation of mental health symptoms as a reason for their substance abuse, others began using in relationships with men, or to help increase energy. This finding is in line with more recent research (Carbone-Lopez & Miller, 2012), which has reasoned that mental health symptomology as a result of early victimization, is not the only causal pathway to delinquency (drug use). Carbone-Lopez and Miller (2012) argued, “Precocious entry into adult responsibilities and roles may, in some circumstances, function as the mechanism that facilitates the onset of drug use and other deviant activities” (p. 191). Regardless of the directional nature between victimization, substance abuse, and psychological problems the truth remains that these factors are intimately

connected for women offenders. This is a finding further supported by the current research project.

Bloom, Owen and Covington (2004) and Covington (2008) have proposed that gender responsive policies should take into account individual lives and “realities” that exist for women. Covington (2008) stated “we need to create programs...based on the reality of their lives and on what we know about female growth and development” (p. 141) One reality, which is commonly apparent, is the fact that victimization as a youth can lead to subsequent problem behavior. As a result, some researchers have suggested that eliminating abusive home lives would alleviate both delinquency and mental health problems for girls and young women (Belknap & Holsinger, 2008). Undoubtedly, a macro level policy shift that focused on prevention of abuse and victimization would decrease the number of girls and women who enter the criminal justice system. A greater commitment to societal protection for many of the acutely stigmatized women in the current study would help them on an individualized level as well.

In order for women with mental health problems to increase their chances of success in all aspects of their lives, criminal justice and mental health personnel must realize how early life victimization routinely influences subsequent problem behavior for female offenders. Trauma informed care is essential for understanding entry into and out of the criminal justice system for women on SMI caseloads. Past victimization affects most aspects of current problem behavior for these women. Combined with substance abuse and significant mental health problems, women are often left with few

opportunities for success. When working with women on SMI caseloads professionals must also realize that victimization, substance abuse problems, and mental illness are not mutually exclusive risks. Instead, these problems form an intricate and entangled relationship with other social factors like economic marginalization and relational concerns. Treatment must focus on aspects of each of these instead of one at a time or choosing only the problem that seems largest. Overall, results from the current study supported earlier findings in female offender populations that highlight the multiplicity of needs that most women in the criminal justice system possess (Holtfreter & Morash, 2003). Women in the current research project (with mental health problems and functional impairment) have even greater needs given their frequent inability to work, heightened mental vulnerability, and especially small social support systems.

The examination of gendered pathways to the criminal justice system in Chapter 4 also revealed that some women in the deep sample came into contact with the criminal justice system exclusively as a result of their mental illness. These women were experiencing profound clinical symptomology at the time of their arrest that initiated their criminal justice involvement. Skeem, Machak and Peterson (2011) recently discussed whether the criminalization hypothesis was still a viable consideration for the criminal involvement of persons with mental illness. The authors overviewed theories that highlight the connection between mental health and crime as mostly mediated by “social/personality” models. Skeem and colleagues (2011) concluded, however, that mental illness “remains viable...there is evidence that criminal behavior is directly

attributable to mental illness for a small subgroup of offenders” (p. 117). That conclusion was supported in the current study of women on the SMI caseload. Within the deep sample, a subset of women, criminalized only as a result of symptoms of mental health disorder, emerged. In these instances delusions, hallucinations, or other mental health symptoms were a direct causal mechanism for contact with the criminal justice system. In sum, although social factors and personality traits may be responsible for the majority of women on the SMI caseload entering the criminal justice system, mental health problems appear also to be a direct cause for a few women’s specific offenses.

### **Considerations for Unified Benevolent and Coercive Control**

A second consideration from the findings of the dissertation is the linked relationship regarding pathways between the criminal justice and mental health systems. The mental health and criminal justice system did not function in opposition to each other for women in the current sample as some earlier scholars have hypothesized (e.g., Black, 1976). Instead, interviews with women revealed that the criminal justice system and mental health system normally served as catchment areas for one another. Essentially the two systems frequently overlapped in their control of the women in the current study. Coupled together, the criminal justice and mental health systems formed a symbiotic relationship of control over many women in this study. This finding supports earlier research that has argued “treatment-control” systems largely work in conjunction with one another (Dallaire et al., 2000; see also Thompson, 2010).

It is also important to reiterate that nearly 40 percent of women in the deep sample had initial points of contact with the mental health system as a result of entry into the criminal justice system. For many of the women, the criminal justice system was the initial catchment area prior to receiving any mental health service. The majority of women in this research project lived with significant mental health problems that were only intensified by being incarcerated. Despite steps (i.e., mental health courts) to provide individuals with mental illness treatment in the criminal justice system, Earley (2006) has rightfully noted that involving individuals in the criminal justice system are *reactive steps*. Earley (2006) further reasoned that individuals with mental health problems predating incarceration should not have to be criminalized and incarcerated to receive mental health care. Earley's point is certainly true for many of the women within this research project who were criminalized as a result of substance addiction, survival crimes, or mental health problems. Aside from mental health symptoms being exacerbated while incarcerated, women were also adversely affected in other ways because of incarceration (i.e., losing needed social services). These losses (often permanent) intensify marked vulnerabilities involving mental health as well as other areas in the lives of women on the SMI caseload.

Considering the services lost for women as a result of a conviction, the primary entryway to the criminal justice system in the current study was through involvement with illegal substances. Scholars have stated that women have paid an unduly harsh price for social policies surrounding the war on drugs over the last 20 years (Allard, 2002;



Bush-Baskette, 1998). While incarceration has increased dramatically for substance related offenses, many policies have taken away services for individuals convicted of drug offenses. For instance, Allard (2002) highlighted that because of the 1996 Welfare Reform Act, individuals convicted of a drug offense are no longer eligible for some services like food stamps. Allard (2002) also discussed that recent legislation has made it significantly harder for many drug offenders to live in government-assisted housing. In both instances the author posited that these policies have affected women to a larger extent than men.

Consistent with the findings of Allard (2002), multiple women in the current study were unable to benefit from programs like food stamps because of their drug convictions. All women that this policy has affected were adversely impacted (but especially those raising children). In other samples of women offenders, researchers found that providing these much needed services for women living in poverty substantially reduced their odds of recidivating (Holtfreter et al., 2004). Additionally, individuals in the current project who became incarcerated in the state of Arizona lost stated funded Medicaid (AHCCCS) while incarcerated. After incarceration ended individuals were normally able to reapply for this insurance, but many women reported profound difficulties in getting the service reinstated after incarceration. The policies highlighted above as well as others have caused most female offenders (including the ones in this study) undue harm by taking away much needed service because of substance

related crimes. Furthermore, these are crimes which some argue should be public health problems and not criminal justice offenses.

The symbiotic nature of the criminal justice and mental health systems worked in unique ways for different groups of offenders in the current study. As noted, the criminal justice system served as a large catchment area for many women to receive subsequent mental health service. For others, however, the coercive involvement of the criminal justice system only occurred after repeated failures to change drug-using behavior in the mental health system failed. To explain, for a small group of women I labeled the *Mad/Bad Dichotomy*, race and social class impacted how they were processed between the two systems. This subset of the *Addiction-Dominated* category only entered the criminal justice system after multiple attempts at psychological counseling and repeated admissions to private drug facilities failed. Generally, their biographies differed substantially from other women in the deep sample. Each woman in this group was White, and most were highly educated. Their biographies contained little physical or sexual abuse and they had been raised in middle-class or affluent families. As a result of their race or socio-economic status, these women were given multiple opportunities to change their behavior before being criminalized. This finding is supported by the quantitative data in Chapter 6 that found that net of multiple legally relevant control variables, African American women on the SMI caseload were significantly less likely to be given early termination. This highly desired, but infrequently used outcome was more often employed for White women on the SMI caseload. These findings are in line with

other research stating that White women see some benefits from the criminal justice system involving drug treatment (Smith, Rodriguez & Zatz, 2006). This finding also brings considerations of race/ethnicity and social class into the context of the current study. Some wealthy, educated, White women were considered more properly suited for benevolent treatment when compared to poor and uneducated women (White or minority) who were reasoned to be in greater need of coercive control.

### **Considerations for Legal, Psychiatric and Medical Control**

A third discussion point focuses on the expanded social control for women in the current study. Covington (2008) wrote that, “Our criminal justice system, which is based on power and control, reflects the dominant/subordinate model of our patriarchal society” (p. 148). The author stressed that the criminal justice system is a mirror of a larger society where women exist on the lowest rungs of the hierarchy. Gido (2009) has speculated that girls and women in the criminal justice system with mental illness are the *most invisible* of all. Despite this invisibility (or perhaps because of it) the current project found that women on the SMI caseload were frequently subjected to expansive formal social control. This control was often noteworthy when women on the SMI caseload deviated from normative gender roles. For example, women involved with crimes against children were punished harshly by the courts despite their limited culpability in many instances. Feminist legal scholars (e.g., Becker, 1995; Cahn, 2000) have argued that women continue to be so identified with motherhood and caretaking that they are punished quite harshly for crimes that involve children. Becker (1995) referred to this as

the “Good Mother-Bad Mother” dichotomy. Some scholars have critiqued the criminal justice system for its application of expanded control involving gender by protecting the fetuses of pregnant women and regulating motherhood (Boyd, 1999).

In the current study stereotypes about gender normative behavior were a reason for increased control. Despite sometimes experiencing profound clinical symptomology at the time of the offense, some women were punished harshly for failing to be “good” and protective mothers. This was true even if they were not involved in the offense. This inability to separate women from the caregiving capacity remains a problem for the criminal justice system (and society in general). Specifically, the current findings showed that despite clinical symptomology so acute she could not get out of bed for days, one woman was still sentenced to lifetime probation as a result of her boyfriend sexually assaulting a small child in the home. This was a sexual assault of which the woman was not aware. In this instance, her boyfriend was on probation and not allowed to be around children. The prosecutors argued because the woman had failed to report the boyfriend’s contact with the child, she was also culpable in the offense. She spent a year in jail before accepting a plea bargain of lifetime probation. This sentence was agreed on despite the fact she was unaware of child protection laws (not to mention so psychologically disoriented at the time of the offense she had not left her bed for days). Another woman who was severely beaten on a regular basis at the hands of her boyfriend was forced to place her mouth on her baby’s penis. Fearing for her life at the time, she complied with her boyfriend’s demands. When she failed to report the offense

immediately she was also deemed culpable. Her offense resulted in a plea bargain of lifetime probation and permanent loss of her biological children. With instances like these in mind, sentencing policies in place that punish women for their *hyper-vulnerability*, even unintentionally, are problematic.

Past research has highlighted that some women act with agency in committing offenses (e.g. Maher, 2000). Maher found in examining the lives of women involved in drug networks in New York that their submissiveness and inaction in committing crime was largely a myth. In the current study, however, *some* women with functional impairment on the SMI caseload had very little agency involving their criminal offenses. Granted, this particular sample of female offenders is in several regards not representative of women within the criminal justice system. This is a point I return to in detail when discussing limitations of the current dissertation.

Merging particular aspects of legal, psychiatric, and medical control were substantially coercive in nature within this project. This finding has implications regarding human agency for women on the SMI caseload. To explain, many women had court ordered treatment as a condition of their probation. This treatment was often in the form of mandated individual psychological and substance abuse counseling, group counseling, parenting classes and psychotropic medication. Scholars in general have voiced concerns over the merging of legal control and psychiatry (see Rogers & Pilgrim, 2010; Link, Castille, & Stuber, 2008). The *Coercion to Beneficial Treatment* perspective (Torrey & Zdanowicz, 2001) argues that forced coercion to treatment can be a positive

thing. This paradigm supposes that individuals will realize eventually that treatment is helping them in the long-term after they are forced to engage in that treatment. An alternative theory comes from the tradition of the antipsychiatry movement (e.g., Szasz, 1997). Proposed by Pollack (2004) the *Coercion to Detrimental Stigma* perspective posits that coercion in treatment only lowers self-esteem, engenders poorer life satisfaction for an individual, and promotes stigma. A recent empirical test of these two theories garnered support for portions of each theory (Link, Castille, & Stuber, 2008). In that particular study the authors found that aspects of coercion do improve clinical symptomology but also led to feelings of increased stigma and decreased self-esteem.

In support of the research of Link et al. (2008) psychological treatment by forced legal control appeared to have both positive and negative impacts in this dissertation. Although many women resented the conditions of their court ordered treatment and believed the treatment overreached into all aspects of their lives, others reported benefits that had positive influences for both their time on probation and whole life. In this regard, however, perhaps the most contentious consideration between the criminal justice system and mental health system involves psychotropic medication.

Medical control by coercion and force was common with the women in this study. Interviews with the deep sample revealed that women frequently took medication they did not want or feel was helping them simply to be in compliance with their psychiatric and/or court ordered treatment. At a policy level, psychotropic medication remains one of the most controversial aspects of treatment for mental health problems. Although

pharmaceutical companies have profited billions of dollars from these medications, many question the problematic side effects that result from these drugs as well as their comprehensive effectiveness (e.g. for a detailed review see Rogers & Pilgrim, 2010). An especially alarming fact is the rates at which these medications are targeted at women. Researchers have shown that medical doctors prescribe more amphetamines, psychoactive drugs, and antidepressants to women than men (Galbraith, 1991). Scholars have also highlighted the unique ways that psychotropic medications were historically targeted to women and their “desired femininity” (for a review see Staub, 2011). This is true despite multiple large-scale epidemiological studies finding women and men do not differ in regard to psychological disorder prevalence (e.g., Kessler et al., 2005)

At a societal level, women with mental health problems have seen increased gendered control at the hands of psychiatry. Scholars have also expressed repeated concern over the use of these “chemical restraints” in female jails and prisons (e.g. Auerhahn & Leonard, 2000). This is also true in many instances discussed in Chapter 5 of the current study. However, women on the SMI caseload in Maricopa County Arizona do not speak with a singular voice regarding increased control with psychotropic medication. Some women greatly resented mandated consumption of countless medications for most of their adult lives in order to be in compliance with their treatment. Others were enormously frustrated by the constant tweaking of “the cocktail.” In these instances doctors would continue to fluctuate medications and dosages despite the women’s repeated protests. In the opposite regard, however, other women truly believed

psychotropic medications improved their lives. Even though these medications only masked clinical symptoms and did not cure them, the medications assisted these particular women in engaging in work, childrearing, probation, treatment, and daily life that they would have been unable to perform otherwise.

Psychotropic medication was harmful for several women and beneficial to others. This is a point often absent from coercive versus critical arguments involving legal, psychiatric, and medical control. At an individual level of treatment (both psychological and medical) there were many negative impacts for women on the SMI caseload. At other times this treatment was seen as extremely helpful and was considered positive. As Covington (2008) and other scholars have noted, policies and treatment with female offenders must be designed with an understanding that we continue to live in a patriarchal society. This patriarchal system has been especially evident in the fields of psychiatry where women have been the focus and in the criminal justice system in which women have largely been ignored for generations. Existing within a patriarchal society neither over-focus nor under-focus has proved to be helpful for women with mental health problems involved in systems of formal social control. Bloom et al. (2004) and Covington (2008) also specified that policies involving women in the criminal justice system must focus on the “realities” that these women face. Bloom and Covington (2000) proposed addressing “the issues of the women” in forming a gender-responsive system (p. 11). The current findings provide evidence that policies of the *one size fits all* variety regarding treatment will not be effective for women. At an individual level many



women suffered at the hands of formal control while others benefited markedly as a result of that control. In the end, it appears that *when* and *how* social control was applied emerged as contextually important for women on the SMI caseload.

The quantitative results of Chapter 6 support the notion that over-classification remains a concern for women on specialty caseloads. To explain, Hannah-Moffat (1999) convincingly argued that classifications systems of risks/needs are inherently gendered as women are so often over classified with actuarial tools (see also Hardyman & Van Voorhis, 2004). Analysis in this project found that women have significantly lower risk and needs scores (even when those scores are adjusted for gender differences) when compared to men on the SMI caseload. Morash (2010) reviewed the concerns of feminist scholars who have critiqued gender-responsive corrections. These scholars fear that gender-responsive programs may increase control and reinforce gender stereotypes. In her detailed comparison of “traditional” and “gender-responsive” probation departments, Morash (2010) reported that these critiques were largely unfounded in the gender-responsive probation departments she examined.

Morash (2010) stated that even when women found gender-responsive probation to be overly controlling or intrusive, the majority of these probationers still considered the experience to be positive. The methods of this dissertation differed from Morash (2010) in that they did not compare multiple caseloads and were focused on a mental health caseload as opposed to a gender-responsive one. Nonetheless, the findings of the current project supported those of Morash (2010) in some key ways. For instance, many

of the women felt their treatment was helpful even when they did not like it. Additionally, a bright spot for most women was the truly valued relationships they were able to form with their probation officers on the SMI caseload. The women in the current study also liked that the SMI probation officers were more accepting of their individual needs, and were willing to work with them on those individual needs. On the other hand, the current study also supported some of the concerns that scholars have put forth regarding placing women on these types of caseloads. For instance, quantitative data supported the notion that in comparison to men, women were over-classified. In fact, gender emerged as the strongest predictor of classification level for offenders on the SMI caseload. Stated simply, women on the SMI caseload have significantly lower risks/needs score categories than men on the caseload. Quantitative analysis also revealed that there are more non-legally relevant predictors of success and failure on the SMI caseload for women than men. This indicates that the court may take less criminally relevant factors into account in revoking women's probation than it may for men. Finally, qualitative examination showed multiple instances where women expressed feelings they were over-controlled in ways that may not have not existed if they were on a non-specialized caseload.

### **Considerations for Relationships of SMI Women**

A fourth overarching consideration of the current study involves the importance of relationships for women on the SMI caseload. Relationships emerged as incredibly significant for women at all data points involved in the current study. This finding is

largely supportive of previous research with female offenders that examined quantitative relational pathways to the criminal justice system (Salisbury & Van Voorhis, 2009), and the importance of relationships to success while on probation (Morash, 2010). Similarly, Covington (1998) and Covington & Surrey (1997) suggested that positive relationships are the core of successful recovery as a result of addiction and trauma.

*Relational Cultural Theory* builds upon the pioneering work of Miller (1976), Gilligan (1982), and the researchers at the Stone Center as part of Wellesley College. These theorists argued that a focal motivation for women across the life-course is to build meaningful relationships with others. According to these theorists, quality relationships are a result of healthy connections and positive relationships that promote continual growth. (for extended review see Covington, 2008)(also see Jordan, 1984, 1985; Surrey, 1985).

In the findings of this research project the relationships of women on the SMI caseload influence their entry into, time during, and successful completion of SMI probation. For instance, some women recognized that they initially engaged in substance use or crime to strengthen relationships with romantic partners. Others continued to use substances as a way to cope with failed or abusive relationships. In interviews with women on the SMI caseload, a few even discussed having domestically violent altercations with their partners as a way to try to engage the other person in the relationship. These failed attempts at connection regarding relationships had detrimental consequences for the criminalization of women on the SMI caseload.

An important finding in the current study was that women who made strong connections with agents of formal social control benefitted significantly from these connections. This is consistent with past examinations of the relationships between probationers and specialty caseload officers (Skeem et al., 2007). For instance, placing the criminal justice system at the center of her analysis, Morash (2010) found, “Women’s lasting, positive, relationships with other program participants, program and agency staff, and supervising officers contribute substantially to their success” (p. 155).

In this dissertation, women who were able to build long-term and trusting relationships with their probation officers often expressed an important and deep connection with them. This is evidenced by women who referred to their probation officer’s as their “best friend,” invited their officer to their birthday party, stated that they wanted their officer to be “proud” of them, and discussed how their probation officer had been the biggest advocate in their lives. However, this is also evidence of the extremely small social networks the women possessed. Even smaller, perhaps, were the amounts of individuals within their social networks who were truly positive and could be counted on. Prior research with women offenders has highlighted the adverse impacts that small networks may have on both social and human capital (see Reisig et al., 2002). In the current study strong relationships with agents of social control (i.e., probation officers) potentially could also increase human and social capital. Beyond overseeing treatment, probation officers also regularly suggested life skills and job training to their probationers

and assisted the women on the SMI caseload with getting government services (e.g. food stamps and Medicare) housing, food, clothing, and transportation.

In the end, positive relationships with their SMI probation officers could serve as “hooks for change” (Giordano et al., 2003) in similar ways that informal controls do. As repeatedly evidenced by the findings of this project, the relationships that were established between specialty court officers and women on the SMI caseload appeared to be crucially important to long-term success. In considering policy ramifications for women in the criminal justice system Covington (2008) proposed that professionals, “move away from power and control toward a system of mutually empowering relationships” (p. 159). The findings of the current study strongly support this important policy suggestion.

## **REVIEW OF POLICY CONSIDERATIONS**

I have discussed several policy considerations/recommendations above based on the findings of the dissertation. In way of review for further consideration I list those recommendations as follows:

**(1) Focus on risks/needs factors of SMI women offenders simultaneously:** When working with SMI women offenders, programs should focus equally on different risks/needs factors as opposed to concentrating only on one or two factors that appear to be the most problematic. Mental health problems, substance use, victimization and economic marginalization form complex relationships with each other. Needs in these areas are not mutually exclusive and must be treated simultaneously.

**(2) Trauma informed care is the cornerstone of working with SMI women:**

Practitioners and policy makers must realize that prior victimization and/or trauma may influence every response that an SMI woman has in any situation. It is important to train agents of social control in trauma informed care.

**(3) More work must be done to eliminate abusive homes:**

Women on the SMI caseload have lives that have been saturated with victimization. This abuse began at early ages and frequently continues across the lifespan. It is an almost universal problem for women in the current study and a prominent social influence on the later development of mental disorder.

**(4) There are no *one size fits all* treatment models:**

All women in SMI probation should be treated on an individual level. Some women are helped by therapy while others are re-victimized as a result. Similarly, some women are placed in “chemical restraints” by psychotropic medication while other women feel they are freed from the chains of mental illness as a result of taking these medications. Several women believe they benefit from expansive control placed on their lives, while others loathe it. Women should have a say in their treatment and the treatment should be tailored to each woman on an SMI caseload.

**(5) Social services are important:**

We must add to, not continue to take away from, needed social services for SMI women offenders. Welfare limitations, ineligibility for Medicaid, and depletion of these social service programs are detrimental to a group of offenders who desperately need those services.

**(6) Building strong relationships is key:**

Probation officers and other criminal justice professionals should undergo training on relational theories to better understand the importance of relationships for women in the criminal justice system. The discretion of probation officers has enormous influence on the chances of successful reentry to the community for these women. The relationships that SMI women offenders build with their probation officers may be one of the core components to their successful completion of probation. Finding social support in the community is also of paramount importance.

**(7) Avoid the over-control of women on specialty caseloads:**

Criminal justice personnel must consider closely who is placed on mental health caseloads. There is evidence in the current study that women were over-controlled in comparison to men on the SMI caseload. Their risks/needs

assessment scores were significantly lower than those of men on the SMI caseload.

**(8) Work for greater gender-informed care:**

Despite having significantly less risks/needs assessment scores, women are commonly seen as “more needy” by the court in the current findings. It is important that agents of formal social control undergo gender-informed training and work to alleviate gendered stereotypes throughout the system.

**(9) Provide multiple services throughout the criminal justice system:**

The criminal justice system is the mental health institution of the 21<sup>st</sup> century. The adverse effects of incarceration are no different today than the negative impacts of psychiatric institutions were in the 19<sup>th</sup> and 20<sup>th</sup> centuries. Mental health courts, while widening the net, also frequently help many women with treatment and service that they would not receive outside of the criminal justice system. We must learn to be proactive in helping our offenders with mental illness before they ever offend. We must also treat SMI women in the most non-coercive manner possible and allow them an active voice in their treatment.

## **LIMITATIONS OF CURRENT STUDY**

This dissertation was built upon a rich dataset to explore the lives of women on the SMI caseload. Few studies have examined the experience of offenders diagnosed with mental illness utilizing multiple research methods. As well, the consideration of gender has been largely absent in examinations of mental health caseloads. Regardless, there are multiple limitations to the current project that should be reviewed in more detail.

First, generalizability and representativeness are prominent concerns. In many ways the women in the this project did not have the same experience as an “average female offender” in the criminal justice system, or even women diagnosed with mental illness in the criminal justice system. The current sample was comprised of a group of

women chosen based on their chronic exposure to both the mental health and criminal justice system. There are no estimates of the total number of women on probation at MCAPD overall who have been diagnosed with a mental illness, or that possess an undiagnosed mental illness. The participants in this study were women on probation targeted to be part of the SMI caseload. Their admission to the SMI caseload was based on having a diagnosed mental disorder in conjunction with persistent functional impairment. Additionally, the women who made up the deep sample were not a random sample. Therefore, there can be no guarantee of how representative their experience was of the overall experience of women on the SMI caseload at MCAPD. To establish as much variation as possible, multiple women were interviewed from each SMI probation officer's caseload. Likewise, some women who were entering, in the middle of, and completing their probation were interviewed. There was a large variation in demographic variables that mostly matched those of the wide sample of 5.5 years of quantitative data. Each of these considerations helped provide assurance that the sample was at least partially representative of women on the SMI caseload at Maricopa County. However, without a statistically random sample, there is no guarantee that the women interviewed were truly representative of a typical woman on the SMI caseload in general.

A second limitation also concerns generalizability and is common to qualitative research methods. The current dissertation examined one mental health court, as part of a single probation unit, during a 12-month period. The results from the current study cannot be considered generalizable to other mental health caseloads, probation



departments, or mental health courts across the country. MCAPD is one of the largest probation departments in the United States and is spread across many field offices. Mental health caseload entrance is mostly at the discretion of a set of specially trained probation officers. There is no designated entrance and graduation date for offenders in the SMI caseload at Maricopa County as exists in many other specialty courts and caseloads. Anecdotally, MCAPD is seen as a rather progressive department in a county and state that leans conservative. In the current dissertation it was not possible to compare how representative MCAPD probation department, MCAPD SMI probation, or Maricopa County mental health court, is in a larger framework regionally or nationally. The findings from the current study should be considered in the context of the limited generalizability that exists in regards to women in the criminal justice system, SMI offenders, probation departments, and mental health courts nationwide.

A third shortcoming of the current analysis is that the design is cross sectional. Although the women were asked about many aspects of their biographies, the interviews were completed at a single point in time. The women in the current sample were highly vulnerable and cycled between competency and incompetency given their mental health symptomology and substance use. The dissertation project was unable to follow these women across time in order to garner a clearer picture regarding why some women were successful while others failed on SMI probation. Likewise, interviews with women during incarceration, or under inpatient psychiatric care were not allowed. In a few instances it was possible to determine what happened to a woman in the deep sample

based on her mental health court dates after she was interviewed as part of the project. In sum, it is unknown what ultimately happened to women who made up the deep sample. The limitation of the cross sectional design is also exemplified in the quantitative data. Multiple models were constructed to examine the predictors for those women who were and were not successful on the SMI caseload. Despite many control variables, a substantial amount of variation was left unexplained in each of the models. This could have been a result of many variables such as employment, stable living situation, current drug use, and other demographic factors being measured at intake only and not at the conclusion of probation. This may also point to the immense discretionary power that probation officers and the courts have over women on the SMI caseload in determining who does and does not successfully complete SMI probation. A longitudinal dataset and interview design could have more adequately explored the impact of static factors on probation completion for women on the SMI caseload.

A fourth limitation of the current project involves consideration of reliability and validity. For each of the 65 women in the deep sample I constructed a pathway to the SMI caseload. The findings revealed that the deep sample was divided into three categories of entry into the criminal justice system (substance involvement, violence, and economics). Within those three categories I explained six emergent pathways. Because the analysis was an independent process, I am unable to state conclusively that strong inter-rater reliability would exist for my constructed pathways.

A final limitation was discussed in detail in the methods section of Chapter 3. I, as a male interviewer, conducted each of the interviews of marginalized women offenders with significant mental illness. The majority of these interviews were completed at the probation offices. In sum, I cannot know how my social location in regards to the women I interviewed may have biased their responses. Similarly, I am unable to know if the location of the interviews had an influence on the information gathered.

## **FUTURE RESEARCH**

This dissertation concludes by considering directions for future research. In addition to the limitations discussed above, future research should explore many avenues. First, more attention should be focused on the relationship between the offender and her probation officer, case manager, the judge, and other members of the courtroom workgroup. A significant amount of work has examined the influences of informal social control on the risk for recidivism (Gendreau, Little, & Goggin, 1996). However, fewer studies have considered explicitly the impact of relationships with agents and formal social control. Research that has been completed with SMI probationers and their officers has found those who develop strong and trusting relationships recidivate less frequently (Skeem et al., 2007). Preliminary studies have also found that SMI probation officers are more successful than traditional officers because of the authoritative approach they employ in working with their clients (Skeem & Manchak, 2010; see also Eno Loudon et al., 2010; Skeem et al., 2008). This appears to even be true when the SMI

offender's clinical symptoms do not improve. Researchers should continue to explore the relationships between agents of formal social control and SMI offenders to investigate when and how these relationships matter.

Future research must also continue to explore the unique functions of women's relationships with agents of formal social control. Morash (2010) found that female offenders benefitted substantially by having gender-informed probation officers. These officers worked closely with the probationers to establish lasting relationships and to promote successful outcomes. The majority of these women felt positively about the attention to their individual needs. This positivity was true even when it resulted in increased control. Few studies comprehensively consider how gender may affect success/failure of mental health caseloads or involvement in mental health court. The discipline would be well served by more in-depth analysis of gender as well as the effectiveness of mental health courts on long-term recidivism.

In addition to women specific concerns about mental health probation, future research should also consider male specific needs. The studies that have been completed have been mostly devoid of gender considerations in regard to offenders with mental illness. Holtfreter and Wattanaporn (2013) recently made a similar suggestion about comprehensive gender responsiveness of the criminal justice system. It is logical to assume that increased gender responsiveness on the part of the criminal justice system will equate to better services for both female and male offenders with mental health

problems regarding their pathways to, time during, and completion of criminal justice involvement.

Finally, at a societal level we must continue to consider the adverse effects that our criminal justice policies have for girls and women. This is a particularly salient concern for women who are effectively controlled by both the mental health and criminal justice systems. This group of offenders is principally vulnerable to being both over-controlled and under-serviced. Neither of these responses alone engenders justice. The treatment-control continuum is a tightrope that we must balance upon carefully.

## **CONCLUSION**

The criminal justice and mental health systems have been two primary agents of formal social control for generations. Women's deviance has been largely regulated as "madness" within the mental health system. On the other hand, men's deviance has historically been considered "badness" and regulated within the criminal justice system. The present study explored multiple aspects of a group of women who were considered both "mad and bad" by being a part of the Severely Mentally Ill caseload at Maricopa County Adult Probation in Arizona. Further, the dissertation investigated the gendered pathways to criminalization by administering qualitative interviews with a subset of women on SMI probation between 2012 and 2013. Additionally, 12 months worth of mental health court observations, case file reviews, and qualitative interviews were analyzed to consider the ways expanded formal social control was exerted over women

on mental health probation. Finally, a quantitative multi-year data set was empirically tested to examine the predictive factors of successful completion of women on mental health probation in comparison to men. In sum, women on the mental health caseload generally followed paths to the criminal justice system that supported the gendered pathways paradigm. For a subset of women, mental health problems played a direct role in their entry into the criminal justice system. Additionally, qualitative analysis revealed that expanded methods of formalized social control do exist for the women on mental health probation. At times this expansive control appeared to be gendered in nature. This control frequently resulted in double binds for women in the current study. Finally, regression modeling determined that there are some gendered predictors of successful completion of mental health probation. Future research should expand upon the current study by further exploring gendered components of entry into and away from mental health probation. The field also would benefit from increased attention to the ways relationships may aid in success and failure for women in the criminal justice system. At a societal level, we must pay close attention to the adverse impacts that current criminal justice policy has over women. This is especially true for the female offenders who are the most susceptible to the pervasive authority of both the criminal justice and mental health systems.

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**Table 1. Demographics for "Deep Sample" of Women on SMI Probation**

	%
Race/Ethnicity	
African American	18.5
White	66.2
Hispanic	7.7
Native American	4.5
Pacific Islander	3.1
Age at Interview (Mean)	37.6
Age Range	20 to 57
Education Level	
Below High School	7.7
Did Not Complete High School	24.6
High School/GED	21.5
Some College	30.8
2 Year / Vocational Degree	7.7
4 Year College Degree	7.7
Current Employment	15.4
Government Financial Assistance	93.8
Relationship Status (Intake)	
Married/Common Law	16.9
Divorced/Separated	33.8
Single/Never Married	49.3
Has Children	73.8
Psychological Disorder Type	
Psychotic	27.7
Mood	63.1
Anxiety	9.2
Taking Psychiatric Medication	89.2
Past Psychiatric Hospitalization	75.3
Past Suicide Attempt	67.7
Substance Use	
Active Use (past 12 months)	30.8
In Recovery (1 to 3 years sobriety)	20.0
Long Term Sobriety (> 3 years)	21.5
No Use / Experimentation only	27.7
Childhood Abuse	
Victim (Physical or Sexual)	58.5
Neglect (Without Abuse)	16.9
Witness (Without Individual Abuse)	6.2
Offense Type	
Violent	24.6
Child Abuse / Neglect	12.3
Non-Violent/Property	26.2
Substance Related	33.8
Past Adult Arrest	
None	18.5
1-2	20.0
3-5	38.5
> 5	23.0
Prior Convictions	
Prior Felony	35.3
Prior Prison	20.0
Incarceration Length (Longest)	
None	9.2
< 3 months	29.2
3 months to 12 months	36.9
13 months to 36 months	18.5
> 36 months	6.2



Probation Sentence Length (Months)	
< 3 years	23.1
Between 3 and 5 years	64.6
> 5 years	12.3
	<hr/>
	n = 65

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**Table 3. Demographic, Offense, and Outcome Characteristics of SMI Caseload Sample**

	Female Sample %	Male Sample %	Sig. Diffs.
Probation Outcome			
Early Termination	17.20	15.71	
Completed	55.67	49.42	**
Unsuccessful	15.80	21.26	**
Revoked	9.68	12.46	*
Race/Ethnicity			
African American	17.80	19.24	
White	66.84	59.49	***
Hispanic	12.68	17.68	**
Other	2.68	3.59	
Age at Sentence (Mean)	36.91 (SD 10.22)	35.21 (SD 11.33)	
Offense Type			
Violent	23.57	21.94	
Non-Violent/Property	29.43	30.40	
Substance Related	38.22	35.00	
Public Order	3.82	3.79	
Other	4.96	8.87	**
Offense Class			
Misdemeanor	14.71	13.24	
Felony	58.18	66.53	***
Undesignated	27.11	20.23	***
Prior Convictions			
Prior Felony	32.74	43.81	***
Prior Prison	18.16	28.50	***
Prior Probation	40.79	49.49	***
Prior Revoke	17.39	22.56	**
Juvenile Arrest	36.56	35.14	
Sentence Length (Months)			
< 3 years	47.01	42.72	*
Between 3 and 5 years	45.10	48.21	
> 5 years	7.90	9.07	
OST Risk Score (Recidivism)			
Low	8.03	2.10	***
Low-Med	31.08	17.67	***
Med-High	48.15	50.78	
High	12.74	29.45	***

p <.001\*\*\* p < .01 \*\* , p < .05 \*

n = 785

n = 1477

**Table 4. Demographic/ Social Characteristics of SMI Caseload Sample**

	Female Sample %	Male Sample %	Sig. Diffs.
Relationship Status (Intake)			
Married/Common Law	11.71	9.82	
Divorced/Separated	30.07	18.62	***
Single/Never Married	49.30	63.99	***
Unknown/Undisclosed	8.92	7.58	
Supportive Romantic Relationship	25.61	23.90	
Education			
No High School	9.55	7.85	
< 6th Grade Reading Level	11.97	13.00	
Employed / Financially Sound (Intake)	54.78	50.98	
Residential Instability (Intake)	18.98	19.36	
Other Factors			
Alcohol Problem (Intake)	21.66	24.58	
Drug Problem (Intake)	43.06	39.13	
Left Home by age 16	21.66	22.68	
Criminal Member of Family	32.48	29.59	
Raised by Biological Parents	84.59	84.97	
Domestic Violence (childhood)	39.87	39.95	
Prosocial Friends	82.68	80.09	
Motivated to complete Probation	90.32	88.63	
p < .001*** p < .01 **, p < .05 *	n = 785	n = 1477	

**Table 5. Predicting SMI Probation Completion**

Variable name	Females only			Males only			Entire Sample		
	b	(SE)	OR	b	(SE)	OR	b	(SE)	OR
<i>Demographic Variables</i>									
Female	--	--	--	--	--	--	-0.06	0.10	0.94
White (ref)	--	--	--	--	--	--	--	--	--
Black	-0.16	0.22	0.85	-0.35	0.15	0.70*	-0.29	0.12	0.75*
Hispanic	-0.90	0.26	0.91	0.09	0.15	1.09	0.01	0.13	1.01
Other	-0.57	0.43	0.56	-0.11	0.30	0.90	-0.22	0.25	0.80
single (ref)	--	--	--	--	--	--	--	--	--
married	0.33	0.27	1.40	-0.035	0.19	0.97	0.16	0.15	1.17
divorced	0.00	0.20	1.00	0.10	0.16	1.11	0.06	0.12	1.06
employed / financially sound (intake)	0.10	0.16	1.10	0.06	0.11	1.06	0.06	0.09	1.06
high school attendance	0.46	0.28	1.59	-0.13	0.21	0.87	0.09	0.17	1.10
reading impairment (< 6th grade level)	-0.19	0.25	0.83	-0.05	0.17	0.95	-0.12	0.14	0.89
<i>Offense Characteristics</i>									
age at sentencing	0.02	0.01	1.02**	0.04	0.01	1.03***	0.03	0.00	1.03***
non-violent property (ref)	--	--	--	--	--	--	--	--	--
violent	0.24	0.23	1.27	0.32	0.16	1.37*	0.31	0.13	1.37*
substance related	0.29	0.20	1.33	0.29	0.14	1.33*	0.26	0.11	1.30
public order	1.03	0.49	2.81*	0.31	0.32	1.36	0.51	0.26	1.67
other	-0.15	0.41	0.86	-0.06	0.21	0.94	-0.11	0.19	0.90
misdemeanor (ref)	--	--	--	--	--	--	--	--	--
felony	-0.87	0.27	0.42***	-0.38	0.18	0.68*	-0.52	0.15	0.60***
undesignated	-0.85	0.28	0.43***	-0.09	0.20	0.92	-0.33	0.16	0.72*
juvenile arrest	0.08	0.17	1.09	-0.01	0.12	0.99	0.02	0.10	1.02
prior prison sentence	-0.91	0.34	0.40**	-0.36	0.17	0.70*	-0.43	0.15	0.65**
prior probation sentence	-0.72	0.20	0.49***	-0.35	0.13	0.71**	-0.46	0.11	0.63***
prior revocation	0.38	0.35	1.46	-0.28	0.18	0.76	-0.15	0.16	0.86
<i>Probation Sentence (months)</i>									
< 3 years (ref)	--	--	--	--	--	--	--	--	--
Between 3 and 5 years	-0.23	0.18	0.79	-0.12	0.13	0.89	-0.16	0.10	0.85
> 5 years	-1.25	0.34	0.29***	-0.86	0.23	0.42***	-1.00	0.19	0.37***
<i>Life Event Factors</i>									
alcohol problem (intake)	-0.52	0.19	0.60**	0.24	0.13	1.27	0.00	0.11	1.00
drug problem (intake)	0.02	0.17	1.02	0.10	0.12	1.10	0.08	0.09	1.08
residential instability (intake)	0.38	0.21	1.47	0.09	0.14	1.10	0.20	0.18	1.22
positive romantic relationship (intake)	-0.25	0.18	0.78	0.06	0.13	1.06	-0.04	0.10	0.96
pro-social peers (intake)	0.42	0.23	1.51	0.18	0.15	1.20	0.26	0.12	1.30*
not motivated to complete probation (intake)	-0.20	0.28	0.82	-0.26	0.17	0.77	-0.21	0.15	0.80
biological parents raised	0.49	0.22	1.63*	0.21	0.16	1.23	0.30	0.13	1.35*
domestic violence in childhood home	-0.14	0.17	0.87	0.05	0.11	1.05	-0.03	0.09	0.97
left home by age 16	0.16	0.21	1.17	0.20	0.14	1.21	0.19	0.12	1.20
history of familial criminal involvement	-0.22	0.17	0.80	-0.11	0.12	0.89	-0.15	0.10	0.86
<b>Sample (n)</b>		785			1477			2262	
<b>McFadden's R-squared</b>		0.116			0.067			0.073	

p < .001\*\*\* p < .01 \*\*, p < .05 \*

**Table 6. Predicting SMI Probation Unsuccessful Outcome**

Variable name	Females only			Males only			Entire Sample		
	b	(SE)	OR	b	(SE)	OR	b	(SE)	OR
<i>Demographic Variables</i>									
Female	--	--	--	--	--	--	0.18	0.13	1.19
White (ref)	--	--	--	--	--	--	--	--	--
Black	0.01	0.32	1.01	-0.05	0.18	0.95	-0.04	0.15	0.96
Hispanic	-0.92	0.39	0.40*	-0.34	0.18	0.71	-0.40	0.16	0.67*
Other	0.33	0.49	1.39	0.03	0.36	1.03	0.07	0.29	1.07
single (ref)	--	--	--	--	--	--	--	--	--
married	-0.19	0.43	0.83	-0.04	0.36	0.96	-0.17	0.21	0.84
divorced	0.32	0.27	1.38	0.11	0.21	1.11	-0.27	0.11	1.17
employed / financially sound (intake)	-0.44	0.23	0.65*	-0.26	0.14	0.77	-0.27	0.11	0.76*
high school attendance	-0.54	0.34	0.58	0.02	0.25	1.01	-0.14	0.20	0.87
reading impairment (< 6th grade level)	0.79	0.32	2.20**	-0.14	0.21	0.87	0.14	0.17	1.15
<i>Offense Characteristics</i>									
age at sentencing	-0.07	0.01	0.93***	-0.05	0.01	0.95***	-0.05	0.01	0.95***
non-violent property (ref)	--	--	--	--	--	--	--	--	--
violent	0.35	0.31	1.41	-0.37	0.19	0.69	-0.20	0.16	0.82
substance related	0.16	0.27	1.18	-0.17	0.17	0.85	-0.06	0.14	0.94
public order	-2.23	0.84	0.11*	-0.67	0.45	0.51	-0.84	0.40	0.43*
other	0.61	0.50	1.84	-0.20	0.26	0.82	-0.06	0.23	0.94
misdemeanor (ref)	--	--	--	--	--	--	--	--	--
felony	1.54	0.50	4.69**	0.19	0.23	1.21	0.46	0.20	1.58*
undesignated	1.25	0.51	3.49**	0.26	0.24	1.29	0.44	0.21	1.55*
juvenile arrest	-0.17	0.23	0.85	-0.10	0.15	0.91	-0.09	0.12	0.91
prior prison sentence	0.98	0.44	2.67*	0.88	0.21	2.42***	0.88	0.19	2.42***
prior probation sentence	0.36	0.29	1.44	0.03	0.17	1.03	0.16	0.15	1.17
prior revocation	0.07	0.44	1.07	0.24	0.21	1.27	0.21	0.19	1.23
<i>Probation Sentence (months)</i>									
< 3 years (ref)	--	--	--	--	--	--	--	--	--
3 to 5 years	-0.09	0.25	0.92	-0.05	0.16	0.95	-0.02	0.13	0.98
> 5 years	0.05	0.43	1.05	0.20	0.25	1.22	0.20	0.22	1.22
<i>Life Event Factors</i>									
alcohol problem (intake)	0.04	0.27	1.04	-0.36	0.16	0.69*	-0.25	0.14	0.78
drug problem (intake)	-0.33	0.22	0.72	0.19	0.14	1.20	0.04	0.12	1.04
residential instability (intake)	-0.01	0.28	0.99	0.07	0.17	1.07	0.03	0.14	1.03
positive romantic relationship (intake)	0.67	0.23	1.95**	-0.13	0.16	0.88	0.09	0.13	1.10
prosocial peers (intake)	0.14	0.30	1.15	-0.01	0.18	0.99	-0.01	0.15	0.99
not motivated to complete probation (intake)	0.65	0.35	1.91	0.42	0.20	1.52*	0.44	0.17	1.55**
biological parents raised	-0.80	0.28	0.45**	-0.10	0.19	0.90	-0.29	0.15	0.75
domestic violence in childhood home	0.18	0.24	1.20	0.01	0.14	1.01	0.06	0.12	1.06
left home by age 16	0.08	0.26	1.08	0.19	0.17	1.20	0.10	0.14	1.10
history of familial criminal involvement	0.26	0.24	1.30	-0.08	0.16	0.92	0.02	0.13	1.02
<b>Sample (n)</b>		0785			1477			2262	
<b>McFadden's R-squared</b>		0.16			0.08			0.09	

p < .001\*\*\* p < .01 \*\* p < .05 \*

**Table 7. Predicting SMI Probation Revocation**

Variable name	Women only			Men only			Entire Sample		
	b	(SE)	OR	b	(SE)	OR	b	(SE)	OR
<i>Demographic Variables</i>									
Female	--	--	--	--	--	--	-0.11	0.15	0.89
White (ref)	--	--	--	--	--	--	--	--	--
Black	-0.18	0.38	0.84	-0.07	0.22	0.93	-0.07	0.19	0.93
Hispanic	-0.97	0.51	0.38	-0.12	0.22	0.89	-0.26	0.19	0.77
Other	0.06	0.59	1.06	-0.20	0.49	0.82	-0.08	0.37	0.92
single (ref)	--	--	--	--	--	--	--	--	--
married	-0.27	0.50	0.76	-0.20	0.32	0.82	-0.27	0.27	0.77
divorced	0.33	0.31	1.39	0.07	0.25	1.07	0.19	0.19	1.20
employed / financially sound (intake)	-0.06	0.27	0.94	-0.20	0.16	0.82	-0.13	0.14	0.88
high school attendance	-0.01	0.41	0.99	0.14	0.31	1.15	0.10	0.25	1.11
reading impairment (< 6th grade level)	0.67	0.35	1.96	-0.24	0.27	0.79	0.10	0.21	1.11
<i>Offense Characteristics</i>									
age at sentencing	-0.06	0.01	0.94***	-0.05	0.01	0.96***	-0.05	0.01	0.95***
non-violent property (ref)	--	--	--	--	--	--	--	--	--
violent offense	0.09	0.30	1.10	-0.30	0.22	0.74	-0.21	0.17	0.81
felony offense	0.62	0.32	1.86*	0.67	0.21	1.95**	0.63	0.17	1.87***
juvenile arrest	-0.28	0.29	0.76	-0.08	0.18	0.92	-0.13	0.15	0.88
prior prison sentence	0.67	0.50	1.95	0.70	0.26	2.02**	0.71	0.23	2.03***
prior probation sentence	-0.12	0.34	0.88	-0.37	0.22	0.69	-0.26	0.18	0.77
prior revocation	0.35	0.51	1.41	-0.03	0.27	0.97	0.06	0.24	1.06
<i>Probation Sentence (months)</i>									
< 3 years (ref)	--	--	--	--	--	--	--	--	--
3 to 5 years	0.01	0.29	1.01	-0.02	0.19	0.98	0.02	0.16	1.02
> 5 years	-0.21	0.53	0.81	0.53	0.29	1.70	0.37	0.25	1.45
<i>Life Event Factors</i>									
alcohol problem (intake)	-0.26	0.35	0.77	-0.16	0.19	0.86	-0.19	0.16	0.82
drug problem (intake)	-0.39	0.26	0.67	0.11	0.17	1.11	-0.05	0.14	0.95
residential instability (intake)	0.11	0.32	1.12	0.36	0.20	1.44	0.26	0.17	1.30
positive romantic relationship (intake)	0.42	0.28	1.53	-0.15	0.20	0.86	0.05	0.16	1.05
pro-social peers (intake)	-0.49	0.44	0.62	0.01	0.22	1.01	-0.13	0.19	0.87
not motivated to complete probation (intake)	0.50	0.40	1.65	0.53	0.24	1.70*	0.51	0.20	1.66**
biological parents raised	-0.65	0.31	0.52*	-0.31	0.23	0.74	-0.39	0.18	0.68*
domestic violence in childhood home	0.32	0.29	1.38	0.21	0.17	1.23	0.25	0.14	1.28
left home by age 16	-0.22	0.33	0.80	0.08	0.21	1.08	-0.01	0.17	0.99
history of familial criminal involvement	0.15	0.29	1.16	-0.44	0.20	0.65*	-0.24	0.16	0.79
<b>Sample (n)</b>		785			1460			2262	
<b>McFadden's R-squared</b>		0.10			0.07			0.07	

p < .001\*\*\* p < .01 \*\*, p < .05 \*

**Table 8. Predicting OST Criminogenic Need / Recidivism Risk Level**

Variable name	Entire Sample		
	b	(SE)	OR
<i>Demographic Variables</i>			
Female	-1.07	0.03	0.34***
White (ref)	--	--	--
Black	-0.06	0.11	0.94
Hispanic	-0.01	0.12	0.99
Other	-0.23	0.22	0.79
single (ref)	--	--	--
married	-0.45	0.14	0.64***
divorced	-0.15	0.11	0.86
<i>Offense Characteristics</i>			
age at sentencing	-0.01	0.01	0.99
non-violent property (ref)	--	--	--
violent	-0.05	0.12	0.95
substance related	0.04	0.10	1.04
public order	0.08	0.24	1.08
other	0.16	0.16	1.17
misdemeanor (ref)	--	--	--
felony	-0.14	0.14	0.87
undesignated	-0.03	0.14	0.97
juvenile arrest	1.37	0.09	3.94***
prior prison sentence	0.39	0.14	1.48**
prior probation sentence	-0.02	0.10	0.98
prior revocation	-0.19	0.15	0.83
<i>Probation Sentence (months)</i>			
< 5 years	--	--	--
Between 3 and 5 years	-0.15	0.10	0.86
> 5 years	0.12	0.19	1.13
<b>Sample (n)</b>		2262	
<b>McFadden's R-squared</b>		0.08	

p < .001\*\*\* p < .01 \*\* p < .05 \*



APPENDIX A  
TIMELINE AND STUDY DATAPOINTS

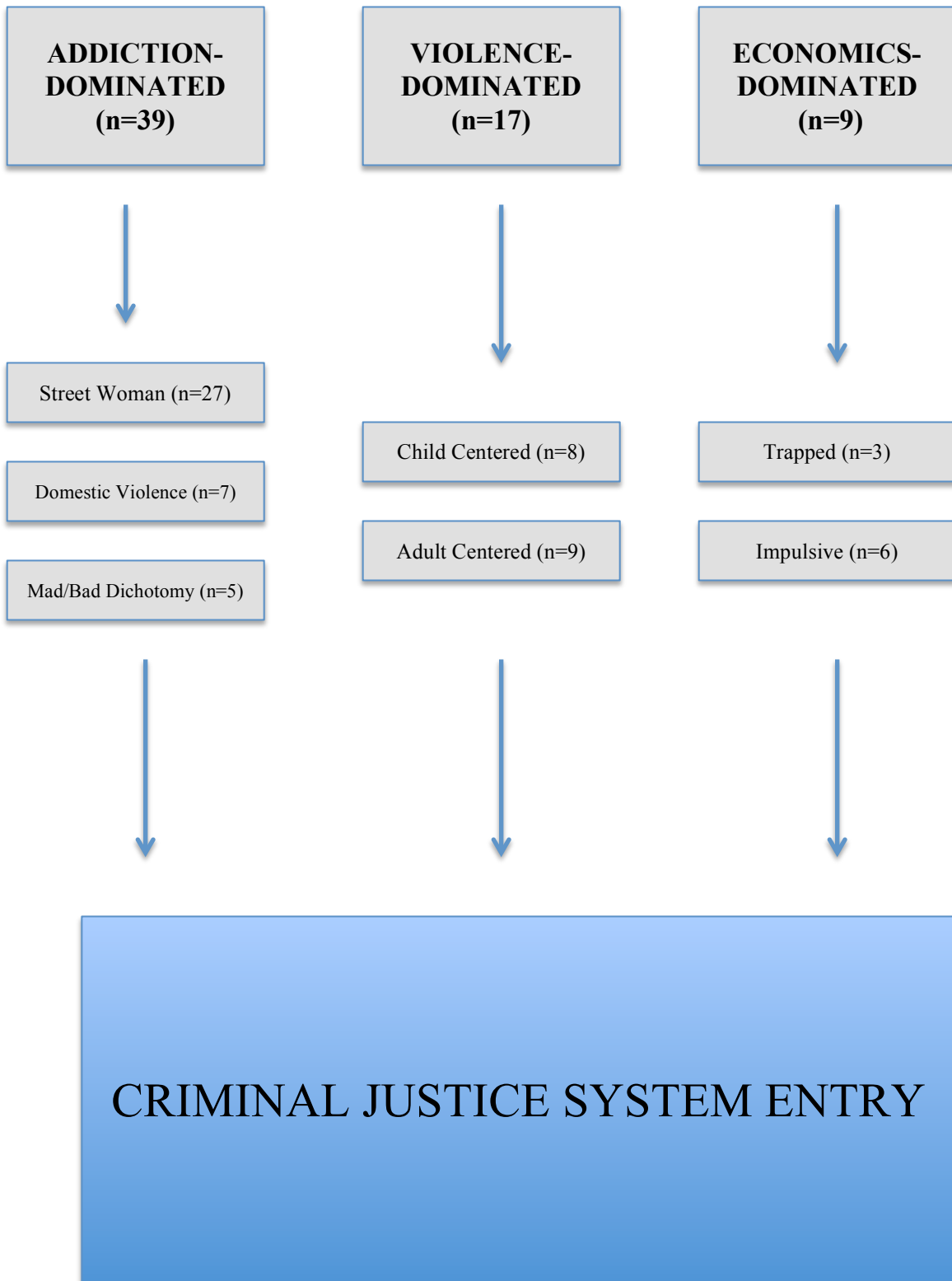
Major Data Points for Women on SMI Probation Project	
"Deep Sample" interviews	65 completed August 2012 to April 2013
"Deep Sample" case file reviews	65 completed (after each interview)
SMI Probation officer/supervisors interviews	24 completed August 2012 to May 2013
Mental Health Court Observation / Field Notes	100 hours completed August 2012 to May 2013
"Wide Sample" demographic/assessment and status data	2814 records over 5.5 years (January 2007 to July 2012)

Timeline for Completion of Women on SMI Probation Project	
Fall 2010	Initial discussions with probation regarding feasibility of project
Spring / Summer 2011	Design project and create interview guides
Fall 2011	Meet with SMI supervisors to discuss ideas and design
January 2012	Submit application to complete project as Maricopa Probation
February 2012	Submit application to ASU IRB - Time 1
March 2012	Resubmit application to ASU IRB - Time 2
April 2012	Approval Given by Maricopa County Probation to collect data
May 2012	Resubmit application Part #2 to ASU IRB - Time 3
May 2012	Application Part #1 approved by ASU IRB
June 2012	Application Part #2 approved by ASU IRB
Late June 2012	Plan project with SMI PO supervisors and Head of Research
July 2012	Pilot test Interview/Begin PO Interviews/Begin Court Observation
August 2012	PO Interviews/Court Observation
September 2012	PO Interviews/Court Observations/Begin Offender Interviews
October 2012	*Break from Interviews/Transcribe & Analyze/ Court observation
November 2012	Offender Interviews/Case File Reviews/Court observation
December 2012	Offender Interviews/Case File Reviews/Court observation
January 2013	*Break from Interviews/Transcribe & Analyze/ Court observation
February 2013	Offender Interviews/Case File Reviews/Court observation
March 2013	Offender Interviews/Case File Reviews/Court observation
April 2013	*Break from Interviews/Transcribe & Analyze/ Court observation
May 2013	Offender & PO Interviews/Case File Reviews/Court Observation completion
June 2013	Full Transcription Reviews and Nvivo coding

APPENDIX B  
PATHWAYS TO CRIMINALIZATION

Pathways to Criminalization for the Deep Sample (n = 65)

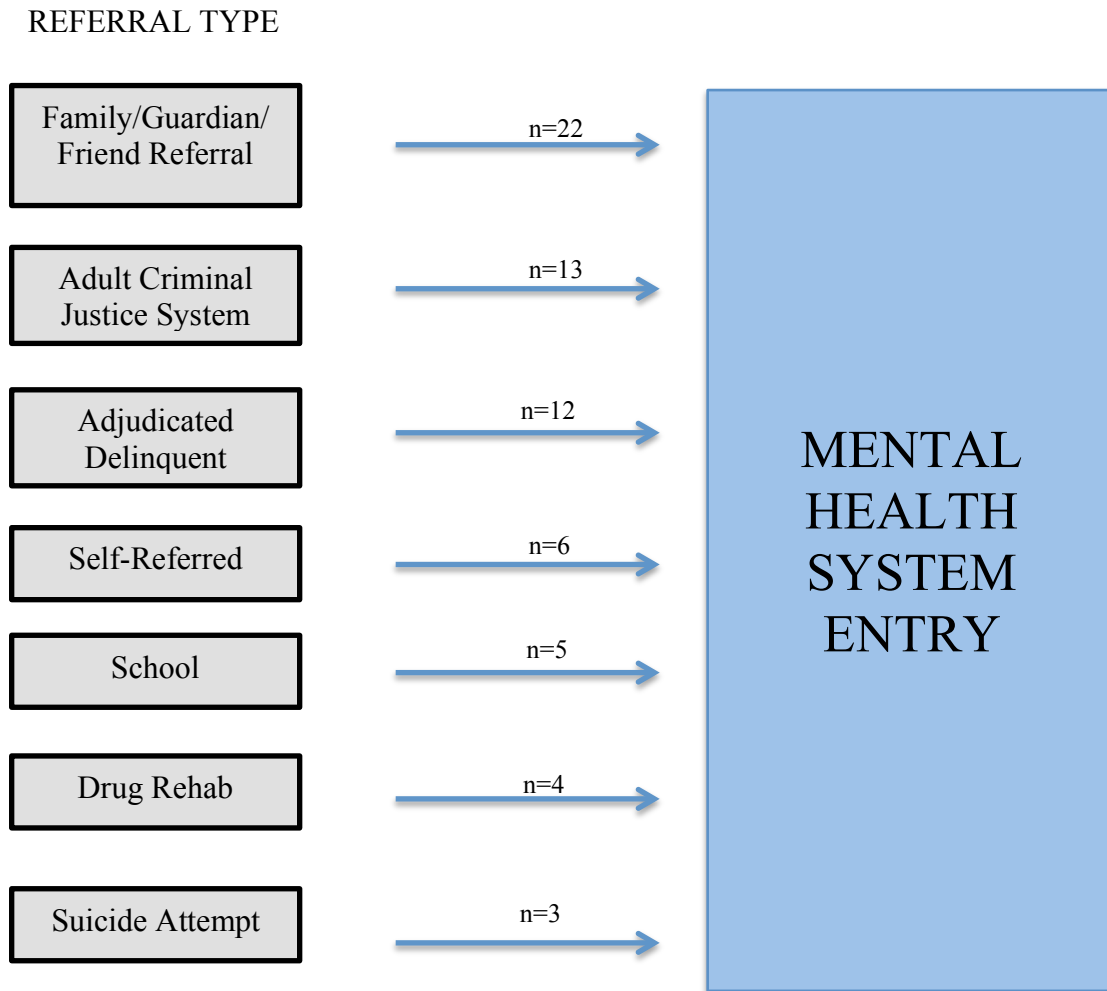
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APPENDIX C  
PATHWAYS TO MENTAL HEALTH SYSTEM

Pathways to the Mental Health System for the “Deep Sample” (n = 65)

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APPENDIX D

SMI PROBATIONER INTERVIEW

## **SMI PROBATIONER INTERVIEW**

**PARTICIPANT #** \_\_\_\_\_

**DATE:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

### DAILY LIFE CONTEXT QUESTIONS

1.) First, I would like to get a sense of your life is like from day to day. For instance – tell me what your day was like yesterday?

INTERVIEWER: EXPLORE DETAIL OF ACTIVITIES AND EVENTS

Probe, Routine:

- a.) What time did participant wake up? Go to bed?
- b.) What is his/her living arrangement? (alone/with others?)
- c.) Children that live with them or Spouse/partner etc.
- d.) Does participant have a job? Social activities?
- e.) What is participant's neighborhood like?
- f.) Who is participant closest to in their lives?

INTERVIEWER: IF YESTERDAY IS NOT A TYPICAL DAY, HAVE PARTICIPANT DESCRIBE WHAT MADE THIS DAY DIFFERENT AND WHAT A TYPICAL DAY WOULD BE LIKE.

2.) I would like to hear a little bit about your life growing up. How was your childhood? Who did you live with?

Probe, Explore with Participant:

- a.) How was relationship with caregivers? How was caregiver relationship with each other?
- b.) How was school life? Did participant enjoy school?
- c.) Siblings and others that participant lived with
- d.) How were friendships growing up? (amount, quality)
- e.) Romantic relationships before 18 Did you date a lot?



## MENTAL HEALTH QUESTIONS

*I would like to move into asking you a few questions about your health now and the impact that health problems may have on your life.*

1.) When in your life did you first have any mental health problems? Tell me a little about that experience

Probe, Explore with Participant:

- a.) What was your first diagnosis? Current diagnosis?
- b.) Psychiatric hospitalizations? Current and past treatment? How successful has treatment been?
- c.) What types of medications do you take? Do you feel they help?

2.) How would you say that mental health problems affect your daily life?

Probe, Explore with Participant:

- a.) What is the impact on family relationships? Friends? Romantic? Children?
- b.) How does it impact work, self-esteem etc.?

3. Do you receive any types of social services? (For example - services like AHCCCS insurance, food or welfare assistance, mental health care assistance, or childcare assistance?)

Probe, Explore with Participant:

- a. What are the challenges to getting this service?
- b. Is this service helpful? How?
- c. How long have you received the service? What are the best and worst parts of that particular service?
- d. Has it become harder or easier to receive that service (if receiving for a long time?) How So?

4. Have you ever abused substances, like drugs or alcohol? If yes (tell me about those experiences)

- a. What drugs?
- b. How old were you when you start using?
- c. Why did you use drugs or alcohol?
- d. How did they help or hurt you?

# CRIMINAL INVOLVEMENT QUESTIONS

*I WOULD NOW LIKE TO ASK YOU SOME QUESTIONS ABOUT PAST INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM AND YOUR CURRENT PROBATION.*

Describe the first time you ever broke the law?

Were you with anyone?  
How did it occur?  
What was the offense?

How many times have you broken the law would you say? What does a normal offense look like for you? (what occurs?)

What has your past involvement in the CJS been like? Tell me about the first time you were arrested. Convicted of an offense?

(If in jail/Prison) What was the experience like? Tell me about it.  
Any previous experiences on probation?

Probe, Explore with Participant:

- a.) How old were they when they started committing crime?
- b.) How many crimes have they committed in their lifetimes? What types?
- c.) How Many times have you been arrested
- d.) Has the participant spent time in jail or prison. Describe each experience.

2.) Tell me a little bit about your current offense. Why are you on probation?

Probe, Explore with Participant:

- a.) What are the conditions of probation?
  - b.) What are the circumstances surrounding the crime?
  - c.) How long was the participant on probation before entering the SMI caseload?
- 3.) How is the relationship between you and your current probation officer? How do you work well together? What are some problems in the relationship?
- 4.) In what ways has your probation sentence impacted your ability to be successful in your life? (What particular positive or negative things stick out?)

Probe, Explore with Participant:

- a. (if romantic involvement) How has it impacted your romantic relationship?
- b. Relationships with friend/family/children
- c. Employment and work
- d. Issues of self-esteem/self worth, how the individual feels about themselves

## MENTAL HEALTH AND PROBATION QUESTIONS

- 1.) Did your mental illness play a role in your most recent criminal offense that got you placed on probation? (If so) How?
- 2.) How has your mental health impacted your ability to be successful on probation? Tell me a little about that:
- 3.) What are the most difficult parts about having a mental illness and being on probation?
- 4.) Has being on the mental health caseload helped you complete probation? (How so? Or Why not? Can you explain a little?)
- 5.) Have you ever been to the Mental Health Court?  
(If Yes, explore in detail)
  - How was the experience? Describe.
  - Was it helpful?
  - Why were you sent to mental health court?

Probe, Explore with Participant:

- What have been some of the best and worst parts of being on the SMI mental health caseload

## FINAL QUESTIONS FOR CONSIDERATION

*In this final questions I want you to think specifically about your future.*

How will you be able to be successful once you complete probation?

What are your hopes for the next year of your life? What are your major goals?

Probe: Do you think those goals are obtainable? Why or why not?

Will being on probation help or hurt you from achieving those goals?

