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Making a Case for Gender-Responsive, Trauma-Informed Mental Health Courts: An Exploration of Participant Trauma Histories

Laura N. Honegger, Ph.D., MSSW
University of St. Francis, Department of Social Work

Stacy Dewald, Ph.D.
University of St. Francis, Department of Criminal Social Justice

Considering the disproportionate number of people in the criminal justice system with trauma histories, in conjunction with the disproportionate number of people with mental illness who have experienced trauma, examining the trauma histories of mental health court (MHC) participants is essential. However, no studies to date have explicitly examined the trauma histories of this vulnerable population. Therefore, the present study aimed to describe the lifetime prevalence of traumatic events and posttraumatic stress disorder (PTSD) diagnosis among a sample of 163 participants within a Northeastern U.S. MHC. Gender differences were also explored. Overall, about 83% of MHC participants reported any lifetime trauma, with significantly higher rates among female participants (94.2%) as compared to male participants (78.4%). Approximately half of MHC participants reported experiencing childhood maltreatment, with women being significantly more likely to have experienced physical and sexual abuse during childhood than men. Further, women had higher rates of sexual assault and intimate partner violence. The percentage of women diagnosed with PTSD was about twice that of the men. These findings underscore the need for a trauma-informed and gender responsive approach to MHCs. Suggestions for MHCs to consider are offered, including trauma screening tools into MHC assessment procedures, cultivating a more trauma-informed culture by adapting key principles, and incorporating trauma-specific programming and therapies into their offerings.

Keywords: mental health court; trauma; gender; adverse childhood experiences

INTRODUCTION

Mental health court (MHC) participants possess two major risk factors associated with having experienced trauma. First, they are a subset of the criminal justice population, which has higher rates of trauma than the general population (Stensrud et al., 2018; Wolff & Shi, 2012). More than 90% of criminal justice-involved individuals report having experienced at least one lifetime traumatic event (Adams et al., 2017; Givens & Cuddeback, 2021; Green et al., 2005; Komarovskaya et al., 2011; Sartor et al., 2012). Second, studies estimate that between 87% and 98% of individuals with a psychiatric diagnosis have experienced at least one traumatic lifetime event (Cusack et al., 2004; Cusack et al., 2006; Mueser et al., 1998). This is presumably because not only are childhood and adolescent trauma linked to the development of mental illness (Álvarez et al., 2011; McKay et al., 2020), but adults with mental illness are at higher risk of violent victimization than adults within the general population (Desmarais et al., 2014; Latalova et al., 2014; Silver, 2002).

Because MHC participants are at a higher likelihood for having experienced trauma due to both mental health diagnosis and criminal justice system involvement, it is imperative that MHCs operate in a trauma-informed manner (Edwards et al., 2020). A trauma-informed approach acknowledges the impact of trauma, identifies the signs of trauma, and responds accordingly with policies and practices aimed at reducing re-traumatization and supporting recovery (McKenna & Holtfreter, 2021; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Experiencing traumatic events during one's lifetime may result in a myriad of negative consequences, including psychopathology (Nelson et al., 2018; Salina et al., 2017; Scott et al., 2016), low self-esteem (Salina et al., 2017), financial issues (Henry et al., 2018), substance use (Adams et al., 2017; McClellan et al., 1997), interpersonal relationship issues (Beck et al., 2009), and poorer employment outcomes (Mueser et al., 2004). Adverse childhood experiences (ACEs), or "potentially traumatic events" experienced from birth to 17 years, include experiencing physical, sexual, verbal, or emotional abuse (Centers for Disease Control [CDC], 2021). ACEs are associated with a multitude of negative outcomes, for example, physical health issues (e.g., heart disease, cancer, diabetes, etc.; CDC, 2021), mental illness (Kim et al., 2016), and vocational and educational impacts (CDC, 2021).

In terms of mental health issues associated with experiencing trauma, there is substantial research indicating an increased likelihood of developing PTSD, depression, anxiety, and substance-related disorders (e.g., Adams et al., 2017; Green et al., 2016; Green et al., 2005). While most individuals who experience a traumatic event do not develop PTSD (National Institute of Mental Health, 2017), approximately 8% of people ultimately meet the criteria (Kessler et al., 1995). In contrast to the general population, 16% of jail inmates with mental health issues were found to have ever been diagnosed with PTSD (Bronson & Berzofsky, 2017).

Mental Health Courts

MHCs are a type of problem-solving court (PSC; also referred to as specialty court) that focuses on treating the "problems underlying criminal conduct" (Haskins, 2019, p. 1). Though individual MHC characteristics differ by jurisdiction, in general,

MHC participants receive mental health treatment while remaining within the community, attend regular court hearings, and receive supervision and other support services. PSCs aim to improve the quality of life for participants, increase public safety, and reduce the cost of criminal justice involvement (Almquist & Dodd, 2009). MHCs use the justice system to motivate and incentivize persons with mental illness to adhere to treatment, sometimes in return for reduced or dropped charges (Thompson et al., 2008).

MHCs operate under the principle of therapeutic jurisprudence (Lurigio & Snowden, 2009) which holds that the legal system has the capacity to act as a "therapeutic agent," and is an entity with the potential for producing "therapeutic or antitherapeutic consequences" (Winick, 1997, p. 3). Thus, MHCs, like other PSCs, are viewed as being capable of serving a therapeutic purpose in participants' lives, focusing on treating underlying conditions that may have contributed to their criminal behavior (Backhouse, 2016).

Though to date no studies have specifically examined the rate of trauma among MHC participants, general criminal justice research has found concerning rates of trauma among the criminally-involved. Studies of PSCs, namely drug courts, have found elevated rates of reported lifetime traumatic events (Sartor et al., 2012; Shaffer et al., 2019; Tossone & Baughman, 2020).

The rate of PTSD among MHC participants is an important consideration, as more general studies of criminal justice populations have found a link between a diagnosis of PTSD and re-offending (Ardino et al., 2013; Donley et al., 2012; Proctor et al., 2012). The exact mechanism by which PTSD increases one's risk for offending is understudied, but growing evidence supports the hypothesis that PTSD increases externalizing behaviors (i.e., engaging in aggressive, risky, or impulsive behaviors), which in turn may increase one's likelihood of engaging in criminal behaviors that come to the attention of the police and other criminal justice system personnel (Donley et al., 2012; Traynham et al., 2019). Research has begun to examine the relationship more closely between trauma, mental illness, and reoffending, with one study finding that childhood and adulthood trauma were not directly related to offending, but were significant predictors of mental health issues, with mental illness subsequently predicting offending (Lynch et al., 2013).

The broader literature suggests that criminally-involved individuals with a trauma history are at greater risk for engaging in future criminal behavior (Ardino et al., 2013; Scanlon et al., 2019), particularly criminally-involved persons with mental illness (Kinsler & Saxman, 2007). Although there has been a call for trauma-informed MHC programming (Canada et al., 2016; Edwards et al., 2020; Council of State Governments Justice Center, 2016), to our knowledge, there is no extant research that explores how many, and to what extent, MHCs have integrated trauma assessment tools and evidence-based trauma-informed approaches.

Gender Differences

The prevalence of traumatic life experiences among criminal justice-involved populations tends to vary by gender. For example, female prisoners experience higher rates of PTSD with significantly higher levels found among United States prisoners as

compared to those from other countries (Baranyi et al., 2018). Similarly, 99% of women entering a state correctional facility reported experiencing trauma at least once during their lifetime, with over three-quarters reporting five or more lifetime traumatic events (Cook et al., 2005). Contrarily, some researchers have found that men in the criminal justice system are more likely to report witnessing community violence as opposed to childhood abuse or neglect (Komarovskaya et al., 2011; Morrison et al., 2019).

Justice-involved women experience disproportionate levels of child maltreatment compared to men, as well as other types of traumatic experiences, including intimate partner violence (IPV) and sexual assault (American Psychiatric Association, 2013a; James & Glaze, 2006; McKay et al., 2015; Salina et al., 2017). Moreover, the number of incarcerated women has grown exponentially over the past few decades, at nearly twice the pace of incarcerated men, and with much of this growth occurring in jails across the United States (Kajstura, 2019). The growing female criminal justice population further underscores the need for trauma-informed care designed to address the needs of women in the justice system.

Gender Responsive, Trauma-Informed Problem-Solving Courts

Justice-involved individuals' traumatic experiences tend to vary by gender, which calls for the justice system to approach these two populations differently (National Resource Center on Justice Involved Women, 2016). To date, no research has examined the effect of gender responsive, trauma-informed treatment with MHC participants. However, drug court research provides important insights into the potential utility of gender-responsive, trauma-informed approaches for PSCs (Covington et al., 2008; Messina et al., 2012). For example, recent research indicates participants within gender specific drug courts were less likely to recidivate and had longer periods of time prior to a new conviction (Myer & Buchholz, 2018). Of note, the drug court program included not only inpatient and outpatient substance-related treatment for women only, but also had a female peer support specialist, a female court coordinator for individual case management, and additional services aimed at addressing childcare issues.

Other studies of PSCs have focused exclusively on assessing the utility of incorporating trauma-informed elements into their programs. For instance, participants receiving the trauma-informed therapy had significant decreases in substance use and mental health issues, and significant increases in employment, educational enrollment, and housing rates (Powell et al., 2012). Moreover, research has found that women may prefer individualized trauma-informed interventions as opposed to group interventions (Gallagher et al., 2021).

These findings underscore the importance of both gender-specific and trauma-informed approaches for criminal justice-related programs. A gender-specific approach acknowledges the differences in men and womens' response to trauma, victimization, and offending and that treatment plans should take these differences into account (McKenna & Holtfreter, 2021). Moreover, the traumatic nature of incarceration highlights the importance of alternatives to incarceration for this population, including MHCs, which represents one such alternative.

Present Study

Despite the prevalence of trauma among criminal justice-involved persons with mental illness, thus far, extant literature has not explored rates of trauma among MHC participants. The purpose of the present study is twofold: (1) to describe the trauma histories of a sample of MHC participants; and (2) to examine possible gender differences in trauma history.

METHODS

The present study draws from a larger retrospective analysis of a suburban MHC located in the northeast region of the United States. To qualify for the MHC program, an individual had to be at least 18 years old, have a non-violent felony charge, and have a Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision; American Psychiatric Association, 2000) Axis I mental health diagnosis. However, exceptions to the two latter criteria were permitted on a case-by-case basis, with some participants having a misdemeanor or a violent index offense charge, and some individuals having a primary diagnosis of a developmental disability. For example, if an individual was in a psychotic state when committing a violent felony, the case may be accepted by the MHC. Participants with co-occurring substance use issues were eligible for the program.

Individuals accepted into the MHC program received a variety of services, including case management, outpatient mental health counseling, substance abuse treatment (e.g., detox, short-term drug rehabilitation programs, and long-term residential rehabilitation programs), assertive community treatment, dual diagnosis day programs, and personalized recovery-oriented services. The MHC program did not contain any explicit gender-responsive or trauma-informed elements. Participants received MHC services for a minimum of 12 months, but up to 18 months or more based upon the severity of the index offense charge(s) and compliance with court mandates during program participation.

Sample

Participants included individuals enrolled in the MHC program between February 1, 2006 and January 1, 2013 who had either graduated or been terminated from the program at the time of data collection (January to April 2014). After two MHC participants were excluded because they remained enrolled in the program at the time of data collection, a total of 163 participants met inclusion criteria. The sample contained over twice as many men (n = 111) than women (n = 52). Participants ranged in age from 18 to 61 years old, with an average of 32.5 years old. In terms of race and ethnicity, nearly four-fifths of all participants were White (77.9%), followed by Latino/Hispanic (4.3%), Multiracial (1.8%), Native American (0.6%), and Asian or Pacific Islander (0.6%). Roughly three-quarters (72.4%) of participants had a substance-related diagnosis upon entering the MHC program. The vast majority of the sample had a primary diagnosis of a mood disorder, with 46.6% having a diagnosis of bipolar disorder, and just under one-quarter (23.4%) having a primary diagnosis of a depressive disorder. About a fifth of the sample was diagnosed with a psychotic-related disorder (e.g., schizophrenia, schizoaffective disorder; 19.6%). Fewer participants had a primary diagnosis of an anxiety disorder (5.5%), a

pervasive developmental disorder (3.1%), or ADHD (1.8%).

Procedures

Prior to the start of the study, research procedures received institutional review board approval. The principal researcher (first author) conducted chart reviews of the county's probation department and MHC electronic and paper databases and files. There was no direct interaction with MHC participants and thus, no consent process was warranted. Each individual was assigned a number and data collected were de-identified.

A licensed clinical social worker (LCSW) employed by the MHC program conducted a biopsychosocial assessment of all individuals being screened for program admission. The same structured biopsychosocial assessment form was consistently used for all individuals being screened to gather demographics, mental health and substance-related diagnoses, and trauma-related information. Psychiatric diagnoses were made by the LCSW using the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision; *DSM-IV-TR*; American Psychiatric Association, 2000). While no specific trauma-related instrument was used to assess lifetime traumatic experiences, each individual was asked the same relevant biopsychosocial assessment form questions by the LCSW, including questions about trauma. Ninety-one percent of participants had an available MHC biopsychosocial assessment. When a biopsychosocial assessment completed by the LCSW could not be located for a participant, demographic, psychosocial, and clinical information were obtained via review of the probation department's records, which included pre-sentence investigation (PSI) reports and prior psychiatric assessments located within the department's electronic database. Probation department records, including quarterly reports and case notes written by the MHC probation officer, were also used to obtain information on psychosocial, clinical, and criminal data for participants.

Trauma-related variables consisted of those related to childhood maltreatment (i.e., emotional abuse, physical abuse, and sexual abuse during childhood); sexual assault; having been a victim of a violent crime; having been a victim of IPV; having ever experienced homelessness; witnessing serious injury, illness, or death of a close family member or friend; natural disaster; transportation accident; having had a life threatening illness or injury; sudden violent death of a close family member or friend (e.g., homicide or suicide); sudden accidental death of a close family member or friend; and combat or exposure in a war zone. *The Life Events Checklist for DSM-5* (*LEC-5*; Weathers et al., 2013) informed the categorization of traumatic events reported within the narrative trauma section of the biopsychosocial assessments. All trauma-related variables were dichotomized as having reported experiencing the specific trauma or not (1 = yes, 0 = no). Additionally, having met criteria for a *DSM-IV-TR* diagnosis of PTSD at intake was also included as a dichotomous variable.

Analysis

All analyses for the present study were conducted using SPSS v. 26. Descriptive analyses were performed for all variables. Pearson Chi-Square tests of association and independent samples t-tests were run to explore gender differences among all study variables, but with a primary aim of identifying any significant

differences in lifetime traumatic experiences and PTSD diagnosis between male and female participants. Fisher's exact tests were run as an alternative to chi-square tests when the expected count per cell was less than 5 within a 2x2 contingency table.

RESULTS

As shown in Table 1, in general, female participants were more likely to report childhood trauma than their male counterparts. About half of all participants (50.3%) reported experiencing at least one form of childhood abuse, with 28.2% reporting physical, 29.4% reporting sexual, and 28.8% reporting emotional abuse. Female participants reported overall child abuse rates (i.e., any emotional, physical, or sexual abuse during childhood) nearly twice as high as males (75.0% versus 38.7%, respectively, χ^2 (1) = 18.6, $p < .001$; not included within Table 1). Female participants were more likely to report a history of childhood sexual abuse (51.9% of females versus 18.9% of males, χ^2 (1) = 18.6, $p < .001$). Male participants most frequently reported experiencing childhood emotional abuse (24.3%). No gender differences were found for reported childhood emotional abuse. Female participants reported significantly higher rates of physical abuse during childhood than males (46.2% of females versus 19.8% of males, χ^2 (1) = 12.1, $p < .001$).

During adulthood, about 17% of participants reported having experienced IPV, nearly one-quarter reported being a victim of a violent crime (22.1%), and about 9% reported being sexually assaulted. Female participants reported experiencing higher rates of sexual assault during adulthood (25.0% versus 1.8%, respectively, $p < .001$), as well as IPV (46.2% versus 3.6%, respectively, χ^2 (1) = 45.1, $p < .01$), than male participants. Similar percentages of males and females reported being a victim of a violent crime (23.4% versus 19.2%, respectively) and being homeless (31.5% versus 26.9%, respectively) at any time during adulthood.

About 14% of participants had a current diagnosis of PTSD. Though a higher percentage of females had a PTSD diagnosis compared to males (21.2% versus 10.8%), differences were not statistically significant (χ^2 (1) = 3.1, $p = .08$).

Table 1: *Trauma Experiences of MHC Participants by Gender*

Traumatic Experience	All Participants (*N* = 163)	Male Participants (*n* = 111)	Female Participants (*n* = 52)	Difference Test Statistic
	n (%)	n (%)	n (%)	
Childhood emotional abuse				
Yes	47 (28.8)	27 (24.3)	20 (38.5)	$\chi^2 = 3.5$
No	116 (71.2)	84 (75.7)	32 (61.5)	
Childhood physical abuse				
Yes	46 (28.2)	22 (19.8)	24 (46.2)	$\chi^2 = 12.1$**
No	117 (71.8)	89 (80.2)	28 (53.8)	

Traumatic Experience	All Participants (N = 163)	Male Participants (n = 111)	Female Participants (n = 52)	Difference Test Statistic
Childhood sexual abuse				
Yes	48 (29.4)	21 (18.9)	27 (51.9)	$\chi^2 = 18.6$**
No	115 (70.6)	90 (81.1)	25 (48.1)	
Sexual assault as an adult[a]				
Yes	15 (9.2)	2 (1.8)	13 (25.0)	FET**
No	148 (90.8)	109 (98.2)	39 (75.0)	
Intimate partner violence				
Yes	28 (17.2)	4 (3.6)	24 (46.2)	$\chi^2 = 45.1$**
No	135 (82.8)	107 (96.4)	28 (53.8)	
Victim of a violent crime				
Yes	36 (22.1)	26 (23.4)	10 (19.2)	$\chi^2 = 0.4$
No	127 (77.9)	85 (76.6)	42 (80.8)	
Ever homeless				
Yes	49 (30.1)	35 (31.5)	14 (26.9)	$\chi^2 = 0.4$
No	114 (69.9)	76 (68.5)	38 (73.1)	
Witnessed serious injury, illness, or death of a close family member or friend				
Yes	39 (23.9)	26 (23.4)	13 (25.0)	$\chi^2 = 0.5$
No	124 (76.1)	85 (76.6)	39 (75.0)	
Natural disaster				
Yes	1 (0.6)	0 (0.0)	1 (1.9)	FET
No	162 (99.4)	111 (100.0)	51 (98.1)	
Transportation accident				
Yes	12 (7.4)	9 (8.1)	3 (5.8)	FET
No	151 (92.6)	102 (91.9)	49 (94.2)	
Life threatening illness or injury				
Yes	2 (1.2)	1 (0.9)	1 (1.9)	FET
No	161 (98.8)	110 (99.1)	51 (98.1)	

Traumatic Experience	All Participants (N = 163)	Male Participants (n = 111)	Female Participants (n = 52)	Difference Test Statistic
Sudden violent death of close family member or friend (e.g., homicide or suicide)				
Yes	13 (8.0)	11 (9.9)	2 (3.8)	FET
No	150 (92.0)	100 (90.1)	50 (96.2)	
Sudden accidental death of close family member or friend				
Yes	15 (9.2)	9 (8.1)	6 (11.5)	FET
No	148 (90.8)	102 (91.9)	46 (88.5)	
Combat or exposure in a war zone				
Yes	1 (0.6)	1 (0.9)	0 (0.0)	N/A
No	162 (99.4)	110 (99.1)	52 (100)	
Any lifetime trauma				
Yes	136 (83.4)	87 (78.4)	49 (94.2)	$\chi^2 = 6.4$*
No	27 (16.6)	24 (21.6)	3 (5.8)	
PTSD diagnosis				
Yes	23 (14.1)	12 (10.8)	11 (21.2)	$\chi^2 = 3.1$
No	140 (85.9)	99 (89.2)	41 (78.8)	

Note. *$p < .05$, p** $< .001$; [a] Fisher's Exact Test used due to a cell with an expected count of less than 5 for a 2x2 table; FET = Fisher's Exact Test; PTSD = Posttraumatic Stress Disorder.

DISCUSSION

This exploratory study sought to describe the trauma histories of a sample of MHC participants and to examine possible gender differences in trauma history. Considering the disproportionate number of people in the criminal justice system with trauma histories, in conjunction with the disproportionate number of people with mental illness who have experienced trauma, examining the trauma histories of MHC participants is essential.

Approximately half of all participants reported experiencing one or more forms of childhood abuse (physical, sexual, and/or emotional abuse). Furthermore, a substantial number reported being sexually assaulted or being a victim of a violent crime during adulthood, with 25.0% of female participants reporting sexual assault as an adult, and just under a quarter of male participants (23.4%) and about one-fifth of female participants (19.2%) reporting having experienced a violent crime.

Notable differences in trauma history of male and female participants were found. Female participants were significantly more likely than males to report being a survivor of sexual assault or IPV as an adult, in addition to having experienced physical and sexual abuse during childhood. Further, about three-quarters of female participants reported experiencing some form of childhood abuse compared to just under 40% of male participants. This corroborates the findings of extant studies that found higher rates of trauma among female inmates (Ardino et al., 2013; Bloom et al., 2003; Browne et al., 1999).

Nearly a quarter (24.3%) of male participants and just under 40% of female participants reported being emotionally abused during childhood. Though emotional abuse is sometimes minimized in terms of harmfulness (Vachon et al., 2015), research suggests that emotional maltreatment may have equivalent, or at times even stronger, effects on long-term psychological functioning than physical or sexual child maltreatment (Spinazzola et al., 2014; Vachon et al., 2015). Further, experiencing psychological maltreatment as the sole form of childhood abuse has been associated with similar or worse mental health outcomes than for those who solely experienced physical or sexual abuse (Spinazzola et al., 2014).

Among male MHC participants, about 20% (19.8%) reported experiencing childhood physical abuse, and just under one-fifth (18.9%) experienced childhood sexual abuse. Of note, the rates of physical and emotional abuse within this sample are markedly lower than other studies of incarcerated males (Morrison et al., 2019). This may be a result of the methods, primarily that the present study was retrospective and data were gathered via chart review and without standardized instruments to assess lifetime traumatic experiences. However, the rate of reported childhood sexual abuse among men within the present sample is alarmingly higher than what some other researchers have found within criminal justice populations. Previous studies have reported rates of childhood sexual abuse among incarcerated men ranging from 6% to just under 10% (Messina et al., 2007; Morrison et al., 2019; Wolff et al., 2009). In contrast to research on non-incarcerated populations, the present study contributes to the large body of research showing that criminal justice-involved men have significantly higher rates of childhood abuse, particularly sexual abuse (CDC, 2010).

Within the present study, about 14% of participants had a PTSD diagnosis at time of admission into the MHC. While a higher percentage of women had a diagnosis of PTSD (21.2%) as compared to men (10.8%), these differences did not reach statistical significance. These findings reflect those of previous studies in that justice-involved women tend to have higher rates of PTSD than men (Baranyi et al., 2018; Jäggi et al., 2016). While data were not available within the present study to explore gender differences in terms of PTSD symptom severity level, Giarratano and colleagues (2017) suggest that justice-involved women may have more severe PTSD symptoms, which is important for MHCs to consider.

Limitations and Future Studies

Several limitations of this study must be acknowledged. First, MHCs vary greatly by jurisdiction, and therefore, findings from this study may not be applicable to other courts. Also, data on trauma history were self-reported to an LCSW during

completion of a biopsychosocial assessment, and likely underestimate the rate of trauma among sample participants (see Swahn et al., 2006).

In addition, *DSM-IV-TR* criteria were used for diagnosing PTSD, which was the most current edition at the time of data collection. When compared to the *DSM-IV-TR*, PTSD criteria within the *DSM-5* included the addition of "sexual violation" as qualifying as a traumatic event, exposure to trauma experienced by first responders or police officers, and four clusters of behavioral symptoms (i.e., re-experiencing, avoidance, negative cognitions and mood, and arousal) instead of three (American Psychiatric Association, 2013b). Changes in criteria for PTSD from the *DSM-5* to the *DSM-5-TR* were limited to the removal of a note for children (American Psychiatric Association, 2022), and thus, is not a relevant change for the adult population within the present study. However, changes made to criteria since the *DSM-IV-TR* limit the generalizability of our findings. Relatedly, the *Life Events Checklist for DSM-5* (*LEC-5;* Weathers et al., 2013) was used to code traumatic events as opposed to the original *Life Events Checklist* (*LEC*; Gray et al., 2004) despite use of the *DSM-IV-TR* by the LCSW. While, according to the National Center for PTSD, changes between the *LEC* and *LEC-5* are "minimal" and "few psychometric differences are expected," (Weathers et al., 2013, para. 5), it is plausible that some traumatic events could have either been included or excluded from the analysis.

Moreover, the retrospective nature of this study limited the analysis to the data that was contained within probation and MHC documents, and a small sample size did not allow for a more intersectional approach to compare racial/ethnic differences between male and female participants.

Despite the limitations of this analysis, this study makes an important contribution to the research of MHCs, as well as the broader criminal justice literature. The high rate of traumatic life events among MHC participants warrants a trauma-informed approach in order to prevent inadvertent re-traumatization. MHC participants should be screened for PTSD by a qualified mental health professional, and, if indicated, should be connected to an evidence-based treatment provider. Future research of these problem-solving courts should further examine the effect of historic and recent trauma on MHC outcomes and assess the level to which MHC programs are trauma-informed. Finally, future research should assess prevalence of lifetime traumatic events among MHC participants using a standardized instrument.

Implications

The findings of the present study highlight the need for not only trauma-informed MHCs, but also gender-specific, trauma-informed programs that can address women's specific needs and their histories of trauma (Abarno et al., 2021; McCoy et al., 2020; Tossone & Baughman, 2020). Likewise, a majority of justice-involved men have experienced trauma that warrants responsive treatment (Pettus-Davis et al., 2019). While we contend a gender-specific program could benefit women in the MHCs, we do not aim to discount the importance of an intersectional approach that would address one's various and intersecting experiences.

In conjunction with the findings of the present study, a clear need exists for incorporating trauma screening tools into MHC assessment procedures. Numerous

instruments exist to aid in assessing individuals for trauma as well as PTSD-related symptoms. *The Posttraumatic Stress Disorder Checklist - for DSM-5* (*PCL-5*; Weathers et al., 2013) is one such example, which is a 20-item self-administered tool that can be useful for screening for PTSD as well as monitoring changes in symptoms over time. The *Trauma History Screen* (*THS*; Carlson et al., 2011) is an alternative assessment consisting of 14 items that indicate endorsement of "high magnitude stressor (HMS) events" and "events associated with significant and persisting posttraumatic stress" (p. 463). The *THS* additionally includes the age at which one experienced an event; whether it involved actual, or fear of, anyone getting killed or hurt; the presence of feeling afraid, helpless, or horrified; duration of distress; and level of distress.

MHCs should also consider using gender-responsive tools for assessing criminogenic risks and needs that include trauma history as a factor, for example, the *Women's Risk Needs Assessment* (*WRNA*; Van Voorhis et al., 2008), as has been suggested for drug courts (Shaffer et al., 2019). The *WRNA* is an assessment process that incorporates criminogenic strengths and needs of women with the traditional principles of the Risk-Need-Responsivity (RNR) model (Bonta & Andrews, 2007), and specifically includes items related to, for instance, childhood and adulthood trauma and parental stress (Boppre & Salisbury, 2016).

MHCs are often insufficiently funded and the availability of services within the community may be lacking (Black et al., 2019; Burns et al., 2013). Nevertheless, MHCs possess the capacity to increase the extent to which they are trauma-informed without spending a tremendous amount of money. This is supported within a SAMHSA report (2011) entitled *Essential Components of Trauma-informed Judicial Practice*, which states:

> Becoming trauma-informed requires re-examining policies and procedures that may result in participants feeling loss of control in specific situations, training staff to be welcoming and non-judgmental, and modifying physical environments. The goal is to fully engage participants by minimizing perceived threats, avoiding re-traumatization, and supporting recovery. There is often little or no cost involved in implementing trauma-informed principles, policies, and practices. (p. 1)

A trauma-informed approach includes not only trauma-specific programming but also a shift in culture to one informed by the key trauma principles. SAMHSA's (2014) six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and culture, historical, and gender issues. Similarly, Fallot and Harris (2006) identified the five core values of trauma-informed services as safety, trustworthiness, choice, collaboration, and empowerment.

Kubiak et al. (2017) provided examples of ways these values can be implemented within a correctional environment. It seems quite feasible that these guidelines could be adapted for MHCs. For example, PSC team members can promote the value of safety by maintaining eye contact with participants, providing explanations of what will be done before it is done, and providing participants with specific instructions for reporting abuse within the MHC. Trustworthiness can be incorporated by PSC team members demonstrating predictably, reliability, and setting appropriate boundaries with participants. Further, trust can be established when team

members demystify the court process for MHC participants by explaining what can be expected, describing the roles of those in the courtroom, and outlining all possible outcomes (McKenna & Holtfreter, 2021). MHC participants should be provided with choices for treatment, when available. MHC personnel should be purposefully collaborative with participants, asking participants for input on treatment planning and relapse prevention planning, for instance. MHCs should empower participants by providing opportunities for learning new skills, whether they be related to coping, symptom management, vocational training, or other relevant areas. MHC participants should also be given opportunities for success, avoiding setting participants up for failure with unrealistic demands. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation (2020) provides a half-day trauma-informed response training entitled *How Being Trauma-Informed Improves Criminal Justice System Responses*, as well as a train-the-trainer event so that these teachings can also be shared with the local community.

In addition to cultivating an overall trauma-informed MHC culture, these specialty treatment courts should also consider the adoption of trauma-specific programming or therapies. For example, *Seeking Safety* and *Trauma Recovery and Empowerment Model* (*TREM/M-TREM*; Fallot & Harris, 2002) are two gender-specific and trauma-informed manualized curricula that MHCs could consider using (Freeman & Lautar, 2015). *TREM*, and *M-TREM* (specifically geared towards men), incorporate elements of cognitive restructuring, psychoeducation, and skill building, and were specifically designed for individuals with serious mental health issues and those with co-occurring substance use disorders (Fallot & Harris, 2002). *Trauma Affect Regulation: Guide for Education and Therapy* (*TARGET*; Ford & Russo, 2006) also has been found to be efficacious for addressing trauma among justice-involved populations (Freeman & Lautar, 2015). *TARGET* utilizes a strengths-based approach and teaches seven skills to address trauma (Advanced Trauma Solutions Professionals, n.d.). MHCs without clinicians trained in such practices should consider investing in training or identifying community providers proficient in such treatments.

Trauma-informed practices may also benefit PSC personnel. For example, Drabble and colleagues' (2013) found that within a family drug treatment court, service providers benefited from the trauma-informed approach as the practices contributed to their clients' success, which in turn contributed to the service providers' job satisfaction.

CONCLUSION

In addition to providing in-house services or linkages to counseling, case management, housing, and other ancillary services, MHC participants would likely benefit from embedding a trauma-informed approach, which would be well aligned with the principle of therapeutic jurisprudence. While the cost of adding gender-responsive, trauma-informed curriculum may be cost prohibitive for many MHC programs, we contend that all MHC programs should work towards the intentional adoption of a trauma-informed approach that includes free and accessible trauma screening tools, as well as modification of existing policies and procedures to reflect the values of safety, trustworthiness, choice, collaboration, and empowerment. The present study indicates a need for infusing trauma-informed elements into MHC

programs. While it is currently unknown how many MHCs operate in a trauma-informed manner, there are ample extant resources and trauma interventions to guide the implementation of such an approach.

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