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Emotional and Behavioral Problems of 13-to-18-Year-Old Incarcerated Female First-Time Offenders and Recidivists

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This exploratory study in Pierce County, Washington, compared emotional and behavioral problems of 13- to 18-year-old incarcerated female first-time offenders ($n = 38$) and recidivists ($n = 78$) using the Massachusetts Youth Screening Inventory, Version Two (MAYSI-2) and demographic data. The study found that adolescent female recidivists had more emotional and behavioral problems, more unstable lifestyles, and less stable family situations.

Keywords: *recidivism; emotional and behavioral problems; juvenile offender; substance use*

This study compared the frequency of emotional and behavioral problems of incarcerated 13- to 18-year-old female first-time offenders and recidivists using Massachusetts Youth Screening Inventory, Version Two (MAYSI-2) and demographic data. The team postulated that the frequency of emotional and behavioral problems would be commensurate with Cauffman's (2004) findings and higher in recidivists than first-time offenders.

Using MAYSI-2 to explore the frequency of emotional and behavioral problems in incarcerated youths, Cauffman (2004) found that there was a high prevalence of mental health problems among youths in the juvenile system. As the awareness of this high prevalence has grown, researchers have recognized the need for accurate assessment of incarcerated youths to ensure that limited treatment resources can be used with those in the greatest need. In addition, she also found that regardless of race or age girls presented with more mental health symptoms than boys. Cauffman further stated that numerous studies have attempted to estimate the prevalence of mental disorders among juveniles in the justice system and that the majority of research on mental health needs of juvenile offenders has been done with male samples. As a result, she did not believe that the results would necessarily generalize to female offenders. This was problematic in that Cauffman noted that female offenders were rapidly becoming more of a percentage of juvenile offenders.

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Sample and Measures

Between June 7 and October 26, 2004, the female schoolteacher, as the test proctor, administered the survey packet to all 13- to 18-year-old females during school intake into Remann Hall in Pierce County, Washington. Prior to participation, each participant signed an informed consent form, which was maintained separately from the survey packets. The data analyst received only numbered packets. Because of release of girls twice weekly by the court, a randomized sample was not possible. The team offered all females processing into the detention center school the opportunity to participate in the study. The detention center had both females awaiting adjudication and those serving sentences of up to several months following adjudication.

For this study, first-time offenders were those girls who were incarcerated for the first time in their lives. This was irrespective of the number of offenses previously committed not resulting in incarceration. Recidivists were those girls who had been incarcerated at least two or more times in their lives. The total sample was 116 completed packets of 153 packets completed by girls during school-intake processing. Eight first-time offenders and thirteen recidivists did not fully complete the survey packet. Four survey packets could not be used as the primary dependent variable regarding recidivism was not marked. The team also did not use 13 survey packets of girls who returned and tested a second time during the data collection period.

MAYSI-2 was the primary instrument for this study. MAYSI-2 is a self-report instrument at a fifth-grade level with a testing time of 8 to 10 min consisting of 52 questions with "yes" or "no" choices indicating whether an item has occurred or not during the past few months. There are a total of seven scales for boys and six scales for girls with items between five and nine. Each scale is used independently of the others. According to Grisso and Barnum (2000), the primary function of the MAYSI-2 is to alert for the possible need of further action of some sort as opposed to being used for treatment decision making. MAYSI-2 scale scores served as the primary independent variables for this study. For females, these were Alcohol/Drug Use, Angry-Irritable, Depressed-Anxious, Somatic Complaints, Suicide Ideation, and Traumatic Experience.

Grisso and Barnum (2000) provided various cutoff scores for the MAYSI-2 scales as noted in Table 1. The Thought Disturbance Scale (TD) was not used in this study as it is only for boys. In addition, there are no cautionary or warning zones for the Traumatic Experience Scale (TE). This scale simply indicates the degree to which youths have been exposed to traumatic experiences to aid in follow-up questioning. For the scales with eight to nine items, the score is invalidated if more than two questions are unanswered. For the scales with five to six questions, the scores are invalidated by more than one unanswered question.

Demographic variables or attributes for this study also functioned as independent variables, and recidivism was the primary dependent variable. Analyses of these variables allowed the team to see the influence of independent variables or attributes on 13- to 18-year-old incarcerated female first-time offenders (nonrecidivists), 13- to 18-year-old incarcerated female recidivists, and combined nonrecidivists and recidivists. Descriptive statistics compared variables of samples within this study and with frequencies noted in Cauffman's (2004) study.

Table 1
MAYSI-2 Caution and Warning Ranges

MAYSI-2 Scale	Caution Range	Warning Range
Alcohol/drug use	4 to 6	7 to 8
Angry-irritable	5 to 7	8 to 9
Depressed-anxious	3 to 5	6 to 9
Somatic complaints	3 to 5	6
Suicide ideation	2	3 to 5
Traumatic experiences	Ad hoc score of 3 assigned	

Findings

Because of the disparity between the sample sizes of first-time offenders (n = 38) and recidivists (n = 78), inferential statistics were ineffective for analysis of the data of this study. Sample size disparity and cell sizes of fewer than five in some areas also rendered X^2 mostly inaccurate for analysis. Analysis was predominantly based on descriptive statistics discovered in this study or was related to Cauffman's (2004) findings.

Table 2 contains self-reported demographic data related to ethnicity, types of offenses, and living arrangements prior to incarceration. The team was unable to obtain the actual offenses committed by the girls because of concerns of the facility regarding confidentiality of personal information of those incarcerated.

The mean age for the entire sample was 15.29 years (N = 116, SD = 1.33). The mean ages were 15.08 years for first-time offenders (n = 38, SD = 1.42) and 15.40 years for recidivist (n = 78, SD = 1.27). The mean level of education for the entire sample was 8.77 years (SD = 1.26). The mean levels of education were 8.50 years (SD = 1.50) for first-time offenders and 8.91 years (SD = 1.10) for recidivists. In the entire sample, only 58.6% regularly attended school or the last month of school prior to summer before coming to detention. Also, 21.6 % had repeated a grade in school, and 14.7% attended special education.

The percentages of those having a clinically significant score on any caution for at least one MAYSI-2 scale were 55% for first-time offenders and 77% for recidivists. Table 3 depicts the percentages exceeding at least one MAYSI-2 cutoff score for this study and Cauffman's study.

This study, per Table 3, nearly paralleled Cauffman's (2004) findings that 81% of the sample of detained adolescent females (N = 3,361) scored at least a caution level clinical cutoff score for one scale of the MAYSI-2. For this study, 70% of 13- to 18-year-old incarcerated females (N = 116) scored that level. The highest individual scale for both Cauffman's study (59%) and this study (53%) was the MAYSI-2 Somatic Complaint Scale. The percentages scoring above the caution level clinical cutoff score on the MAYSI-2 Depressed-Anxious Scale for Cauffman (54%) and this study (42%) exceeded the *DSM-IV* (APA, 1994) diagnosis of depression (27%) of the *Annual Report to Congress on the Comprehensive Community Mental Health Services and Their Families Program*'s (1998) sample.

Table 2
Description of the Sample

Characteristic	Total ($N = 116$)		First-Time Offender ($n = 38$)		Recidivist ($n = 78$)	
	n	%	*n*	%	*n*	%
Ethnicity						
White	54	46.6	16	42.1	38	48.7
Hispanic	4	3.4	1	2.6	3	3.8
Black	17	14.7	5	13.2	12	15.4
Asian	5	4.3	3	7.9	2	2.6
Pacific Islander	2	1.7	1	2.6	1	1.3
Native American	5	4.3	3	7.9	2	2.6
Other	29	25.0	9	23.7	20	25.6
Type of offense						
Violent	44	37.9	8	47.4	26	33.3
Property	23	19.8	9	23.7	14	17.9
Status	46	39.7	9	23.7	37	47.4
Drug	14	12.1	5	13.2	9	11.5
Living with whom						
Both parents	5	4.3	5	13.2	0	0.0
Birth mother	56	47.3	19	50.0	37	47.7
Birth father	6	5.2	1	2.6	5	6.4
Other relative	11	9.5	4	10.5	7	9.0
Step & birth parent	11	9.5	2	5.3	9	11.5
Adoptive parents	4	3.4	2	5.3	2	2.6
Foster parents	5	4.3	3	7.9	2	2.6
Other/homeless	18	15.5	2	5.3	16	20.5

Note: "Type of Offense" category includes multiple offenses by individuals and exceeds sample total.

Table 4 indicates the frequencies and percentages for caution scores and warning scores for the various MAYSI-2 scales for first-time offenders and recidivists. As per Table 4, recidivists had a higher combined percentage for both caution- and warning-level cutoff scores compared to first-time offenders on all MAYSI-2 scales, and recidivists (77%) versus first-time offenders (55%) scored at least a clinically significant caution level on at least one MAYSI-2 scale. The MAYSI-2 Somatic Complaints Scale had the highest percentages for recidivists and first-time offenders. The MAYSI-2 Angry-Irritable Scale was the second highest percentages for recidivists and first-time offenders. The recidivists had higher percentages of emotional and behavioral problems than the first-time offenders.

Table 5 compares the mean scores for first-time offenders and recidivists on the MAYSI-2 scales. Table 5 indicated that the recidivists had higher mean scores on all scales than the first-time offenders. For this sample, the recidivists clearly had more emotional and behavioral problems than the first-time offenders.

Table 6 contains reported data regarding various mental health issues for first-time offenders and recidivists. Table 6 provided additional evidence that recidivists have higher percentages for both mental health diagnoses and mental health hospitalizations compared

Table 3
Percentages Exceeding at Least One MAYSI-2 Cutoff Score

	Current Study ($N = 116$)	Cauffman's Study ($N = 3{,}361$)
MAYSI-2 Scale	%	%
Any caution	70	81
Alcohol/drug use	30	36
Angry-irritable	46	56
Depressed-anxious	42	54
Somatic complaints	53	59
Suicide ideation	30	33
Traumatic experiences	35	43

Note: "Any Caution" category excludes "Thought Disturbance," a scale for only males, and "Traumatic Experiences," a category without an established cutoff score but with an ad hoc cutoff of 3.

Table 4
Comparison of MAYSI-2 Cutoffs for First-Time Offenders and Recidivists

MAYSI-2 Scale	($n = 38$)	C%	($n = 38$)	W%	Total %	($n = 78$)	C%	($n = 78$)	W%	Total %
Alcohol/drug use	6	15.8	4	10.5	26.3	20	25.6	5	6.4	32.0
Angry-irritable	13	34.2	3	7.9	42.1	22	28.2	15	19.2	47.4
Depressed-anxious	10	26.3	4	10.5	36.8	27	34.6	8	10.2	44.8
Somatic complaints	15	39.5	3	7.9	47.4	40	51.3	4	5.1	56.4
Suicide ideation	1	2.6	9	23.7	26.3	6	7.7	19	24.4	32.1
Traumatic experiences	13	34.2				28	36.0			

Note: C = MAYSI-2 Caution Cutoff & W = MAYSI-2 Warning Cutoff. "Traumatic Experiences" has an ad hoc cutoff score of 3. See page 4 for MAYSI-2 cutoff ranges for all other scales.

to first-time offenders. Of first-time offenders, 28.9% had ever received mental health medication, with 23.7% still taking mental health medication at the time of incarceration. Of recidivists, 28.2% had ever received mental health medications, but only 12.8% still took mental health medications at the time of incarceration. Although 9.0% of recidivists versus 15.8% of first-time offenders had ever been hospitalized for alcohol or drug treatment, 10.5% of first-time offenders compared to 24.4% of recidivists had ever received community alcohol or drug treatment prior to incarceration. There may be several factors related to the severe drop in medication use by recidivists: (a) stigma (Williams, Hollis, & Benoit, 1998), (b) the legal age of 13 years for consent for or refusal of mental health services in the State of Washington, and (c) lack of primary support (homelessness, foster care, or single parent). Cauffman (2004) expressed concern that female juvenile delinquency might actually be a sign of significant mental health problems.

Additionally, the study found that nearly twice as many recidivists (25.6%) indicated that their parents had a problem with amphetamines compared to first-time offenders (13.2%). With respect to those who used nicotine at or before 11 years, 88.5% were recidivists

Table 5
Mean Scores for MAYSI-2 Scales for First-Time Offenders and Recidivists

	First-Time Offender (n = 38)		Recidivist (n = 78)	
Scale	*M*	*SD*	*M*	*SD*
MAYSI-2 A/D use	2.11	2.73	2.35	2.49
MAYSI-2 A-I	3.50	2.95	4.50	2.73
MAYSI-2 D-A	2.18	2.26	2.58	2.22
MAYSI-2 SC	2.53	2.06	2.76	1.79
MAYSI-2 SI	1.13	1.74	1.18	1.67
MAYSI-2 TE	1.97	1.60	2.05	1.67

Note: A/D = Alcohol/Drug use; A-I = Angry-Irritable; D-A = Depressed-Anxious; SC = Somatic Complaints; SI = Suicide Ideation; TE = Traumatic Experiences.

Table 6
Comparison of Mental Health Issues for First-Time Offenders and Recidivists

	First-Time Offenders		Recidivists	
Mental Health Issue	(n = 37)	%	(n = 78)	%
Mental health diagnosis (ever)	11	28.9	27	34.6
Mental health hospitalization (ever)	2	5.3	6	7.7
Mental health medication (ever)	11	28.9	22	28.2
Mental health medication (currently)	9	23.7	10	12.8
Alcohol/drug hospitalization (ever)	6	15.8	7	9.0
Alcohol/drug community treatment (ever)	4	10.5	19	24.4

compared to 11.5% being first-time offenders. The use of nicotine at or before 11 years and recidivism was significant ($X^2(1) = 4.90$, $p < .05$).

The high percentage of first-time offenders who scored at a clinically significant caution or warning level for the MAYSI-2 Angry-Irritable Scale may relate to the violent offense variable at 47.4%. Cauffman (2004) noted that girls sent to detention centers tended most likely to be those with the most serious behavioral problems. In addition, the MAYSI-2 Angry-Irritable Scale for first-time offenders compared to recidivists was much lower. This might be a time and chance to intervene for the first-time offenders who were likely at most adolescent-limited delinquents and to prevent their becoming life-course delinquents (Bartol & Bartol, 1998). The study also showed that 47.4% of recidivists came to Remann Hall with status offense as the most reported type of offense. These were girls who were likely violating the conditions of release in many instances. Without intervention, these female adolescents would be at higher risk of becoming life-course delinquents (Bartol & Bartol, 1998).

With respect to alcohol or drug use, demographics obtained in this study clearly demonstrated that for both first-time offenders and recidivists the substances of choice were

cannabis and alcohol. Recidivists had higher percentages for use of cannabis, use of alcohol, and alcohol intoxication. Of first-time offenders, 36.8% ever used nicotine versus 53.8% of recidivists. In America in 1995, in 12- to 17-year olds who had ever used marijuana in their lifetime, 74% had tried cigarettes prior to using marijuana (Gabe, Norton, Taleff, & Benson, 1999). Nicotine has been understood by those treating addiction to be a primary gateway drug. More startling for this study is that of those who used nicotine at or before 11 years, 88.5% were recidivists and 11.5% were first-time offenders. Nicotine use at or before 11 years seems to be a potential risk factor for recidivism in adolescent females and may indicate an initial breakdown of boundaries with respect to illegal use of a substance. Recidivists had more serious issues with respect to cannabis, alcohol, and nicotine. Nearly twice as many recidivists than first-time offenders considered their parents to have a problem with cannabis, and more recidivists considered their parents to have an alcohol problem. First-time offenders were more involved in experimentation with more serious substance use. Except for amphetamines, the first-time offenders exceeded the recidivists in use of other substances such as hallucinogens, inhalants, and opiates. For recidivists, the higher level of community drug and alcohol treatment with likely urine toxicology screens may have served as somewhat of a deterrent to the use of hallucinogens, inhalants, and opiates, but the higher level of status offenses could relate to positive urine toxicology screening results as part of probation or parole requirements.

Recidivists tended to be angrier and more depressed than first-time offenders. They may have had a greater resignation at being in the juvenile justice system for repeated times and during a longer period of time. The frustration at being repeatedly incarcerated could possibly explain the higher mean score for recidivists compared to first-time offenders on the MAYSI-2 Angry-Irritable Scale. Astin and Forys (2004) explained that depression, anxiety, adverse or negative feelings, meanings, concepts, and beliefs tended to relate to negative health outcomes. According to them, studies indicate that hostility was associated with behavioral risk factors such as smoking, alcohol, and dietary fat intake. Interestingly, first-time offenders and recidivists scored most frequently at either the clinically significant caution- or warning-level cutoff score on the MAYSI-2 Somatic Complaints Scale. The MAYSI-2 Angry-Irritable Scale was the second most frequent problem area on MAYSI-2 for first-time offenders and recidivists. Cannabis, alcohol, and nicotine were the three most frequently used substances by both first-time offenders and recidivists. The incarcerated adolescent females may neither effectively convey their concerns or feelings nor feel heard by those they saw in authority. This could explain their anger turning to somatic complaints, depression, anxiety, and substance use.

With regard to living situations prior to incarceration, although 13.2% of first-time offenders lived with both biological parents, none of the recidivists lived with both biological parents. Living with their biological mother was the most common living arrangement for first-time offenders (50%) and recidivists (47.7%). Disturbingly, 20.5% of recidivists versus 5.3% of first-time offenders were either homeless or without any biological, adoptive, or foster family. They were likely living with friends or in actual transient living situations. Of the 18 recidivists who were homeless, 50% of them listed their parents as having an amphetamine problem. The family situation for recidivists may have been poor prior to even their first offense or it may have disintegrated compared to that of first-time offenders. Poor family factors may predispose one to recidivism.

Bartol and Bartol (1998) stated that there was extensive evidence that family played a significant role in juvenile delinquency. Flouri and Buchanan (2002) expressed concern that youths who attempted suicide were less likely to be residing with both parents. This would support a greater need for accurate mental health assessment regarding suicide risk for incarcerated female adolescents because of the low number living with both parents.

Cross-tabulation revealed that of the 15 participants who indicated a prior suicide attempt requiring medical care, 2 scored in the caution and 8 in the warning cutoff ranges of the MAYSI-2 Suicide Ideation Scale. The data indicated that MAYSI-2 Suicide Ideation Scale detected at caution level or warning level approximately two thirds of those who indicated a suicide attempt on the demographic sheet of this study. MAYSI-2 would seem to be an effective and helpful screening tool for the safety of those in-processing at Remann Hall.

Based on cross-tabulations with those indicating a prior suicide attempt on the demographic sheet, the MAYSI-2 Depressed-Anxious Scale detected at both the caution or warning levels combined that approximately half of them were depressed or anxious, and the MAYSI-2 Alcohol/Drug Use Scale detected at both the caution and warning levels combined that approximately one third were using alcohol or drugs. These data would support the possible need for using multiple instruments in conjunction with one another to aid in assessing suicide risk.

Conclusions

MAYSI-2 served as an excellent instrument for initial assessment of emotional and behavioral problems for incarcerated adolescent females. The use of additional instruments could aid in greater differentiation with respect to diagnosis of mental illnesses. The use of multiple instruments would meet Liao's (2001) idea of grouping by clinical characteristics as being a more accurate diagnostic method for children and adolescents.

The data of this study clearly supported that recidivists had a higher frequency of emotional and behavioral problems than first-time offenders. The severity of the emotional and behavioral problems was also higher in recidivists than in first-time offenders.

The higher frequency of emotional and behavioral problems noted in this study supported the idea of the need for adequate mental health staffing and services in the juvenile justice system to allow for better intervention or coordination of resources to aid first-time offenders and recidivists. The need for clear assessment and determination regarding the need for mental health medications was apparent. Even though the percentages needing mental health medications were almost identical for first-time offenders and recidivists, nearly 50% of recidivists were not taking mental health medications at the time of incarceration. Mental health workers should seek to lessen the stigma of taking mental health medications. Screening first-time offenders to see whether the age of first nicotine use was at or before 11 years and to check their perceived parental substance use could serve as a useful indicator of subsequent recidivism. This in turn would allow for earlier and better targeted intervention for these girls with respect to prevention of recidivism. With the

frequency of drug and alcohol use by first-time offenders and recidivists, it would be helpful to have psychoeducation and discussions while incarcerated.

First-time offenders could benefit from intervention to help them process their greater sense of hopelessness after finding themselves incarcerated. Nonattendance of school by 48.7% of recidivists versus 26.3% of first-time offenders may indicate a need to counter their resignation and disenfranchisement from life. Thorough assessment of school-related capabilities and competencies would be essential to help reintegrate the incarcerated female adolescents into the school system. Flexible programming to help regain lost skills and to gain confidence may be beneficial in encouraging incarcerated female recidivists to return to school.

The first-time offenders could benefit from coordinated services to involve the family in treatment to prevent recidivism. None of the recidivists, compared with 13.2% of first-time offenders, checked the block for living with both biological parents prior to incarceration. Nearly four times as many recidivists (20.5%) as first-time offenders (5.3%) claimed to be in transient living situations or homeless prior to incarceration. Both first-time offenders and recidivists could benefit from wraparound services or some form of multisystemic family therapy. These treatments remain cost-effective and empowering for the family to prevent incarceration, mental hospitalization, or foster placement of youths (Biggins & Oss, 2003).

The primary areas of focus to aid in reducing recidivism are effective family living situations, effective anger processing, reduction of drug and alcohol use, and regular school attendance. In addition, thorough assessment of emotional and behavioral problems to determine the need for suicide risk reduction and mental health medication treatment is essential for the safety of the incarcerated adolescent females. This would take the form of using MAYSI-2 along with other possible instruments. The instruments should not take the place of face-to-face interviews by mental health workers. The instruments, however, could aid in obtaining greater focus of limited resources to those most in need.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Annual report to Congress on the evaluation of the comprehensive community mental health services for children and their families program: Executive summary. (1998). Atlanta, GA: Macro International.

Astin, J. A., & Forys, K. (2004). Psychosocial determinants of health and illness: Integrating mind, body, and spirit. *Advances in Mind-Body Medicine, 20*(4), 14-21.

Bartol, C. R., & Bartol, A. M. (1998). *Delinquency and justice: A psychosocial approach* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Biggins, S., & Oss, M. E. (2003). Reaching mentally ill young offenders. *Behavioral Health Management, 23*(5), 10-13.

Cauffman, E. (2004). A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 430-439.

Flouri, E., & Buchanan, A. (2002). The protective role of parental involvement in adolescent suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 23*(1), 17-22.

Gabe, J. E., Norton, M. A., Taleff, M. J., & Benson, K. (1999). *Basics of addiction counseling: Desk reference and study guide* (8th ed.). Alexandria, VA: NAADAC.

Grisso, T., & Barnum, R. (2000). *Massachusetts youth screening instrument: Second version (MAYSI-2): User's manual and technical report* (2nd ed.). Worchester: University of Massachusetts Medical School.

Liao, Q. (2001). Describing the population of adolescents served in systems of care. *Journal of Emotional and Behavioral Disorders, 9*(1), 13-29.

Williams, R. A., Hollis, H. M., & Benoit, K. (1998). Attitudes toward psychiatric medications among incarcerated female adolescents. *Journal of Child and Adolescent Psychiatry, 37*, 1301-1307.

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