

ADAPTING A SUBSTANCE ABUSE COURT DIVERSION MODEL FOR FELONY OFFENDERS WITH CO-OCCURRING DISORDERS: INITIAL IMPLEMENTATION

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Treatment Alternatives for Dually Diagnosed (TADD) was developed to address the need for criminal justice diversion of seriously mentally ill substance-using felons and persistent misdemeanants. The population served by the TADD program and key elements of the program are described, including identification, screening and assessment, specialized court processing and judicial oversight, case management monitoring, joint case conferencing between community and monitoring staff, enforcement, and key stakeholder collaboration. One hundred and thirteen clients diverted by the TADD program were followed for six months. A description is provided of these clients, the community services

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accessed, as well as the monitoring of clients drug use. During six months of program involvement 87% remained connected to the diversion team, 80% remained in community treatment and the majority took advantage of the rich service environment created through TADD's case management linkage services. The majority of these clients tested drug-free during this six-month period.

KEY WORDS: post-booking diversion; court diversion; dual diagnosis; co-occurring mental illness and substance abuse disorders; felony offenders.

INTRODUCTION

Of the almost two million adults incarcerated midyear 2001 in jails and prisons (1) 10 to 16 % evidence mental health problems (2,3). While the risk for incarceration among the general U.S. population is less than one percent (4), the risk for police encounters, arrest and incarceration is significantly higher among those with psychiatric disorders (5,6,7,8,9). Substance abuse is also well established as a risk factor for arrest; 60% of those arrested test positive for drug use (10). In New York City (NYC) among male arrestees, 41% are at risk for drug dependence and 23% for alcohol dependence (11). The mentally ill may also be more likely to recidivate than nonmentally ill offenders if ongoing treatment is not received (12,13). However, rather than as a direct consequence of mental illness, recidivism by the mentally ill may be more aptly explained by the type of monitoring received (13,14), by substance abuse (15,16), by homelessness and its sequelae (17,18), or perhaps other factors.

Almost three-quarters of those with serious mental illness incarcerated in jails have a co-occurring substance use disorder (19), compared to 20% of the seriously mentally ill in the general U.S. community population (20). For those with a primary substance abuse or dependence disorder, 46% of a NYC arrestee sample had a current major or moderate mental health diagnosis (15). However, substance abuse by the mentally ill is inherently difficult to assess and quantify (21), definitions of what constitutes serious mental illness and methods for its assessment vary (8), and standard methods for estimating prevalence rates likely underestimate (22).

In community and arrested samples, those with co-occurring substance use disorders are more likely to have multiple problems, compared to those with a single disorder, including frequent hospitalizations, increased risk for suicide, poor treatment compliance, homelessness, low education levels, poor social supports, infectious disease and trauma histories (15,23,24,25). Further, those with co-occurring

substance abuse who are noncompliant with medication are at increased risk for violence and arrest (26,27). Individual help-seeking beliefs, health services policies, and community provider and criminal justice biases toward this population have been well described in terms of deterring access to services (28,29). Given these factors, diversion from criminal justice settings, or contact, to community treatment has received increasing attention, primarily as a services access mechanism to address the multiplicity of this population's needs.

While research into effectiveness of postbooking diversion for mentally ill substance using offenders is too sparse to yet call evidence-based, there are a number of initial findings. Consistent with substance abuse diversion research (30,31) postbooking diversion for the mentally ill offender increases access (32), is cost neutral or moderately cost-savings in the short-term (33), reduces days spent in jails and or prisons (34,35) and decreases recidivism for misdemeanor offenders (36). Models of postbooking diversion are heterogeneous in terms of processing strategies, location and timing of the diversion during the criminal justice process, and even the populations targeted (37); the majority of models studied have focused on misdemeanants. The comparative effectiveness of postbooking diversion models for this population in reducing a compendium of related negative outcomes (e.g., homelessness, substance use, infectious disease, treatment drop-out, psychiatric instability) is yet unknown. Further, while the potential benefits, or lack thereof, of legal coercion on retention and other factors, has been well studied in the criminal justice substance abuse field (38), and recently explored for out-patient commitment of the mentally ill (26,39), there is only preliminary study of the comparative effects of coercive versus noncoercive diversion of those with co-occurring disorders (35).

This article presents a descriptive implementation study detailing the adaptation of a coercive substance abuse case management and court-monitoring model for dually diagnosed felony and persistent misdemeanor offenders. We include a preliminary description of the type of clients seen by the program and the initial services they received in the community during a six-month period following their diversion.

PROGRAM IMPLEMENTATION

Adaptation of a Substance Abuse Diversion Model

Drug Treatment Alternatives to Prison (DTAP) was developed by the Kings County District Attorney's Office (KCDA), Brooklyn, New York

to divert prison bound nonviolent drug offenders to residential (therapeutic community) treatment. Effectiveness studies of DTAP have found that its explicit and coercive structure reduces recidivism when compared to program failures and nonparticipants (40) and increases treatment retention when compared to clients monitored through a traditional Treatment Alternatives to Street Crimes (TASC) program or through probation supervision (38). The model's core elements include case screening (through paper review of charges and staff presence in a preindictment court part), case management assessment, deferred sentencing (whereby a plea to a felony charge is taken and then reduced or dismissed upon successful treatment completion), monitoring, and enforcement of plea conditions (41). However, DTAP screened out those with mental illness; in fact psychiatric history is one of several variables that predicted DTAP program noncompletion (42). Consequently, KCDA adapted DTAP, creating Treatment Alternatives to the Dually Diagnosed (TADD) to offer the same diversion opportunities to the seriously mentally ill as is offered to drug offenders. Each of DTAP's key elements is described below in terms of their adoption or adaptation by the TADD program.

Referrals and Identification

Table 1 describes the current sources of referral to TADD. That there is a range of stakeholders which refer to TADD—those involved in the diversion, processing, management or care of a defendant—has helped the program expand beyond conventional criminal justice identification mechanisms and partnerships. Each referral source identifies the defendant differently, though the primary reasons for referral are similar. Eight percent of the 328 referrals to TADD were made by judges, 13% by the prosecutor's office, 22% by defense council, 27% by the partner case management agency (Education and Assistance Corporation (EAC)-TASC and -LINK), 28% by jail mental health staff and 1% each by probation and family members. In describing their motivation for program involvement during stakeholder meetings, the criminal justice and jail mental health representatives had expressed concern over management issues, difficulty resolving cases and length of potential prison sentences. As defense counsel referrals were by majority felony offenders facing prison sentences, there was less concern of "net-widening" beyond those who would otherwise be under criminal justice supervision than if the program served low-level misdemeanants.

One to four reasons for identifying defendants were selected by the referral sources. The primary reason for referral was the report of a

TABLE 1
Referral Sources and Reasons for Referral

<i>Identification reasons/ referral sources</i>	<i>Judges (n = 25)</i>	<i>Prosecution (n = 42)</i>	<i>Defense (n = 72)</i>	<i>Case management (n = 88)</i>	<i>Jail mental health (n = 93)</i>	<i>Probation (n = 4)</i>	<i>Family (n = 4)</i>
Psychiatric treatment history	48% (n = 12)	45% (n = 19)	72% (n = 52)	55% (n = 48)	85% (n = 79)	75% (n = 3)	100% (n = 4)
Past behavior	32% (n = 8)	24% (n = 10)	18% (n = 13)	40% (n = 35)	15% (n = 14)	0	0
Competency examination	8% (n = 2)	12% (n = 5)	6% (n = 4)	5% (n = 4)	0	0	0
Behavior during offense	12% (n = 3)	19% (n = 8)	4% (n = 3)	1% (n = 1)	0	25% (n = 1)	0

psychiatric history; a second reason endorsed by all but family members and probation was past defendant behavior that may not have been treated psychiatrically, but indicated to the referrer that the behavior seemed indicative of a problem. The remaining two reasons, whether a defendant had a competency to stand trial examination or demonstrated what was viewed as bizarre behavior during the commission of the index offense, were differentially endorsed and likely based on the type of information for which a referrer would have access. Thus, prosecutors followed by judges, both with access to the full case file, were most likely to refer a defendant based on behavior during the offense.

Screening and Assessment

Screening is usually completed by prosecution, case management and jail staff. The prosecution “paper screens” all cases for drug abuse history (e.g., current and past drug charges, past drug treatment) and reviews the facts of the cases to see if there is indication of mental illness-related behavior. As part of the case file, interviews with family members and victims may provide information that would indicate un- or previously treated mental illness. As the District Attorney’s Office prefers to screen its cases rather than establish a rejection policy based solely on charge, referrals are likely to include serious violent offenses, which constitute a significant contributing reason for rejecting a client (see Table 2). EAC, through its TASC (for substance abuse) and LINK (for mental illness) units screen all drug and mental health referrals for past or present mental health treatment, suicidal behavior, and overt psychotic symptoms. Cases that meet mental health criteria are conferenced with the prosecutor’s office for appropriateness of diversion from a criminal justice perspective, and per defense counsel consent.

Assessments are made without the use of standardized measures with demonstrated reliability or validity. Whether done by the jails or by the case management agency, the assessment is usually two-fold: a psychosocial case management assessment and a psychiatric interview. Twenty-two percent of rejected defendants did not receive an evaluation prior to rejection. Simultaneously some cases identified, screened or assessed are referred by prosecution, judges, defense or by EAC directly to other diversion programs without cross-conferencing between partners.

TABLE 2
Demographic and Criminal Justice Characteristics: Rejected vs. Accepted Defendants

Variable	Rejected (N = 164)		Accepted (N = 153)		t-statistic	Statistic	
	M/%	R	M/%	R			SD
Age (years)	33.46	17-61	9.73	35.03	17-71	10.90	1.36
Male	0.85		0.35	0.81		0.39	1.06
Hispanic	0.26		0.44	0.34		0.48	2.66
Black	0.54		0.50	0.48		0.50	1.36
White	0.19		0.39	0.17		0.38	0.20
Other race	0.01		0.11	0.01		0.11	+
<i>Criminal justice history</i>							
Arrest history	0.80		0.40	0.86		0.35	1.48
Conviction history	0.67		0.47	0.75		0.44	2.11
# Past arrests	6.53	0-63	8.96	8.33	0-81	11.49	0.12
# Past convictions	4.72	0-57	7.40	6.06	0-74	10.29	0.18
<i>Current index offense charge category^a</i>							
Violent	0.42		0.50	0.29		0.46	5.51**
Felony	0.70		0.46	0.73		0.44	0.37
Drug	0.20		0.40	0.35		0.48	9.15**
Nonviolent against person	0.06		0.24	0.06		0.24	0.27
Property	0.09		0.29	0.16		0.37	3.72
Procedural	0.13		0.34	0.06		0.28	5.09*
Quality of life	0.06		0.24	0.07		0.24	0.01
Weapon possession	0.03		0.17	0.01		0.08	+

TABLE 2
(Continued)

Variable	Rejected (N = 164)		Accepted (N = 153)		Statistic	
	M/%	R	M/%	R	t-statistic	Chi-square
<i>Days from arrest to referral, referral to disposition, and arrest to disposition^b</i>						
Arrest to referral	138.53 (n = 160)	0-1098	163.29 (n = 151)	1-701	167.67	1.33
In jail: Arrest to referral	140.82 (n = 119)	0-1098	172.83 (n = 103)	8-701	163.01	.33
Referral to sentence/ placement	109.66 (n = 110)	0-667	108.33 (n = 113)	0-445	92.29	.18
In jail: Referral to sentence/placement	111.16 (n = 85)	1-562	101.40 (n = 79)	0-445	93.18	.62
Arrest to sentence/ placement	243.96 (n = 109)	19-1315	202.69 (n = 111)	15-743	195.60	1.77
In jail: Arrest to sentence/placement	255.91 (n = 85)	19-1315	213.83 (n = 79)	24-743	167.02	.29

^aTypes of charges included for categories are as follows. Violent: attempted murder, robbery, attempted and assault, attempted sexual abuse; for rejected: also murder, arson, rape, sexual abuse. Drug: possession or sale. Nonviolent against other persons: endangerment, harassment, and menacing. Property: burglary and theft; for accepted, also fraud and for rejected, also larceny. Procedural: criminal contempt; for rejected, also intimidation and false report. Quality of life: petit larceny and mischief; for accepted, also trespass; for rejected, also operation of a motor vehicle under influence.

^bFor analysis of days from arrest to program referral and arrest to sentencing/placement disposition, four rejected defendants whose original arrests were in 1992, 1998, and 2000 and two accepted clients whose original arrests were in 1999 were excluded.

* $p < .05$, ** $p < .01$, ± sample size too small to test for significance.

Court Processing and Judicial Oversight

The deferred sentencing model used in DTAP is also employed in TADD, as over 80% of those accepted have plead to a charge prior to treatment placement of which 69% are to the top charge. In terms of where the diversion occurs, TADD like DTAP maintains the general court diversion model serving judges throughout the court, and also has developed a special track with the Brooklyn Mental Health Court. Cases seen in specialized courts have on-going judicial oversight in addition to case management monitoring and enforcement.

Diverting clients from multiple courts and following them in the standard compliance part, as well as having a portion that are processed through a specialized court, is consistent with the original DTAP model. These two methods allow for choice within the court system for judges to complete their own cases through a plea and then to have them followed through a standard compliance part or to refer their cases to one judge for the diversion-plea arrangement and postplea mental health court compliance.

Each method may confer potential benefits. Partnering with a mental health court may potentially conserve resources (e.g., one court location for case management/monitoring and defense and prosecution staff), streamline the process for defendants, reinforce on an ongoing basis the plea terms/consequences, and through specially trained judicial oversight perhaps gain retention benefits over and above that produced by traditional case management monitoring. However, by tradition, mental health court staff is based primarily in the courts, rely on providers in the community to report to court staff, do not have mobile enforcement capabilities, and are not available on a 24-hour basis. By maintaining case management and enforcement teams, the prosecutor's office reasons that it can both provide flexibility to the courts and divert felony offenders by being able to account for the whereabouts of defendants and their progress in the community on a 24-hour basis.

Linkage and Monitoring

As with the DTAP program in Kings County, the partnership with EAC for case management was continued, but expanded to incorporate mental health screening, specialized monitoring strategies, a more varied service rich set of choices to clients, and cross-training of community providers and criminal justice (judicial and attorney) staff. Cross-training is aimed at developing treatment proficiency in engagement, assessment and integrated treatment in the community and an

informed, consistent, yet individualized oversight approach by the judiciary. TADD case management is oriented toward: screening for mental health problems, integrated or parallel treatment planning, community liaison and monitoring for those linked through diversion into community residential and outpatient services for up to 24 months, court liaison reporting and monitoring, and drug testing. EAC-LINK has staff in the courts, the community and also in New York City jails (to enhance referrals, receipt of jail-based psychiatric and medical assessments, and entitlement applications begun by the jail-based discharge planners). Monitoring staff meets with community providers monthly for joint case conferencing.

Enforcement

As with DTAP, there are several elements to the enforcement component. Clients sign a program participation agreement that is explicit as to terms of the diversion and consequences to failure to stay in treatment, which terms are to be reinforced by criminal justice staff (e.g., judge, defense, prosecutor), monitors (e.g., forensic case management), and community treatment providers. Agreements with community providers to report lapses in treatment participation or other violations to the terms of plea agreement are also secured prior to allowing client placement. Additionally, employed by the prosecutor's office, an enforcement officer, per issued warrant, and in collaboration with the New York City Police Department specialized units, seeks clients who have absconded and returns them to the court. From the prosecutor's perspective, the enforcement component of this model allows for the diversion of a wide-range of cases as defendants in the community who have left treatment or violated a condition of the plea agreement can be quickly apprehended and either relinked to treatment by the monitoring team or reincarcerated. It is reasoned that having enforcement capability minimizes public safety risk, provides a level of comfort to the criminal justice system for what it perceives as "riskier" cases, and maintains the structure of a legally coercive alternative to incarceration model. From the DTAP client's perspective, perhaps, the explicitness of consequence comparatively increases treatment retention over the course of a year (38).

In summary, in adapting DTAP, TADD maintained core elements, but added activities and capabilities, primarily in the areas of identification, screening, assessment, staff and stakeholder training, services (types of treatment settings and range of services), and reengagement strategies sensitive to the complexity of co-occurring psychiatric disorders. Further, the local context within which these activities have

taken place has facilitated rapid implementation. Under the lead of the Kings County District Attorney, Brooklyn has pioneered diversion and reentry for both adult and adolescent populations initially in the area of substance abuse and now in mental illness. Stakeholder forums and collaborative projects are in abundance and have spawned different models of diversion with varying degrees of coercion lead by different stakeholder groups (43). The fostering of consensus and multiple stakeholder collaboration is viewed as key to the infrastructure of diversion for this population (44,45). With the exception of enforcement, DTAP/TADD key model components are consistent with what is described as the core elements for general and court diversion of the co-occurring disorders population (37,43,45,46,47,48,49).

METHODS

Program Referrals and Participants

All clients referred had cases pending in Kings County, Brooklyn. The program screened 328 referrals to TADD between October 1, 2002 and December 30, 2002. Referred defendants were on average 34 years old (Range = 17–71; SD = 10.31) and 83% were male and 17% female. In terms of race and ethnicity, 52% were identified as black, 29% as Hispanic, 18% as white, and 2% were classified as “other.” One hundred sixty-four defendants were rejected and 153 clients were accepted, of which 113 have so far been diverted from jail detention or from the community (where they were facing placement failure, violation or new charges) to community treatment. Rejected and accepted defendants’ baseline demographic, criminal justice and diagnostic information is described in Tables 2 and 3.

Procedure

Program activities and model elements were collected through observation, documents review, monthly attendance at project meetings, individual interviews with model developers and program staff, and stakeholder feedback. Client data was collected and recorded by program case management and KCDA staff following training and with the aid of a coding manual. On referral, basic demographic, criminal justice (charge, history and case resolution from collateral arrest, court and prosecutor files), mental health and substance abuse diagnosis (made by a psychiatrist and extracted from a written report), medication (from community and jail records), source of, and reason for referral, were collected.

TABLE 3
Mental Health and Substance Abuse Diagnoses:
Rejected and Accepted

<i>Psychiatric diagnoses</i>	<i>Rejected</i> (<i>n</i> = 99)		<i>Diverted</i> (<i>n</i> = 113)		<i>Statistic</i> <i>Chi-square</i>
	<i>M/%</i>	<i>SD</i>	<i>M/%</i>	<i>SD</i>	
<i>Mental health diagnoses^a</i>					
Psychotic	.32	.47	.36	.48	.37
Major Affective	.32	.47	.36	.48	.37
Anxiety and Moderate Affective	.04	.20	.10	.30	2.60
Other Disorders	.17	.38	.17	.38	.01
No Diagnosed Disorder	.14	.35	.01	.09	14.10***
Psychotic Symptoms	.35	.48	.42	.50	1.12
Personality Disorder	.22	.42	.16	.37	1.37
<i>Substance use diagnoses</i>					
	<i>(n</i> = 88)		<i>(n</i> = 113)		
Polysubstance	.18	.38	.42	.50	12.94***
Opioid	.11	.32	.18	.38	2.51
Cocaine	.15	.36	.18	.38	.84
Other ^b	.20	.40	.18	.38	.01
No substance use	.35	.48	.05	.23	30.61***
<i>Cooccurring mental health/substance use</i>	.60	.49	.94	.24	34.87***

^aPsychotic disorders included for both groups: schizophrenias, delusional disorders, psychosis NOS, brief psychotic disorder; major affective disorders included for both groups: major depression, bipolar disorder, depression NOS; moderate disorders included for both groups: mood disorder NOS; dysthymia, posttraumatic stress disorder, generalized anxiety disorder; and other (less serious) disorder included for both groups: adjustment disorder, impulse control disorder, intermittent-explosive disorder, and also for rejected, attention-deficit disorder. Personality disorders included for both groups: antisocial, borderline, avoidant, obsessive-compulsive and personality NOS.

^bOther included: alcohol, cannabis, hallucinogens, and inhalants.

*** $p < .001$.

Following the decision to accept or reject, acceptance status along with the type of services recommended for the client by the diversion staff and rejection status with case disposition was recorded by the case management agency for the accepted clients and by the prosecutor's office for the rejected clients. Upon acceptance to diversion community placement, collateral placement information, diagnosis and current medication was recorded by the case management staff. At one month follow-up to the diversion, and monthly thereafter, monitoring staff documented: type, frequency and location of treatment, housing and other services, client participation, toxicology results,

hospitalization, relinkages, sanctions, warrants, absconding and other retention information.

Statistical Methods

Diagnostic information was not consistently available as many cases were rejected prior to a formal psychiatric evaluation either as a result of a paper review of criminal justice records or by a defendant's withdrawal from or disinterest in participation. Mental health diagnoses were available for 60% ($n = 99$), and substance use diagnoses were available for 54% ($n = 88$) of rejected defendants. For accepted clients, psychiatric diagnoses were available to the evaluation at program placement—74% of the accepted sample ($n = 113$). However, in comparing rejected defendants with diagnoses (including “no diagnosis”) versus rejected defendants missing diagnoses and accepted participants versus accepted/diverted participants on demographic characteristics (age, race, gender), arrest history (number of arrests and convictions) and charge type (literal and severity), no significant differences were found per chi-square analyses for categorical variables and 2-tailed t -test analyses for continuous variables. Therefore, in comparing demographic, psychiatric diagnosis and criminal justice variables between refused and accepted or diverted clients, rejected defendants and diverted defendants with mental health diagnoses were used as representative of their respective larger rejected and accepted cohorts. For follow-up of diverted participants, 70 clients were included of the 113 diverted in order to create a consistent cohort that had been diverted into the community for at least six months; follow-up data was collected monthly for each month's activity. Monthly data was aggregated for the first three months, the second three months, and for descriptive purposes, the six month follow-up. Paired t -test analysis was used to test for significance between the first and second three month periods to describe potential differences in client behaviors, program activities or services received during these two postdiversion time periods.

FINDINGS

Baseline Demographic, Criminal Justice, and Processing Characteristics

In comparing rejected and accepted clients on basic demographic and criminal justice characteristics, both groups were equally likely to be male, in their 30s, self-identify as black or Hispanic, and to have

extensive histories of criminal justice involvement and index offenses that ranged from minor to serious and nonviolent to violent. However, rejected clients were significantly more likely to have a violent or procedural index offense, and less likely to have an index drug offense as compared to those accepted for diversion (see Table 2 and the table's index offense footnote).

Seventy-three percent of rejected defendants and 67% of accepted were in jail at time of referral with the remaining 27% and 33%, respectively, referred from the community. As described in Table 2, there were no significant differences between rejected and accepted defendants on time spent from arrest to program referral, referral to disposition (e.g., sentencing for rejected and community placement for accepted) or from the arrest to disposition, whether incarcerated or not during their trial or diversion process. To test for differences for each of these time intervals a within group *t*-test comparison was completed for rejected defendants who remained in the community versus rejected defendants who remained incarcerated during these time periods and those accepted in the community versus those accepted who were incarcerated. There were no significant differences found for: arrest to referral (rejected: $t = .301,158$; accepted: $t = -.068,149$), referral to sentence or diversion placement (rejected: $t = .460,108$; accepted: $t = 1.539,111$), and arrest to sentence or diversion placement (rejected: $t = .008,107$; accepted: $t = .257,109$). Eighty-three percent of rejected defendants were sentenced, dismissed, hospitalized, or re-diverted to another program. The remaining 17% had pending dispositions. Of those 135 who reached a criminal justice disposition, 39% were incarcerated, 24% were referred to other diversion programs (e.g., drug only, adolescent mental health) or if sentenced, a jail reentry program. Twelve percent received a sentence other than incarceration or redirection (e.g., Adjourment in Contemplation of Dismissal or violation), 8% received probation and 4% were hospitalized for psychiatric treatment and restoration of competency to stand trial. Thirteen percent of those rejected were either acquitted following trial or had their cases dismissed. In terms of the sentencing procedures for those who were accepted and diverted, 81% took a plea prior to program placement, consistent with the program's deferred sentencing practice.

Comparing Baseline Psychiatric Diagnosis for Those Rejected and Accepted

As depicted in Table 3, when comparing rejected and diverted groups, there were no significant differences for mental health diagnoses except

that those rejected were significantly less likely to have any psychiatric diagnosis (14% versus 1%). For diverted and rejected defendants, 36% versus 32% presented with a psychotic disorder and 36% versus 32% were diagnosed with a major affective disorder. Forty-two percent versus 32% of those accepted versus rejected experienced psychotic symptoms (all those with a psychotic diagnosis and nine defendants with major affective disorders). Ten percent of those diverted versus 4% of those rejected were diagnosed with a more moderate depressive disorder or an anxiety disorder. Seventeen percent of each of the two groups presented with less serious mental health disorders. In addition to their primary diagnoses, an overlapping 16% of those diverted and 22% of those rejected presented with a personality disorder.

Diverted participants were significantly more likely than the rejected defendants to have a polysubstance dependence disorder (42% versus 18%) and less likely to have any substance use disorder (35% versus 5%). There were no other significant differences. Overall, diverted clients were significantly more likely to have co-occurring psychiatric and substance use disorders than rejected defendants (94% versus 60%).

Community Services Received Postdiversion

Table 4 describes 70 of the 113 diverted clients, placed into community services for at least six months. We compared the first three months to the second three months for various services received, along with urinalysis testing, to describe predicted differences in types of services and housing received. All clients received services during the first three months, however 19% did not receive services during the second three-month period. The 13 clients who received no services had absconded, been dismissed by the program or were returned to jail until a new placement in the community was found. The significant reduction in those receiving individual counseling and medication during the second three months may reflect the inclusion of these clients in the analyses; when excluded from analyses, those engaged in treatment consistently received medication and counseling and at the same level over the course of the six-month period.

In terms of services per overlapping categories, 91% of the cohort received medication treatment in the community; 44% either had the type of medication prescribed changed or the frequency/dose of the medication titrated during this period. Almost 100% of those diverted received counseling during the six months (99% received group treatment, 94% individual counseling). Over the course of the six-month follow-up, 27% received counseling in outpatient settings with a mean average of 72

# Substance Abuse	.01	0-1	.12	.07	0-3	.39	-1.16	.09	0-3	.41
# Psychiatric	.07	0-2	.31	.01	0-1	.12	1.65	.07	0-2	.31
<i>Urinalysis</i>										
Urine Tested	.94		.23	.77		.42	3.78***	.94		.23
# Urine Tests	5.43	0-15	3.80	5.51	0-20	4.78	-.19	10.9	0-26	7.79
Positive Urine	.14		.35	.06		.23	1.93*	.17		.38
# Positive Urine	.37	0-12	1.53	.14	0-5	.71	1.80	.44	0-17	2.12
<i>Housing</i>										
Short-Term/Crisis	.20		.40	.01		.12	3.97***	.20		.40
Inpatient hospital	.03		.17	.00		.00	1.43	.03		.17
Long-Term residential	.63		.49	.53		.50	2.41**	.66		.48
Family/own	.27		.45	.24		.43	1.43	.27		.45
In Jail/unknown ^a	.17		.38	.19		.39	-1.00	.19		.39

^aOf the thirteen clients who were not in community housing during the six-month follow-up period, eight were in jail, and five participant's whereabouts were unknown and warrants were issued.
* $p < .05$, ** $p < .01$, *** $p < .001$.

sessions (Range = 6–64.5, SD = 28.35) and 71% received counseling in a residential setting averaging 74 sessions (Range = 0–129, SD = 26.87); the rates of sessions per month held steady. Eighty-one percent participated in self-help support during follow-up and 49% received other types of treatment in addition to individual or group counseling, such as anger management, clubhouse programming, and family therapy. Participants were more likely to receive clubhouse programming in their second three-month period in the community (this was so as well for analyses that excluded drop-outs). Over half of those in treatment received on-going medical care. Overall, 46% also received vocational, education and other legal assistance. These adjunctive services were often (49%) held off-site while mental health, substance abuse and medical treatment were usually (94%) provided on-site and by the client's primary provider agency.

In terms of acute care substance abuse treatment, 10% received substance abuse detoxification over six months: six clients received detoxification treatment once, while one client was treated in three different facilities. Ninety-four percent of the sample received urinalysis testing, though clients were more likely to receive such testing during the first three months, which may explain the significant difference in positive urinalysis between the two time periods: 10 clients (14%) tested positive during the first three months of treatment while four (6%) tested positive during the second three months. Overall, of the 94% tested for drug use, over 80% remained drug free during a six-month period.

Seven of the 70 clients required hospitalization during the first three months, among them four for psychiatric reasons (e.g., behavioral, suicide risk and medication compliance issues), two for medical reasons, and one for substance abuse detoxification on an inpatient unit. Four new hospitalizations occurred during the second three-month period; three for substance abuse detoxification, and one for psychiatric re-hospitalization. Upon hospital release, these clients returned to their previous community treatment. Acute intensive services, thus, seemed to be utilized on an as-needed basis, but not as the primary service treatment option.

In terms of type of housing, percentages reported are overlapping as clients could receive more than one linkage during the six month follow-up. Twenty percent were linked to temporary housing following initial diversion during the first three months, significantly more than 10% in the second three months. Over the six months, 66% of TADD diversion clients were linked to long-term mental health or substance abuse-oriented residential treatment settings; 27% returned to family or their own housing and received outpatient treatment. While clients

were more likely to receive long-term residential housing during the first three months, those who had been dismissed from treatment or absconded were in residential treatment and thus may account for the change.

Treatment and Diversion Program Retention

Four-fifths of the diverted clients remained in community treatment at six months. When comparing the first and second three month time periods, as shown in Table 5, during the first three months clients were significantly more likely to be dismissed from treatment, be terminated from the diversion program or be moved to another placement (see Table 5). Although clients averaged one placement, some had as many as eight in the six-month period. Case managers described several reasons for change in treatment settings. Four clients who felt that the specific type of treatment they were receiving was ineffective, left the facility (“absconded”), but returned to the diversion team. Seven other clients were dismissed from community residential facilities (e.g., not following rules, having positive urine, evidencing acute psychotic symptoms or aggressiveness secondary to their illness). Fourteen clients changed placements as their initial linkage had been to a short-term crisis or brief substance abuse treatment program (e.g., residential detoxification or rehabilitation). Three clients were moved in order to better match treatment need with treatment being offered.

In terms of program retention goals, a fifth of clients absconded from their community linked treatment services during the first three months from initial diversion, while one additional client absconded during the second three months. At six months, 80% of placed clients were participating in community treatment and 87% were still connected to the diversion program; four clients were awaiting re-linkage to community treatment, nine were terminated from the program, and the whereabouts of five were unknown, for which three were issued warrants.

DISCUSSION

In terms of its limitations, this study is descriptive and noncomparative, thus causality and effectiveness cannot be inferred. This is, in fact, preevaluative with follow-up data presented within the context of detailing the program: how it operates and who it serves. However, as little has been published about diversion of mentally ill felony offenders or adapting coercive substance abuse models to this co-occurring disorders offender population, this study contributes to the postbooking

TABLE 5
Six-Month Program Retention

<i>Program Retention</i>	<i>First Three Months</i> (<i>N</i> = 70)			<i>Second Three Months</i> (<i>N</i> = 70)			<i>Overall Six Months</i> (<i>N</i> = 70)			
	<i>M/%</i>	<i>R</i>	<i>SD</i>	<i>M/%</i>	<i>R</i>	<i>SD</i>	<i>M/%</i>	<i>R</i>	<i>SD</i>	
# Days in Treatment ^a	73.26	1-90	30.01	71.11	0-90	36.11	.64	144.37	1-180	60.24
# Treatment Re-Linkages	.57	0-8	1.33	.29	0-1	.17	3.54***	.61	0-8	1.40
Remained in Treatment	.81		.39	.80		.40	1.00	.80		.40
Dismissed from Treatment	.10		.30	.00		.00	2.77**	.10		.30
In Diversion	.89		.32	.87		.34	1.00	.87		.34
Terminated from Diversion	.11		.32	.01		.12	2.41***	.13		.34

^aThe number of days in treatment includes days spent in hospitalization, and excludes those days spent in jail or time absconded from treatment.

** $p < .01$, *** $p < .001$.

diversion program model literature. Further, the description of client receipt of services, retention and program failure can be inferentially contextualized within what is known from other quasi- or experimental research with substance abuse or mentally ill diverted populations.

While individuals accepted for diversion were more likely to have an index drug offense than those not accepted for diversion, a closer look at their drug use indicates that both had drug involvement. Yet, those who were diverted were characterized by polysubstance dependence disorders, in contrast to those not diverted, who typically had a single substance use disorder. Diverted clients also were more likely to have co-occurring psychiatric and substance use disorders than those who were not diverted. In effect, this highly structured, or coercive, diversion model focused on the somewhat more disturbed clients, especially in relation to substance abuse. Further, while these clients were significantly less likely to have a violent index offense compared to those rejected, 30% did in fact have such an offense.

Once diverted, most TADD clients remained in treatment—only one-fifth of this otherwise potentially problematic population absconded. And the vast majority (all except one) absconded within the first three months after entering the program, consistent with instability and risk for treatment drop-out during the first three months of engagement (50). Of those who remained in the program, almost all received counseling during the six months after diversion, and those who needed medication received it. Four-fifths of these clients participated in self-help support and half received other types of adjunctive treatment such as anger management, clubhouse programming, and family therapy, as well as on-going medical care. Almost half of these clients also received vocational, education and supplemental legal assistance. Two-thirds were linked to long-term mental health or substance abuse-oriented residential treatment settings; and a quarter returned to family or their own housing. In effect, the clients who participated in diversion received a rich service environment consistent with recommendations for implementing a wrap-around services environment for those with co-occurring disorders (23,24).

The impact of this rich service environment may have been demonstrated by the difference in use between the first and second three month period. Keeping in mind that almost all diverted clients had a substance abuse diagnosis upon entering the program, and 94% had co-occurring mental health and substance use disorders, a potentially significant level of abstinence from drug use may have been observed by urine testing. Of the 94% of clients tested for drug use during the six months, 80% remained drug free. A previous study that compared

a small cohort of TADD clients to clients in a less-structured mildly coercive diversion program and to defendants not diverted, similarly suggested that these clients were more likely to access services, remain in treatment longer and have reduced substance use at one-year follow-up (35). Whether these potentially positive indicators are comparatively robust is not possible to ascertain from this implementation process study. Further, questions as to whether potential gains in treatment retention, substance use reduction and psychiatric stability are attributable to the structure of TADD adapted from DTAP (38) or due to other factors like extent of services and impact of the program's structure on staff performance, as studied in other coercive programs for the mentally ill (26,39), can not yet be answered, but will be the focus of future study.

ACKNOWLEDGMENT

Program expansion and evaluation was funded by a grant from the U.S. Department of Health and Human Services, Substance Abuse Mental Health Services Administration, Center for Mental Health Services through the Building Healthy Communities Targeted Expansion grant program (Grant No. SM53923-02). The first author's work was also in part supported by a National Institute of Mental Health (NIMH) Mental Health Services Research postdoctoral fellowship at the Institute for Health, Health Care Policy and Aging Research, Rutgers (Grant No. MH16242-20). The opinions expressed in this manuscript are strictly those of the authors and no endorsement by the funding agencies is to be inferred.

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