

# **Diversion for People with Concurrent Disorders**

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And the Investigative Team of the Diversion-Concurrent Disorders Project

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## Key abbreviations used in this article

CD	Concurrent disorders	PMI	persons with mental illness
OMHLTC	Ontario Ministry of Health & Long Term Care	SA	substance abuse
MHC	Mental Health Court	SUD	substance use disorders
PCD	Persons with concurrent disorders		

### *Executive Summary*

#### ***Rationale***

*Reducing unnecessary criminalization of persons with concurrent disorders (PCD), that is, substance abuse and mental illness through diversion from the criminal justice system into appropriate mental health and addiction services and supports, is a commitment of the Ontario Ministry of Health and Long-Term Care.*

#### ***Research Questions***

- *What barriers to diversion have researchers and others identified for PCD? Conversely, what conditions/strategies encourage optimal access to diversion programs?*
- *What are the constituents of effective diversion programs, including the skills and competencies of service providers?*
- *What criteria should be used to assess the appropriateness, effectiveness and outcomes for Persons with Mental Illness (PMI), who undergo mental health diversion for concurrent disorders?*

#### ***Methods***

*With the Sequential Intercept Model as a framework, a multi-method approach was used that included: a literature review of both published and grey literature in English-speaking countries; site visits and interviews with key informants from several major organizations, agencies and courts that were identified in the literature as especially innovative or effective.*

#### ***Defining Pre- and Post-Charge Diversion***

*Diversion is a process whereby alternatives to criminal sanctions are made available to persons with concurrent disorders who have come into contact with the law. The objective is to secure appropriate treatment without invoking the usual criminal justice control of trial and/or incarceration. Police pre-arrest or pre-charge diversion allows the police to use their discretion in laying charges. Post-charge, pre-arraignment diversion encompasses court diversion/liaison and special dockets/courts such as drug courts or mental health courts. These programs that involve staying charges for eligible offences if the person agrees to treatment.*

**Key Findings**

*Evidence of the efficacy of integrated treatment for PCD is provided by the literature, yet integrated treatment is seriously deficient in the community and thus not available to diversion programs.*

**Barriers to Integrated Treatment for Persons with Concurrent Disorders***Systemic barriers:*

- *Unavailability of integrated treatment for CD*
- *Uncoordinated services across health and criminal justice systems*
- *Staff attitudes and acceptance*
- *Lack of long-term services*

*Situational Barriers*

- *Transportation, housing, isolation, employment*

*Personal/familial Barriers*

- *Stigma, resistance/denial, lack of awareness*
- *Lack of culturally-based or gender-based services*

*Assessment/Identification Barriers*

- *Logistics of dual record keeping*
- *Differing confidentiality mandates*
- *Lack of standards and instruments*
- *Lack of cross-trained staff*

**Constituents of Effective Diversion Programs for Persons with Concurrent Disorders**

- *Planning is facilitated by inter-governmental CD diversion policy framework that includes outcomes*
- *Multiple funding streams need amalgamation*
- *Planning on an inter-organization basis at the local or regional level needs to be supported by planning grants and technical assistance.*
- *Leadership involves a 'boundary spanner' who can effect multi-agency partnership and service agreement*
- *Early case finding using standardized screening instrument enhances post-charge diversion*
- *Pre and post-charge diversion programs need to be culturally- and gender-based*
- *Diversion for PCD must recognize that treatment recidivism will occur and that treatment is a long-term prospect*
- *Extensive and on-going and cross-training of personnel is a hallmark*
- *Personnel with a passion for people, who are flexible and open-minded and from a variety of backgrounds are required*

### **Recommendations:**

**I. Overarching recommendations** include: (a) Best Practices for diversion of PCD involves integrated treatment; (b) PCD should be identified as a priority population for planning and service delivery; (c) inter-ministerial policy frameworks should include development of the required elements of diversion and evaluation, and technical assistance needs to be available to communities; (d) consensus on identification and definition of outcomes is required; (e) planning grants should be provided to develop diversion programs; (f) with the implementation of the Local Area Health Integration Networks, boundaries of Human Services and Justice Coordinating committees, regional forensic programs, courts and police jurisdictions need to be reviewed and aligned; (g) diversion programming for PCD need to be culturally- and gender-based; (h) future research topics include diversion for PCD with personality disorders, juveniles, in-jail, post-release and probation services for PCD.

**II. Pre-charge diversion recommendations** include: (a) capacity for community-based withdrawal management beds should be addressed; (b) police services and community agencies need to develop diversion plans for PCD; (c) police should have regular meetings with diversion partners; (d) monitored safe beds with priority for police ought to be established; (e) changes to the Ontario Mental Health Act be made to deputize all hospital security personnel in Schedule I facilities to retain custody of PCD are required; (f) replication of Janofsky & Tamburello (2006) study be conducted; (g) PCD be encouraged to sign an Advanced Directive to share information in order to facilitate sharing of information between health and criminal justice systems.

**III. A. Post-charge court diversion recommendations** include: (a) public records of arrests should be released daily by police to community CD agencies to facilitate case finding; (b) court support workers need access to collateral criminal justice documents, (c) cross-training of court and community CD staff on diversion processes need to be conducted; (d) case finding through attendance at mental health docket hearings, cells, liaison with duty counsel and remand centres should be implemented, (e) lawyers and court personnel should receive bulletins about the court diversion processes. (f) cross-training for lawyers and court personnel on symptoms of CD and pre-screening procedures should be conducted.

**III.B. Post-charge mental health docket/court diversion recommendations** include: (a) planning grants and technical assistance should be provided to establish MH dockets, (b) cross-training for dedicated judges, justices of the peace and court personnel should be undertaken, (c) Ministry of Attorney General should develop a Practice Memorandum for the establishment of MH courts for serious indictable offences for PCDs; (d) OMHLTC is urged to provide planning grants and technical assistance to establish MHCs for PCD. (e) drug courts clients should be screened for CD and those diagnosed be referred to the mental health court for diversion.

*Broner, Lattimore, Cowell and Schlenger (2004) argue that "...diversion does not automatically create access to services, and can remain in effect a diversion "from" the criminal justice system rather than diversion "to" the treatment system model" (p. 538).*

## Introduction

### Background

This report identifies key issues related to the provision of diversion services to people with concurrent mental health and substance use disorders (PCD<sup>1</sup>). Diversion of people with mental illness (PMI) from the criminal justice system into appropriate treatment is a key theme of the Ontario Ministry of Health and Long-Term Care's (OMHLTC) major planning document *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* (1999), and of the reports produced by the provincial Mental Health Implementation Task Forces in 2002. In 2004, the OMHLTC commissioned the report *Evidence-based practices in diversion programs for persons with serious mental illness who are in conflict with the law: Literature review and synthesis* (Hartford, Davies, Dobson, Dykeman, Fuhrman, Hanbidge et al., 2005) and, in 2006 it released the document *Program framework for: Mental health diversion/court support services*. In 2006, the Centre for Addiction and Mental Health also released *Concurrent disorders policy framework* (2006) and *Concurrent disorders parameters for new MOHLTC funding for crisis-outreach and criminal justice proposals* (Christine Bois, personal communication, February. 5, 2007). All of these documents recognize that an important population in the delivery of mental health services is those who experience concurrent disorders (CD), specifically persons with mental illness (PMI) and substance abuse (SA). Some estimates suggest that as many as 50% of the PMI population also has a SA problem, and are more likely to experience encounters with the criminal justice system than the general population (Substance Abuse and Mental Health Services Administration (SAMHSA), 2002; 2003).

### Concurrent Disorders

The term 'CD' refers to any combination of mental health and substance use disorders (SUD) as defined by the Diagnostic and Statistical Manual (DSM) of Mental Disorders (American Psychiatric Association, 2006). DSM Axis 1 diagnostic categories include major psychiatric diagnoses, such as mood disorders and SA: criteria for CD. The term 'SUD' refers to a habitual pattern of alcohol or illicit drug use that results in significant problems related to aspects of life, such as work, relationships, physical health, and/or financial well being. Substance abuse and substance dependence are two mutually exclusive subcategories (Health Canada, 2002).

### Prevalence of concurrent disorders

In the US, the prevalence of SUDs among people with a mental disorder was 29% compared to 16% in the general population (Reiger, Farmer Rae, Locke, Keith, Judd et

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<sup>1</sup> In this document, the acronym PCD will be used to indicate Persons with Concurrent Disorders (CD). The terms *co-occurring disorders*, *dual disorders*, and *dual diagnosis* are used interchangeably to describe this population. Although precise diagnostic criteria may vary, the most common general definition of CD within the criminal justice system is of a co-occurring major mental health and substance use disorder (SAMHSA 2002, 2003; Health Canada, 2002). Studies in Ontario have determined that three out of four adult substance abusers who seek help have a co-occurring Axis I psychiatric disorder (Dickey & Azeni, 1996; Ross, Lin & Cunningham, 1999).

al., 1990). Recently, Kessler, Nelson, McGonagle, Edlund Frank & Leaf (1996), using data from the 1990-1992 National Comorbidity Study, found a total of 28.8% of the general population aged 15-54 had a concurrent alcohol and/or drug and mental disorder diagnosis (i.e., in the last year). For those with any current SUD, 42.7% reported a concurrent mental health problem while 14.7% of those presenting with a psychiatric disorder showed a concurrent SUD. In Canada, 18.6% of respondents from the 1990 Ontario Mental Health Supplement presented with one or more current alcohol, drug or mental health problems (Offord, Boyle, Campbell, Goering, Lin, Wong et al., 1996). Using the same data, Ross (1995) found that 55% of those with an alcohol disorder also qualified for a mental disorder.

### ***Concurrent disorders and criminalization***

Changes to criminal justice policies in the last two decades have prolonged the involvement of PMI and PCD in the criminal justice system (Council of State Governments (CSG), 2002). In response to community or government leaders' demands to increase quality of life and to reduce crime and fear of crime, many police departments have instituted "zero tolerance" policies, arresting people for offenses such as loitering, urinating in public, and disturbing the peace (Broner, Nguyen, Swern & Goldfinger, 2003); many individuals netted as a result of these tactics were publicly demonstrating the symptoms of untreated mental illness and a concurrent SA problem (SAMSHA, 2003). Also as legislatures in the US have increased the length of prison sentences (and frequently made them mandatory) for the possession or sale of some illegal substances, growing numbers of PMI have been incarcerated - and for longer periods of time (National GAINS Centre, 2001).

Research indicates that PCD experience a high degree of criminalization (SAMHSA, 2003). It is estimated that approximately 5% of jail detainees and 13% of prison inmates suffer from CD (National GAINS Center, 1997). Epidemiological studies examining offender populations suggest even higher rates of CD: 84% of male inmates entering the Washington State prison system met DSM-III-R criteria for Axis I or II mental health disorders and also met diagnostic criteria for SUD (Chiles, Von Cleve, Jemelka, & Trupin, 1990). Among jail inmates, Abram and Teplin (1991) estimated that 80% of 728 randomly selected male detainees in Cook County jail met DSM-III-R criteria for CD. Hiller, Knight and Simpson (1996) found that 80% of probationers charged with SA offences and sentenced to participate in a SA treatment program also had mental health problems. An estimated 50% of female offenders were identified as having both Axis I and Axis II mental health and SA disorders (Jordan, Schlenger, Fairbank & Caddell, 1996).

### ***Diversion***

One response to criminalization of PCD is diversion, a process where alternatives to criminal sanctions are made available to those persons who have come into contact with the law for certain offences (Steadman, Morris & Dennis, 1995). The objective is to secure appropriate therapeutic services without invoking the usual criminal justice control of trial and/or incarceration. Treating the disorder, it is hoped, reduces the likelihood of further offending and the focus is on helping individuals to access community support

and treatment. In a major review of the literature of diversion of PMI funded by the Ontario Mental Health Foundation, the following key themes were identified in the development and maintenance of successful diversion programs: Comprehensive inter-agency agreements and memoranda of understanding (MOU); regular meetings between key personnel from the various agencies; streamlining services through a treatment centre with a no-refusal policy for police cases; a strong liaison person or "boundary spanner" with a mandate to effect strong leadership in the coordination among agencies; awareness of pre-trial diversion options among lawyers and court staff; formal case finding procedures for the early identification of mentally ill offenders, and adequate community resources, including housing; extended mental health treatment combined with active case management (Hartford et al., 2005).

### ***Types of Diversion***

In general, diversion programs take one of three forms: (a) police pre-arrest or pre-charge diversion; (b) court diversion; and (c) specialty courts such as drug courts or MHCs. Pre-arrest diversion allows the police to use their discretion in laying charges. Court diversion programs, on the other hand, are post-charge, pre-arraignment or post-plea programs that involve staying charges for eligible offences if the person agrees to, and completes, treatment.

### ***Drug Courts***

Beginning with the Dade County (Miami, FL) program in 1989 (Finn & Newlyn, 1994), drug treatment courts have established an important presence in the US's criminal court system. In many jurisdictions, drug courts have become the preferred mechanism for linking drug- or alcohol-involved offenders to community-based treatment (National Institute of Justice, 1998). Drug court clients often have other serious physical and mental health problems that can complicate the recovery process (Belenko, 2001; Broner, Franczak, Dye & McAllister, 2001; Peters & Hills, 1997). For example, 40% of Mendocino County (CA) and 20% of the Syracuse (NY) clients reported a need for mental health services at admission to drug court. Based on the Addiction Severity Index, 57% of Salt Lake County (UT) clients had an indication of a psychological problem, and 46% needed treatment for this problem. Nearly 30% of Butler County (OH) clients had received past psychiatric care, as did about 40% of Santa Barbara (CA) and 48% of the Utah participants. In summary, the preponderance of evidence indicates that drug court clients have high rates of mental illness, suggesting that programs need to include of CD services.

### ***The Consensus Project***

The public profile of diversion was advanced markedly in the U.S. by the Criminal Justice/Mental Health Consensus Project (CSG, 2002). To address the numerous issues related to PMI in all phases of the criminal justice system, the CSG collaborated with six major organizations. The resulting Consensus Project Report (URL:<http://consensusproject.org/>) provides 47 policy statements to improve the criminal justice system's response to PMI. Following each policy statement is a series of recommendations that highlight practical implementation steps. The report contains



examples of programs, policies, or elements of state statutes that illustrate jurisdictions' attempts to implement a particular policy statement. A key policy theme of the report is system and services integration for PCD and it specifies that SA expertise is needed to address the large percentage of PCD. By providing an array of services tailored to an individual's needs, agencies are more likely to keep clients engaged, enabling many to develop the skills necessary for them to live successfully in the community (CSG, 2002).

### ***Scope of the Present Project***

In September 2005, the OMHLTC called for the identification of issues related to the provision of diversion services to PCD. Accordingly, this report addresses the following questions:

- What barriers to diversion have researchers and others identified for PCD? Conversely, what conditions/strategies encourage optimal access to diversion programs?
- What are the constituents of effective diversion programs, including the skills and competencies of service providers?
- What criteria should be used to assess the appropriateness, effectiveness and outcomes for PMI who undergo mental health diversion for concurrent disorders?

The primary focus of this project is the diversion of PCD from the criminal justice system. Specifically, it concentrates on pre-charge and post-charge diversion programs, including mental health courts (MHCs) and drug courts. This report does not consider issues relating to the provision of diversion services to people diagnosed with personality disorders. It also excludes juveniles and CD treatment in-jail, on probation and post-release. As per our directives from the OMHLTC, this study addresses issues related to the special populations of rural communities, women, and Aboriginal people.

## **Method**

### ***The Sequential Intercept Model***

Addressing the assessment, treatment, and supervision needs of PCD involves a wide range of systems, institutions, and agencies that often have different missions, values, responsibilities, structures, and resources. Since the literature studied arose from various disciplines and perspectives, it was advisable to adopt a general model of diversion applicable to a wide range of conditions. The Sequential Intercept Model (Munetz & Griffin, 2006) was most appropriate because it envisions a series of points of interception at which individuals can be diverted from the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The five interception points are identified as illustrated in Table 1. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization.

### ***Literature review***

Using the Sequential Intercept Model, the investigators evaluated the published and

unpublished research literature on the effectiveness and outcomes of diversion programs for PCD. To recover peer-reviewed articles from the scholarly literature, various databases and Internet resources were searched (Appendix B). Investigators reviewed articles corresponding to their areas of expertise, assessed the literature for strengths and weaknesses and identified key themes germane to the research questions. A standardized literature appraisal tool (Appendix C) was used, which noted research methods, the number and measures of data, the author's findings, intercept point, and any conceptual or methodological problems. The same method was successfully employed in a previous project on mental health diversion (Hartford et al., 2005).

#### *Site visits, Telephone Interviews and Mail Contacts*

From the literature review, an interview/observation schedule was designed (Appendix D) to obtain supplemental data from site visits (Appendix E) and telephone interviews and mail contacts (Appendix F) with several major organizations, agencies and courts that have been identified in the literature as especially innovative or effective. Since recent literature indicates that diversion for CD requires an integrated and comprehensive approach, the site visits and interviews were an important way to identify "real world" practices and problems. After transcription, interviews were analysed for key themes by a Research Associate. The University of Western Ontario's Office of Research Ethics granted ethical approval for the interviews.

#### *Advisory Committee*

An Advisory Committee met to provide guidance and feedback to the investigators and to maximize inter-ministerial policy uptake. Senior representatives of the Ministries of Health and Long-Term Care, Community and Social Services, community agencies and experts in the field served on the committee that met at the inception of the project and to review the final draft.

<b>Table 1 Sequential Points of Interception for Diverting Individuals with Mental Illness away from the Criminal Justice System (Munetz and Griffin, 2006)</b>	
<b>Point of Interception</b>	<b>Intervention for Enabling Diversion</b>
<b>Intercept #1:</b> Law enforcement and emergency services	Strategies used by police depts.. involving police officers with specialized mental health training or police officers partnering with mental health workers.
<b>Intercept #2:</b> Post arrest initial hearings and initial detention	Assistance at initial court hearings to provide assessment and treatment advice from: <ul style="list-style-type: none"> <li>- mental health workers employed by the court</li> <li>- collaboration with community mental health agency</li> </ul>
<b>Intercept #3:</b> Post-detention initial hearings, jails, courts, forensic evaluations and forensic commitment	Courts with separate docket or court program for persons with mental illness
<b>Intercept #4:</b> Re-entry into community from jails, prisons and forensic hospitals	Assessing, planning, identifying and coordination for transitional care involving housing and treatment
<b>Intercept #6:</b> Community corrections services on probations and parole	Strategies involving probation and parole officers with and community support for individuals specialized mental health training or partnerships with various mental health services
<i>Note: Ideally, it is expected that most people would be intercepted and diverted from the criminal justice at earlier points with decreasing numbers at each subsequent point.</i>	

### **Barriers to Effective Treatment for Persons with Concurrent Disorders**

The existence of separate mental health and SA treatment systems has created sizable barriers to providing appropriate CD treatment (Ridgely, Golman & Willenbring, 1990). In the 1980s, as epidemiologic studies began to show the high prevalence of CD in both clinical and community settings, researchers began to grasp the magnitude of this problem (Regier, Farmer & Rae, 1990). While early treatment strategies focused on identifying the primary disorder and thus the appropriate target of treatment, evidence now supports the view that most CDs are independent disorders and that each requires treatment (Kessler, Anthony, Blazer, Bromet, Eaton, Kendler et al., 1997). Although integrated treatment approaches emerged in the 1990s, most PCD failed to receive effective treatment (Hoff, Rosenheck, Baronofsky, Buchanan & Zonana, 1999). Indeed, recent data show that over 50% of adult PCD received neither SA nor mental health treatment in the past year (SAMSHA, 2002 ) since persistent barriers often make access to integrated services problematic (Herman, Frank, Mowbray, Ribisl, Davidson, BootsMiller et al., 2000; Moos, McCoy & Moos, 2000). Broner et al. (2004) argue that "...diversion does not automatically create access to services, and can remain in effect a diversion "from" the criminal justice system rather than diversion "to" the treatment system model" (p. 538). Thus, in the following section, the most salient barriers to effective treatment of PCD are reviewed and include obstacles arising from systemic causes as well as impediments arising from situational, personal/familial and assessment/identification circumstances.

<b>Figure 1: Barriers to Integrated Treatment and Diversion</b>	
<p><i>Systemic</i></p> <ul style="list-style-type: none"> <li>Specific services not available</li> <li>Services not coordinated</li> <li>Staff attitudes and acceptance</li> <li>Lack of long-term services</li> </ul>	<p><i>Situational</i></p> <ul style="list-style-type: none"> <li>Transportation</li> <li>Housing</li> <li>Isolation</li> <li>Lack of employment opportunities</li> </ul>
<p><i>Personal/Familial</i></p> <ul style="list-style-type: none"> <li>Stigma</li> <li>Resistance/denial</li> <li>Lack of awareness</li> <li>Family problems</li> </ul>	<p><i>Assessment/Identification</i></p> <ul style="list-style-type: none"> <li>Logistics of dual record keeping</li> <li>Confidentiality mandates</li> <li>Lack of standards and instruments</li> <li>Lack of cross-trained staff</li> </ul>

### *Systemic Barriers*

Prior to the 1980s, Drake and Mueser (2000) point out that two CD treatment modalities tended to predominate. In the *sequential treatment* approach, patients were advised to seek treatment in one system before entering treatment in another system. In the *parallel treatment* approach, patients were advised to seek independent treatments in the mental health and SA systems. Further, both approaches placed the burden of integrating services on patients rather than on providers, and ignored the need to modify mental health and SA services for PCD.

Reviews of treatment outcomes for CD (Ridgely et al., 1990; Minkoff, 1989; Osher & Kofoed, 1989; Solomon & Drain, 1993; Miller 1994; Ziedonis, Smelson, Rosenthal, Batki, Green, Henry et al., 2005; Dixon, McNary & Lehman, 1997) noted problems arising from both approaches. For example, since many SA treatment programs were reluctant to admit PMI, most PCD received little or no SA treatment. Poor outcomes and higher costs were documented when one disorder was treated and the other ignored (Dickey & Azani, 1996). Conversely PCD experienced poor outcomes in the mental health system because their SA was undetected or untreated. Thus, the separation of mental health and SA treatment systems often led to situations in which PCD was excluded from both.

The differences between parallel and sequential treatment modalities are themselves part of systemic disjuncture (Ridgely et al., 1990; Ridgely, Lambert, Goodman, Chichester & Ralph, 1998). Frequently denied care in a single system because of the complexity of their disorders, many PCD could not obtain either type of treatment. Also distinct mental health and SA treatment systems have militated against integrated treatment services for PCD (Ridgely et al., 1990). Researchers have identified several key elements of the disjuncture between the two systems: (a) different educational and experiential requirements to work in the two fields (Ridgely et al., 1998); (b) low tolerance in some SA programs for any psychoactive medication (Minkoff, 1991; Ridgely et al., 1998); (c) lack of acceptance of harm reduction approaches in some SA services, which may be necessary for effective engagement of this population (Health Canada, 2000); (d) use of therapeutic techniques that are inappropriate or ineffective for PCD (for example, a sole

reliance on peer counseling) (Minkoff & Cline, 2004); (e) different policy, planning, funding and governance streams (Burnam & Watkins, 2006).

The last point deserves special emphasis. Separate administrative and regulatory structures and funding streams compound the challenges involved in coordinating services and programs for PCD. Mental health and SA treatment systems have been shaped by different traditions of treatment philosophy. Locally, such disjuncture may result in unavailability of specific services or inadequately coordinated services, or lack of long-term services (Ridgely et al., 1990). Moreover, program administrators often lack the clear service models, administrative guidelines, quality assurance procedures, and outcome measures needed to implement CD services and/or have difficulty hiring a skilled workforce with experience in providing CD interventions, and lack the resources to train staff (Drake, Mercer-McFadden, Mueser, McHugo & Bond, 1998). Discrete executive administrative structures tend to discourage the application of consistent standards and instruments for both assessment and evaluation (Haugland, Siegel, Hooper & Alexander, 1997).

### ***Situational Barriers***

Researchers have noted that PCD may experience situational barriers that inhibit their ability to seek help or to continue with an established treatment program. The most prominent situational barrier is housing. Evidence points to extremely high rates of arrest and incarceration among homeless PCD (Koegel & Burnam, 1988; Roth & Bean, 1986). PCD may also be denied housing due to behavior related to SA or mental illness, despite being in the early stages of SA treatment (Drake, Osher & Wallach, 1991; De Leon, Sacks, Staines, & McKendrick, 2000). The lack of affordable transportation and employment opportunities as well, often makes it less likely that PCD will continue an established treatment program (Haugland et al., 1997).

### ***Personal/Familial Barriers***

The literature demonstrates various personal/familial barriers. Although support from families plays a critical role in recovery for PCD, few programs offer psycho-educational services (Carey & Simons, 2000). Family members are often unaware of SA, blame all symptoms on drug abuse, or attribute symptoms of substance misuse to other factors; in fact, PCD themselves often deny or minimize problems related to their disorders (Test, Wallish, Allness & Ripp, 1989) and may believe these substances are helpful in alleviating distress. Alternatively they may be confused about whether the mental illness 'causes' the SA or vice versa because they recognize the immediate effects of drugs rather than the intermediate or long-term consequences (Mueser, Drake & Wallach, 1998). The result is that PCD may lack motivation to pursue treatment (Drake, Essock, Shaner, Carey, Minkoff, Kola et al., 2001).

### ***Assessment/Identification barriers***

Separate funding streams often meant separate information systems and dual record keeping. As well discrete government departments have unique confidentiality requirements and enabling legislation that prevents systems/agencies from sharing information about the same client: a problem when CD treatment is delivered in a parallel

or sequential fashion. Lack of measurement standards and instruments compounds evaluation of treatment and diversion. Not only are credentials different in the mental health and substance abuse systems, clinicians in one system are not trained in the other system; this may result in exclusion from jobs. When trying to introduce integrated treatment agencies lack the resources to train current employees (Clark, Dain, Xie, Becker & Drake, 1998). Appendix G provides a concise description and evaluation of integrated treatment for PCDs.

## **Pre-charge Diversion for Persons with Concurrent Disorders**

### ***Definition***

Pre-charge diversion allows the police to exercise discretion in laying a charge against an offender thought to have a mental illness or a CD (Steadman et al., 1995). These programs incorporate a centralized diversion location, such as an ER or a drop-off facility, where PMI and/or PCD are taken for assessment, stabilization and subsequent referral (Steadman, Cocozza & Veysey, 1999). This form of diversion is the earliest point of interception in the Sequential Intercept Model as the potential arrestee is directed into a system of care without being further involved in the criminal justice system (Munetz & Griffin, 2006). Indeed ERs meet many of the basic criteria for diversion described by Steadman, Stainbrook, Griffin, Draine, Dupont & Horey (2001). Another way in which pre-charge diversion of PCD can occur is for them to undergo medical assessments further to the provisions of the *Ontario Mental Health Act (1990)*, that is, through applications by family or physicians to a court for the ordering of such an assessment, or via their apprehension and transport by police to an appropriate place for such an assessment, pursuant to sections 15, 16, or 17, as the case may be. Most often though pre-charge diversion refers to the following models that involve personnel – either police officers or civilians – who have had substantial mental health training (Deane, Steadman, Borum, Vessey & Morrissey, 1999; Hartford, Carey & Mendonca, 2006).

### ***Types of Pre-charge Diversion Programs***

*Crisis Intervention Teams (CIT)*. Uniformed officers who have had training in mental health issues respond to calls involving mental health and/or substance abuse issues. The program, first implemented in Memphis, Tennessee in 1988 includes within its staff, officers with 40 hours of special training in mental health issues and CD. The Memphis CIT model shows a low arrest rate for police calls involving PMI/PCD, a rapid response time, and frequent referrals for treatment (Borum, 2000). In Canada, the CIT model has been adapted by police departments in cities such as Vancouver (BC), Camrose (AL), Chatham (ON) and Calgary (AL). A related model is the Comprehensive Advanced Approach, in which all officers on the force are given advanced mental health training. This model is sometimes used by smaller police forces (e.g., the Athens-Clarke County Police Department, Georgia) (CSG, 2002).

*Mental Health Professional Co-Responders*. Employed by police departments these personnel are licensed, specially trained mental health professionals who either accompany officers in special teams or respond when called by an officer. An example is

the Birmingham Police Department's Community Service Officer (CSO) Unit, which uses social workers to assist officers in mental health emergencies by providing crisis intervention and follow-up assistance. New CSOs participate in a six-week training program (CSG, 2002). A survey of Birmingham police officers found that more than one-third thought the CSO program was effective in meeting the needs of people with mental illnesses who were in crisis; half thought the program helped keep individuals out of jail and maintained community safety (Bazelon Center for Mental Health. Fact Sheet #6). This model has been adapted in Canada by departments in New Westminster (BC), Gatineau (QC) and Halifax (NS).

*Mobile Crisis Teams (MCT).* Mobile Crisis Teams are composed of licensed mental health professionals who are employed by community mental health organizations and respond to police calls. In some jurisdictions, MCTs can provide transport to a mental health facility. In San Diego's Psychiatric Emergency Response Team (PERT), which has been operating since 1996, both the mental health professionals and the police officers receive 80 hours of training over a 4-week period, and both respond to situations involving PMI. According to the Council of State Governments (2002), the San Diego PERT program has responded to 3,000 calls since 1996, with only 1% resulting in incarceration. A similar model has been adopted in Hamilton (ON).

### ***Pre-charge Literature***

There are few studies specifically addressing pre-charge diversion programs for PCD. The low number is partly due to our search criteria: we excluded articles that dealt solely with pre-charge diversion for PMI, a phenomenon discussed in an earlier report for the OMHLTC (Hartford et al., 2005). It is fair to say that the effectiveness of pre-charge diversion programs for PCD has been vastly understudied. Underscoring the dependence of diversion programs to access to community-based services is Project Link in Rochester, NY (Weisman, Lamberti & Price, 2004). This descriptive study is a university-led network involving health, criminal justice and community services which is reflected in its three models of service delivery: assertive community treatment (ACT), a modified therapeutic community and jail diversion. It features a mobile treatment team, access to a dual diagnosis treatment residence, culturally competent staff and close collaboration with all facets of the criminal justice system including pre-charge diversion for PCD. Clients are enrolled in Project Link and have access to a wide range of services ranging from ER to inpatient. Average daily per client costs decreased from \$73,878 (US) during the year prior to enrolment to \$34,360 (US) during the first year of Project Link.

In 1999, police in 194 US cities were surveyed about their strategies for dealing with PMI (Deane et al., 1999). Of the 174 cities that responded, 68% reported using crisis or drop-off centres. With the high prevalence of SA, associated with mental illness, it does not seem unreasonable to extrapolate this to PCD. Lattimore, Broner, Sherman, Frisman & Shafer (2003) compared pre- and post-booking programs for PCD in terms of participants' characteristics. After studying three pre-booking diversion programs and five post-booking diversion programs, the authors describe several differences between PCD at the time of diversion. In comparison with post-booking diverted PCD, pre-booking diverted PCD: were better educated, experienced greater life satisfaction, had

fewer arrests, were less likely to be involved in treatment, were less likely to use emergency rooms for mental health problems, were less seriously involved with drugs and alcohol, and less likely to have been prescribed psychotropic medication. The authors conclude that, even accounting for between-site variation, the categorization of diversion by pre-booking and post-booking may describe a valid difference in the populations: "In general, it appears that post-booking subjects, as a group, are more functionally impaired than those who are diverted at the pre-booking stage" (Lattimore et al., 2003, p. 58). Outcomes associated with this study are reported in the post-booking section of this report.

Janofsky and Tamburelo (2006) examined diversion to emergency psychiatric evaluations at John Hopkins Hospital during 2002 and 2003. A retrospective chart review of 300 ER records found that 63% of people brought to the ER via an emergency petition were admitted to hospital. Those brought in on a police-initiated petition were significantly more likely to be discharged from ER than those brought in on petitions initiated by a health professional or a judge. Paradoxically, the study found further that persons with behaviour that could have resulted in an arrest were more likely to be involuntarily admitted; yet police were less likely to describe such behaviour. Also police-initiated forms were more often incomplete: an indication for additional training.

## **Post-charge Diversion**

### ***Definition***

Post-charge diversion occurs after a person has been arrested and booked for a criminal offense. Programs occurring at this intercept are characterized by three components: screening, assessment, and negotiation between diversion and criminal justice personnel to create a mental health treatment disposition and to waive or reduce charges or time spent in jail or prison (Steadman et al., 1994). Other critical systems elements of effective post-charge programs are integrated treatment services, key agency meetings, boundary spanners, strong leadership, early identification, and specialized case management (Steadman, Morris & Dennis, 1995).

### ***Types of Post-charge diversion programs***

Two types of post-charge programs exist. In the first, court diversion or court liaison programs involve staying charges for eligible offenses if the person agrees to treatment, while diversion staff work at any stage in the criminal justice process and in the community, providing a case management and monitoring liaison role between community service providers and the court (Broner, Borum & Gawley, 2002). In Ontario, court diversion guidelines are well articulated and do not preclude PCD from the eligibility criteria *per se* (Ontario Ministry of the Attorney General, 2006). However, to implement court diversion requires that CD treatment be available in the community and the absence of such services is a paramount barrier.

The second type of post-charge diversion is MHCs, these may be pre-arraignment or post-plea, that typically feature a primary judge, a specialized team (typically consisting of a designated prosecutor, public defender, and mental health liaison), separate court



calendar, court supervision, and interaction with the mental health treatment system (Goldkamp & Irons-Guynn, 2000; Watson, Hanrahan, Luchins & Lurigio, 2001). Characteristics of MHCs include: (a) all identified mentally ill defendants are handled in a single court/docket, (b) a collaborative team is used which includes a clinical specialist who recommends and makes linkages to treatment, (c) the availability of appropriate clinical placement is assured prior to the judge making a ruling, and (d) the court provides monitoring with possible sanctions for noncompliance (Steadman, Davidson & Brown, 2001). These courts vary in degree of court monitoring and type of sanctions imposed (Griffin, Steadman & Petrila, 2002). While participation in MHCs is voluntary, the MHC's oversight has been described as coercive and as part of a continuum of social control (Monahan, Bonnie, Appelbaum, Hyde, Steadman & Swartz, 2001) - its purpose being to encourage participation in treatment to reduce negative behaviors that, when managed, reduce the risk to public safety.

### *Post-charge Literature*

Post-charge CD diversion literature, while not extensive, ranges from planning guidelines for local communities, cross training in the legal process and in the use of screening instruments for mental health professionals, and descriptions of populations and programs to evaluative studies. Articles focus on the conditions/strategies that encourage optimal access to diversion. Studies described and/or evaluated both pre- and post-charge diversion but are only reported on once.

*Planning.* In developing post-charge diversion programs, a consensus-building infrastructure for stakeholders is recommended. SAMHSA (1999) has described building of successful coalitions, the start-up and implementation processes, funding and sustainability in its document, *The courage to change: Communities to create integrated systems for people with concurrent disorders in the justice system*. Four key elements that support decision-making have been identified: (a) facilitative leadership to initiate and promote the program, (b) networks of key researchers, practitioners, consumers and policy-makers, (c) processes for consensus building and strategic problem-solving, and (d) "...continued creation of multi-dimensional dialogue through information dissemination" (Broner et al., 2001, p.79). In the US, planning grants to develop diversion programs are provided to local networks by SAMHSA. Further, several agencies have sponsored workshops to develop a framework for collaboration (Broner et al., 2001). Broner et al. (2001) also identified four infrastructure elements that a network requires and a nine step problem solving and group consensus model in which associated activities and deliverables are identified for providing treatment to PCD.

*Cross-training.* Since planning networks are normally composed of agencies without a comprehensive knowledge of the criminal justice system, Broner, Lamon, Baryl & Karopkin (2003) have described the post-charge to arraignment process. Education of stakeholders in this problem-solving court model is critical (Denckla & Berman, 2001). Further, few jurisdictions formally screen and assess for CD upon arrest, prior to or following bail, or first appearance, or upon entry to jails although brief 'pre-screening' for previous diagnosis, hospitalization and psychiatric utilization may be done by lay persons such as defense counsel. However, mental health professionals need to screen and assess offenders for CD prior to court diversion, jail diversion and referral to mental

health courts in order to ‘flag’ PCD who need further assessment. Reviews of the many CD screening instruments are available (Peters & Bartoi, 1997; Rush, 2007). Additionally, guides for conducting intake interviews (Brems, Johnson & Namyniuk, 2002) and a concise summary for different levels of staff and the training required are available (Broner, Borum, Whitmire & Gawley, 2002).

*Descriptive Studies.* A recent survey of 116 MHCs in the US identified that nearly one quarter were CD courts (Redlich, Steadman, Monahan, Robbins & Petrila, 2006). In a 2003 study of the Brooklyn felony MHC for PCD, Broner, Nguyen, Swern & Goldfinger followed 113 diverted and 99 rejected PCDs for six months. Diverted offenders were more likely to have a polysubstance dependence disorder while rejected offenders had a single SU disorder. Diverted clients were more likely to have CD and more likely to remain in treatment. Treatment was characterized by wrap-around services recommended for CD. At six months, 94% of clients were tested for drug use and 80% remained drug free.

Not only is integrated treatment for PCD required for post-charge diversion, integrated service systems are also required. Jurisdictions such as King County, Seattle and Bexar County, Texas have re-organized the delivery system to facilitate diversion at each intercept point. King County describes its integrated system among its many partners as consisting of sharing clients, information, planning, and resources (National Gains Centre, 2000). Initial results from September 2003 to February 2006 for Bexar County Jail Diversion Program for CDP show that 3,674 persons were diverted from jail resulting in an estimated \$3.8 million to \$5.0 million savings from within the criminal justice system (Evans, 2006). In Bexar County “...a mental health docket that combined data from ten criminal courts was reengineered”(Evans, 2006, p.1522) and PCD were identified and screened before arriving at the docket and a treatment plan was recommended. Twenty-two agencies participated in planning and implementation of this pre-and post-booking diversion and post-release services (Gilbert Gonzales, personal communication, January 18, 2007). Annual funding for the program and its 146 multi-disciplinary staff is \$8.4 million.

As has been previously stated, drug courts are prevalent in the US and have expanded into Canada. Yet a conundrum exists as many felony offenders with SA also have CD and do not receive treatment for their mental illness. Key elements in a SAMHSA-funded Bronx MHC that delivers services to PCD include: (a) planning meetings with partners. Appendix H includes the *Bronx criminal justice co-occurring disorder network’s change readiness assessment used in the formation of consensus* and also their *Participation, panel expansion, resources and needs* form; (b) screening for CD done by prosecution, case management and jail staff; (c) diversion-plea arraignment and post-plea court monitoring and sanctions. Clients voluntarily sign a program participation agreement with explicit terms, the consequences of which are reinforced by the MH C, monitored through forensic case management and community treatment providers; and (e) joint case conferencing between community and monitoring staff occurs (Broner et al., 2003).

*Evaluation Studies.* Shafer, Arthur & Franczak (2004) evaluated two post-booking diversion programs in Arizona with 248 PCDs who completed baseline measurements; 154 received diversion while 97 did not, and all were followed up at 3 and 12 months. All

PCDs were enrolled in their community's behavioral care system. All PCDs were more stable on mental health, SA, physical health, criminality and housing variables 12 months after diversion than 12 months before. Diverted PCDs used significantly more ER services for mental health and SA but had less frequent access to primary care facilities, and lower scores of depression and anxiety than non-diverted PCD. However, diverted PCDs showed no significant differences on overall arrest rates and re-arrest rates for low level misdemeanours. In addition to several methodological problems, a major weakness was the poorly defined process of diversion in the two communities. But importantly post-booking was considered a safe alternative to incarceration.

From 1997-2001, SAMSHA sponsored a quasi-experimental multi-site study of the effectiveness of three pre-booking and five post-booking diversion models (i.e., police, court, jail) resulting in several papers (Lattimore, Schlenger, Strom, Cowell & Ng, 2002; Broner et al., 2004). Two thousand diverted and eligible non-diverted PCD were identified and assessed at baseline, at 3 (n=1500) and 12 months (n=1300). The mechanism of diversion varied from simple referral to community services to provision of CD treatment on site. This study found that at baseline, subjects differed on most sociodemographic, psychiatric and SA history, criminal history, functioning and quality of life (QOL) characteristics. After controlling for these differences, diverted subjects: (a) used more services (b) had improvements in QOL, (c) had no increased risk for arrest, (d) had reduced jail days; and (e) had increased time in the community than non-diverted subjects. Differences existed between the populations of the pre and post-booking sites. Pre-booking divertees were more educated, more involved with employment and more satisfied with their lives, health and finances. They were also less often arrested, less involved with treatment (ER and psychotropic drugs) and less involved with SA (Lattimore et al., 2003).

In examining cost and cost-effectiveness at four sites, Cowell, Broner and Dupont (2004) report a significant reduction in unadjusted mean total costs for one post-booking diversion site and one non-diversion site. Looking at total criminal justice costs were significantly lower for divertees than non-divertees at three sites, while total treatment costs were consistently higher in divertees than non-divertees (only significantly higher at one site) reflecting the shifting of focus to treatment. Cost-effectiveness also varied considerably across and within sites. Generally, limitations of this study included insufficient sample size, heterogeneity across study groups, variation in program models and relatively small differences in treatment between diverted and non-diverted subjects. Lattimore et al., (2003) concludes, "...while those persons diverted who have been charged with violent offences were not at increased risk for recidivism, diversion is dependent on not just diversion 'from' the criminal justice system but diversion 'to' treatment...and the treatment must be appropriate" (p.538).

Mandated versus non-mandated post-booking CD diversion was evaluated by Broner, Mayrl and Landsberg (2005). In the former, treatment involvement was imposed and monitored by the court along with court-imposed sanctions for non-compliance, while in the latter; there was neither court involvement nor sanctions. Using a quasi-experimental design in this study, diversion clients (33 mandated and 51 non-mandated) were compared to 91 non-diverted offenders at Rikers Island between 1998 and 2002: follow-up occurred at 3 and 12 months. Compared to the other two groups the study

demonstrated that mandated clients spent less time in prison, and that 50% spent more time in the community with 95% receiving either residential or outpatient treatment. However, mental health outcomes were mixed, with some improving, others deteriorating, and, still others showing no change. Not all clients benefited equally. Those who benefited: (a) did not perceive themselves as coerced, (b) had insight into their mental illness, and (c) received more treatment regardless of diversion condition. In the same study, Broner et al. (2005) found that diversion works best for those with less severe problems and mandated treatment improved some outcomes and that programs providing regular counseling and medications (whether on a residential or outpatient basis) reduce recidivism. Further, the study found that lack of broad-based integrated treatment is likely a factor in the less robust effects. Related supports are often required (e.g. child care housing, community supports, etc.). Finally, the study identified that screening for insight into mental illness may enhance diversionary outcomes. Conversely, psychopathy, trauma and symptom severity complicate treatment: treatment needs to be tailored.

A quasi-experimental design was used by Moore and Hiday (2006) to assess the re-arrest rates and re-arrest severity between participants from MHC in North Carolina (n=82) and those from traditional criminal courts (TCC) (n=183). Nearly 2/3rds of MHC defendants completed court supervised treatment. MHC defendants had a re-arrest rate of about half that of TCC defendants and MHC 'completers' had a re-arrest rate of less than one quarter of TCC defendants. No differences in re-arrest severity were found between the two groups. These results highlight the need for MHC participants to obtain a 'full dose' of MHC (Moore & Hiday, 2006).

A retrospective secondary analysis of mental health service utilization and jail data for 368 clients of the post-plea Clark County MHC was conducted from 2000-2003 (Herinck, Swart, Ama, Dolezai & King, 2005) with the following results. On average individuals had 6.3 previous lifetime bookings. Seven categories of MH services and arrests were compared for 12 months pre- and post-enrolment. Post-enrolment, the crime rate was four times lower with 54% having no arrests. Probation violations were reduced by 62%, thus breaking the cycle of crime. "Completers' had lower recidivism rates. Five of 7 MH services showed significant changes at 1-year.

Evaluation of a post-booking arraignment CD court diversion was conducted using a quasi-experimental design (Frisman, Lin, Sturges, Levinson, Baranoski & Pollard, 2006). Participants were recruited from 7 courts with diversion (n=113) and 5 courts without (n=98) in Connecticut. Data was collected at baseline, 3 and 12 months. Inadequate sample size, and adjustment for uneven follow-up times resulted in no positive findings except that the diverted group spent significantly less time incarcerated or re-incarcerated. Diverted clients were arrested at the same rates as non-diverted clients, and enrolment in diversion seemed to mitigate against incarceration because the courts and diversion teams offered additional opportunities. Additionally diverted clients got access to services that would not have been available in jail.

Finally, Peters and Osher (2004) provide a comprehensive review of CD and specialty courts, and summarize evidence-based practices and principles of care for CD. Further, they discuss modification and enhancement of specialty courts for CD that includes

modified drug courts and training issues.

### **Diversion for Specific Populations**

The OMHLTC requested that diversion for three specific CD populations be addressed: (a) women, (b) Aboriginal people, and (c) rural PCD. To those ends targeted literature searches were conducted and site visits were made to the San Francisco's Women's Integrated Skills and Health (WISH) project, the Toronto Gladu Court and a telephone interview with Ms. Victoria Cochran of the Virginia State Mental Health Board was carried out.

#### ***Diversion for Women with Concurrent Disorders***

Abram, Teplin, McCormick & McClelland (2003) found that at jail intake, 12.2 % of women are diagnosed with SMI, almost twice the rate of males and 72% exhibited a concurrent SA disorder. Recent Canadian data indicate that approximately 35 of 354 incarcerated women have special needs and/or mental health problems that require long-term intensive mental health treatment (Correctional Services, Canada, 1999).

Teplin, Abram & McClelland (1996) reported that women in jails have often been victims of abuse and that 33% are diagnosed with PTSD. A 2001 Bureau of Justice Statistics survey found 48% of women reported a history of physical or sexual abuse, and 27% reported having been raped. Other research has estimated that 48-90% of community-dwelling women with CD also have abuse histories (Perkonigg, Kessler, Storz & Wittchen, 2000). Moreover, women entering the criminal justice system may be pregnant or have children in the community with family or in care. According to Bloom, Owen, Covington & Raeder (2003), approximately 1.3 million children have a mother in the criminal justice system. A history of abuse is a known correlate of behavior leading to contact with the justice system (National GAINS Center, 2002). Women victimized as children frequently end up losing custody of their own children due to allegations of abuse or neglect; more than 50% of child abuse and neglect cases involve parental SA (Stevens & Arbiter, 1995).

Of women admitted to SA treatment, those with CD were less likely to be employed and referred for treatment by the criminal justice system than these with no psychiatric disorder (Office of Applied Studies, 2002). Compared with community-dwelling men, women with CD were more likely to seek help in mental health and outpatient settings, have poorer job skills, and suffer from serious physical health problems. Nevertheless, women are disproportionately represented in diversion programs: data from the SAMHSA Jail Diversion Study (Steadman, Deane, Morrissey, Wetcott, Salasin & Shapiro, 1999) identified that 34% of jail diversion referrals are for female offenders, while only 11% of jail detainees and 6% of prison inmates in the U.S. are women. Women are frequently detained on prostitution or drug-related charges (GAINS 2002). Yet, while diversion programs receive a large number of referrals for female offenders, few are tailored to women's specific needs (Veysey, 1997).

Though some correctional facilities recognize that women have different treatment and programming needs than those established for male detainees, many have not adapted

their practices to that end (National GAINS Center, 2002). Veysey (1997) identified several critical gender-specific diversion strategies for women with CD in jail settings that can be applied to diversion programs. These include: (a) parity of mental health services; (b) screening/assessment tools to identify a history of abuse, medical problems and parenting needs; (c) special crisis intervention procedures for abuse and trauma; (d) peer support and counseling programs, to help women to address mental health problems and trauma/abuse, and to re-connect the women with their communities; (e) parenting programs directed at education and practical skills; (f) integrated services; (g) training programs for security, mental health and substance abuse professionals; and (h) outcome measures sensitive to gender-specific treatments. A series of bulletins entitled "*Justice-involved women with co-occurring disorders and their children*" is available (National GAINS Center, 2002) as is a training manual entitled "*Special needs of women with co-occurring disorders diverted from the criminal justice system*" (Hills, 2004). A generic publication *Developing integrated services for women with co-occurring disorders and trauma histories* is also applicable to diversion programs for women (Moses, Huntington & D'Ambrosio, 2004). Bloom and McDiarmid (National Institute of Corrections, 2000) have developed criteria to assist pre- and post-booking diversion programs to assess their policies and programs for gender-responsivity. A pre-booking, gender-specific diversion program for women with CD was developed in Maryland, called the Phoenix Project. In this project, a mobile crisis unit composed of a MH professional, a case manager and a sheriff's deputy respond to police calls. Eligible women who agree to participate are diverted into either emergency crisis housing for stabilization and assessment or to their homes where they will receive case management and clinical interventions. An evaluation component was also built into the SAMHSA funding for the Phoenix Project (Gillece, National Institute of Corrections, 2000). A centralized post-booking assessment program for women with CD has been developed in Cincinnati (OH). There, administrative changes facilitate re-offenders to appear before the same judge, and bail bond and fines were eliminated to prevent jail entry for impoverished women (National Institute of Corrections, 2000).

A process evaluation of a post-booking court diversion program for women with CD in Hartford, CT assessed program fidelity (Pollard, Schuster, Frisman & Chiang, 2006). In this study, outcomes were assessed at baseline (n=59), 6 months (n=59) and 12 months (n=43) and results showed significant decreases in: SA, average number of days using illegal drugs, percentage of women who were homeless, number of arrests, and nights spent in jail. Significant improvement in overall health generally, as well as mental health specifically, was also noted but no significant differences over time in inpatient or ER use was found although participants received significantly more outpatient treatment.

In San Francisco, the establishment and evaluation of a behavioural mental health court was developed and a post-booking, post-plea diversion program specifically for women with CD was recently funded entitled the Women's Integrated Skills and Health Project (WISH Project). Appendix H contains a program description and eligibility criteria of the WISH project. To summarize, women with CD have different personal histories than their male counterparts, and less serious offense backgrounds, and programming at whatever intercept point, should reflect this.

### ***Diversion for Aboriginal People with Concurrent Disorders***

Three factors are especially salient to the diversion of Aboriginal PCD from the criminal justice system: (a) high rates of Aboriginal engagement with the Canadian criminal justice system; (b) high rates of mental illness and substance misuse issues among Aboriginal peoples; (c) a lack of culturally appropriate resources and services for Aboriginals seeking treatment. Incarceration rates of Aboriginal people are five to six times higher than the national average: Aboriginal people comprise 18% of federally sentenced offenders although the general Aboriginal population is only 2.8% of the general population (Correctional Service Canada, 2006). Also evidence exists that Aboriginal communities experience higher rates of mental illness, addiction and suicidal behaviour than the general population (Kishk Anaquot Health Research, 2003). Moreover, Aboriginal peoples who live off-reserve are 1.5 times more likely than the non-Aboriginal population to have experienced a major depressive episode in the previous year and the prevalence of foetal alcohol syndrome/foetal alcohol effects in some Aboriginal communities is higher than the national average (Statistics Canada, 2002). The foregoing factors are compounded by cultural matters, including past government policies, creation of the reserve system, the change from an active to a sedentary lifestyle, the impact of residential schools, racism, marginalization and the projection of an inferior self-image (Kirmayer, Brass & Tait, 2000).

Specific barriers to diversion for Aboriginal PCD include: (a) lack of integrated treatment providers and service programs (Gallon, Gabriel & Knudsen, 2003); (b) a failure to integrate allopathic and traditional healing, such as sweat lodges and healing circles (Walls, Johnson, Whitbeck & Hoyt, 2006); (c) a failure to adequately diagnose or screen for CD (Jonathan Rudin, personal communication, February 2, 2007); (d) a lack of housing and other services for Aboriginal PCD (Jonathan Rudin, personal communication, February 2, 2007); and (e) a critical shortage of adequately trained Aboriginal mental health and addiction professionals. As of 2004, there were only four Aboriginal psychiatrists in Canada (Senate Standing Committee on Social Affairs, Science and Technology Services, 2004). The SAMHSA document, *Culturally competent standards in managed care, mental health services for four underserved underrepresented racial/ethnic groups* (1998) outlines systemic and clinical standards and provider competencies that could be applied to CD diversion programs. Diversion for Aboriginal people depends upon culturally competent CD services being available. While planning for these services is underway in Toronto (Toronto Aboriginal Concurrent Disorders Program, Doug Smith, personal communication August 6, 2006), inclusion of diversion clients is not enunciated.

### ***Diversion for Rural Persons with Concurrent Disorders***

Studies have addressed the broader issue of treatment of rural PCD. Foremost barriers noted are: (a) fewer mental health and SA resources: some studies have shown that rural residents are less likely to receive mental health treatment in both specialty mental health and primary care settings (Hauenstein, Peterson, Rovnyak, Merwin, Heise & Wagner, 2006); and, (b) distance to care: PCD living in rural and remote regions are often forced to travel to receive services (Senate Standing Committee on Social Affairs, Science and Technology Services, 2004). One study has shown that case management for rural PCD

diverted from the justice system improved access to appropriate treatment (Godley, Finch, Dougan, McDonnell, McDermeit & Carey, 2000). Nevertheless, diversion may remain an unlikely option for rural PCD due to insufficient or inaccessible resources in the surrounding region. Successful diversion programs for rural PCD have overcome these barriers through interagency collaboration intended to foster the best use of available community and regional resources (Ridgely et al., 1998). Such collaboration consists of the following steps: (a) inviting all relevant agencies to participate in the collaboration; (b) using mechanisms such as monthly meetings and training staff in the activities of more than one agency to create and maintain a shared knowledge base about CD; (c) ensuring ongoing participation by consumers; (d) encouraging collegiality among service providers across service sectors; and (e) using joint treatment planning, collocation of staff, and training across agencies.

A key challenge in creating diversion programs for rural PCD, therefore, is establishing regional interagency collaboration among geographically scattered agencies and police forces (National GAINS Centre, 2006). An example of successful interagency collaboration in a rural setting comes from a telephone interview with Victoria Cochran of the Mental Health Association of the New River Valley in the state of Virginia and is described as follows. The New River Valley Crisis Intervention Team was developed based on the Memphis model. Currently, the program has 61 trained officers and deputies, drawn from 14 law enforcement agencies across five governmental jurisdictions in rural Virginia. More than 60 regional stakeholders - including police, mental health agencies and consumers - were involved in the project's planning. The program staff consists of a facilitator, a project director and a CIT team training coordinator. A local private hospital with a psychiatric ward has an office staffed with a mental health crisis worker from a participating agency who handles involuntary commitment patients brought in by police. The office also has video-conferencing for assessment by a local magistrate. This program was accomplished with two \$150,000 SAMSHA grants over 2 years (Victoria Cochran, personal communication, July 26, 2006). The same inter-agency group of stakeholders is also creating a post-booking, pre-trial diversion program with a team of: a court liaison, a clinician, a case manager, a trauma counselor, a nurse practitioner, a psychiatrist and an ombudsperson. Team members will visit local jails each morning to identify, screen, and enroll eligible clients. Judges will grant pre-trial release based on participation in the program. Successful completion of the program will lead to charges being dropped. The program is being funded by a \$1.2 million SAMSHA grant (Victoria Cochran, personal communication, July 26, 2006).

### **Site Visits and Key Informant Interviews**

The information derived from the site visits and key informant interviews, conducted as part of this research project, was qualitatively analysed with reference to the project's three research questions. Observation (of courts, case conferences, group work, etc. in action), interviews (of key program personnel), and document collection (from the various programs contacted) were the three main data collection methods. Where consent was given, interviews were taped and transcribed. An interview guide provided a framework for the interviews conducted (Appendix D).



## ***Systemic Barriers***

As a result of the site visits and telephone contacts, barriers that hinder optimal access to diversion programs for PCD were identified, falling within the systemic, situational, personal/familial, and assessment/identification categorizations described above. In the discussion of these obstacles that follows, specific concerns relating to each barrier are set out under italics and precede the strategies identified that encourage optimal access to diversion programming.

*'Disconnect' between the mental health and the criminal justice systems.* To facilitate a coordinated response between these two systems, comprehensive, collaborative consensus building, planning, and cross training (between the systems) involving all stakeholders is critical to the solution. As well, regular and on-going inter-agency collaborative meetings must take place.

*Separate uncoordinated systems.* This problem makes access to treatment less than optimal. In order to streamline services, agencies must clearly define their roles at the outset and identify points of convergence with other organizations. Generally, policies (and funding) must promote integration of services systems so that the client becomes the point of convergence.

*Integrated treatment not occurring.* To achieve an integrated approach, comprehensive case management (or, a centralized team) must form the core of diversionary programs and of problem-solving courts and 'one-stop', comprehensive services, acting together as teams, must be available to the clients served: to accomplish this requires a change in the structure of the services' operations, how cases are transferred, how costs are covered, and how finances are structured.

*Multiple funding streams<sup>2</sup>* This raises accountability issues and requires programs to sustain considerable, costly infrastructure. To address this concern, collaboration (in terms of policies, funding, and resources) is key. Success is seen when funding obstacles are eliminated.

*Funding Terms.* In the U.S., funding is often lacking or insufficient for program sustainability, though it is typically available for planning and short-term implementation purposes. Conversely, in Canada, monies for planning are rarely provided whereas operating implementation funds are generally forthcoming. A comprehensive planning process will serve to identify the barriers and also the solutions to moving forward with diversion programming.

It must involve all stakeholders, that is, law enforcement, mental health, substance abuse and public (and, in the USA, also private) health care providers, together with consumers and families. In the US, funding applicants must also develop and demonstrate a sustainability plan and program research must be used both for 'research' and 'sustainability and development' purposes. Ultimately, streamlining of care generates

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<sup>2</sup> In the US, funding can be at the local, state or federal levels. In Canada, funding usually occurs at the provincial 'Ministry' level (e.g. Health, Corrections, Attorney-General, and the like).

cost savings for governments in reduced police, jail, ER and hospital utilization.

*Early case finding.* Initial case finding and early diversion of eligible PCD as well as longer-term monitoring is seriously obstructed if relevant health authorities and criminal justice personnel encounter difficulties communicating and/or sharing information or records with each other about the clients. Privacy legislation, while ensuring the fundamental rights of PCD to consent to the release of their private information and the requirement to maintain it confidential, must also make sufficient provision (with all necessary and appropriate safeguards) for the timely and uncomplicated exchange of relevant information relating to PCD between the systems and, more particularly, between the stakeholders that deal with PCD.

### ***Situational Barriers***

*Lack of services.* A dearth of services is a significant barrier to diversion (e.g. lack of appropriate, safe housing, an absence of crisis stabilization facilities, deficiencies in insurance coverage, staff shortages (e.g. forensic psychiatrists)) and may impact negatively on liberty issues for PCD (e.g. PCD may be incarcerated for longer periods of time before release due to a shortage of supported housing). In addition to funding related concerns, resource issues can result from a lack of collaboration between systems/stakeholders, or from gaps in cross training.

*Leadership.* Strong leadership is key to successful consensus building and streamlining programming for PCD. Without it, programs for PCD rise and fall on their own energy, without realizing the benefits for clients fostered by an integrated treatment approach or affecting the demonstrable cost savings generated by streamlined services. Robust leadership can emerge from any of the systems addressing the problems of PCD (e.g. criminal court judge, forensic psychiatrist, psychologist or social worker), but generally and ideally requires the person to function in partnership with the person assuming the 'boundary spanning' role.

*Lack of knowledge of concurrent disorders.* Denial of and/or a lack of knowledge about the problems of PCD, within communities and within systems were identified as another barrier. Also the public generally prefers to spend tax dollars on jails rather than on treatment; thus, resistance is also a significant barrier. Educating the program staff and, ideally, also the public is an on-going requirement: content should include basic common knowledge about mental health, substance abuse and concurrent disorders as well as training in crisis intervention and how to work together effectively. A variety of resources, such as centers of excellence, community-based trainers or consultants, educational tool-kits and training programs, sometimes peer-driven or internet or web-based, can provide invaluable training support to fledgling diversion programs as well as police, who often are called upon to deal with PCD in the first instance. Of note, effective training inherently leads to better case finding, one ultimate goal of diversionary programming for PCD.

*Evaluation data.* The assessment of diversion programming for PCD is at a very preliminary stage and much of what data is being collected is being done imprecisely. Setting up a centralized data base and facilitating the sharing of the information collected

is pivotal. A variety of demographic, clinical and criminal justice variables can be tracked. The collection of essential evaluative data must occur from the outset and starts in the initial planning phase.

### ***Personal/familial barriers***

*Recidivism.* Clients not completing treatment or taking more than the allotted time to do so is a challenge for CD programs. Recognizing that recidivism is an outcome measure commonly requested by governments to gauge success, successful programs urge that different evaluative foci or measures be used (e.g., whether the PCD has linked with a treatment program).

*Culturally-based or gender-based programs.* Programs need to recognize and attend to the unique requirements of the populations they serve in order to result in better program engagement (e.g. provide multi-lingual services, offer gender-specific programs).

### ***Assessment and identification***

*Instruments.* The challenges for many programs was to determine whether they should develop their own screening and assessment tools or use one already developed, how they should screen, and what the purposes and parameters of screening should be? Whatever decision programs make regarding the assessment/identification of PCD for diversionary program(s), a wide variety of screening tools and methods are currently used, some that are 'unique' to a particular program and others of that are more broadly-known and -used amongst service providers.

### ***Constituents of effective diversion programs***

Several factors were identified from the site visits and telephone contacts as essential to program effectiveness for PCD. First, every effective diversion program has undertaken and successfully completed three distinct but inter-related phases: that is, organization (or planning), consensus building and implementation. To that end, all relevant stakeholders must be identified and become involved in the process and the community must 'buy-in' to the program. Further, to ensure that support typically also requires the leader and/or the person acting as boundary spanner is typically required to network extensively with 'persons of influence', both within the government and the community, to educate and encourage them about the program's merits. The process requires a problem-solving approach and a collaborative attitude in order to develop the inter-system, inter-agency, and inter-stakeholder trust that is fundamental to success. These mindsets ensure that the program created is individualized to the community's needs and that the multiple systems and services engaged in the programming are integrated. Throughout, both process issues should be resolved and training/educational matters should be undertaken. Upon completing the organization/planning and consensus-building processes, the stakeholders are advised to enter into 'Memoranda of Agreement', addressing a range of issues such as the division of responsibility between agencies and fiscal arrangements, amongst other things.

Constant evaluation is another essential element of effective programs. Stakeholders

must be educated in and required to always work towards a ‘deliverable’ and the on-going measurement of the programs’ worth (specifically, to identify which variables support or are responsible for the efficacy of the program). For US-based programs where on-going operating funds operations may be limited, program sustainability must also be a planning consideration.

Extensive and on-going training and cross training are other hallmarks of successful programs. Sensitivity to ethnicity/cultural and gender differences, a passion for people, flexible personality, and open-minded outlook are all qualities found in staff of flourishing diversionary programs. Ideally, such programs employ persons from a broad range of backgrounds, including a medical director, court liaison coordinators, case managers and specialists (such as psychiatrists), and/or a dietitian, physiotherapist, occupational therapist, and vocational, recreational and housing specialists, endocrinologists, and specially-trained CIT officers. If possible, staff should possess clinical and management backgrounds as well as experience in teaching and training.

Finally, a ‘Best Practices’ program addresses individual client’s diverse needs, such as their ‘basic’ needs (e.g. housing, social assistance), their ‘clinical’ needs (e.g. crisis workers and/or facilities for stabilization, ACT teams), their ‘treatment’ needs e.g. group therapy (such as for trauma recovery or harm reduction), urine/toxicology testing, individual counseling, etc.), and their ‘legal’ needs (e.g. linkage with qualified legal counsel, court reports, risk assessment, etc.). Pre-arrest diversion was identified as a major factor in program success. To this end, all programs highlighted the importance of round-the-clock crisis care being available to police in the community.

### *Evaluation Criteria*

The site visits and telephone contacts made revealed that various evaluative measures are used in assessing the effectiveness of diversion programs for PCD, which are either of a ‘process’ or ‘outcome’ nature and which may conflict. For example, practitioners tend to prefer contextual measures of effectiveness, such as linkage with a treatment program, client’s sense of well-being and hope, and so on. On the other hand, funding sources often request outcome-oriented measurements of effectiveness, such as rates of recidivism, time between arrest and diversion, hospitalization days, and the like. Generally speaking, careful thought must be given to which domains are to be evaluated and how standardization in response is to be obtained.

Program evaluation should occur at several levels, such as at community, systems, and program levels. By way of example, one program, the Bronx MHC, effected all three levels of evaluation: first, stakeholders were asked what their views were on community-wide resources (or lack thereof) and then programs were developed from that information, effectively determining the community’s needs; next, stakeholders’ views towards the population served and satisfaction regarding services provided over time were monitored, providing a systems-level evaluation; and finally, basic statistics of numerous variables (e.g. race/ethnicity, number of arraignments, etc.) were collected, either via court staff or from operational documents (i.e., case management intake forms) providing a program-level evaluation. Also of note, most programs interviewed give satisfaction forms to both the stakeholders and their clients to complete.

## Recommendations

To augment the paucity of evidenced-based practices for diversion of PCD in the literature, we conducted site visits and interviews with persons and agencies involved in the planning and delivery of such programs. It is recognized that the province of Ontario cannot wait for the requisite research in order to take steps to further develop programs to decriminalize CD. We support the recommendations of earlier reports: the Ontario Ministry of Health and Long-term Care's *Program framework for: Mental health diversion/court support services* (2006), the Centre for Addictions and Mental Health's *Concurrent disorders policy framework* and *Concurrent disorders parameters for new MOHLTC funding for crisis-outreach and criminal justice proposals* (2006) (Christine Bois, personal communication, Feb. 5, 2007) and *Evidence-based practices in diversion programs for persons with serious mental illness who are in conflict with the law: Literature review and synthesis* (Hartford et al., 2005). In addition we conclude to the following guidelines emanating from our study.

### *Overarching recommendations*

- **Background.** Since the prevalence of CD is so high, separation of mental illness services and substance abuse services cannot be justified in the light of rigorous scientific studies. Best Practices for all people with CD require integrated concurrent disorder treatment (ICDT). Because this is generally absent in Ontario, accessing such services for people with CD who come into contact with the criminal justice system is problematic.

*#1 Recommendation.* In the light of this systemic lack of ICDT in Ontario, it is recommended that an inter-ministerial, system-wide approach is necessary to develop and fund provincial-wide ICDT services. Treating people with both the mental illness and the substance abuse in an integrated manner represents *Best Clinical Practice*, the ultimate intercept in the Sequential Intercept Model and will lead to a reduction in contact between people with CD and the criminal justice system. When, for multi-faceted reasons, contact between the criminal justice system and people with CD occurs, accessing integrated treatment will be facilitated. It should be reiterated that ICDT programs require recognition that concurrent disorders are chronic, relapsing diseases. This recognition must be made operational: (a) abstinence should not be an eligibility criterion for admission to programs; (b) harm reduction should be the short and intermediate-term goals; (c) consequences for using/abusing should be modified and matched to stages of change in the client; and relapse seen an opportunity to re-engage with services.

*#2 Recommendation:* Persons with concurrent disorders should be identified as a priority population for planning and service delivery.

- **Background.** Currently there is a lag in central planning for the development of diversion services and local planning has been conducted without timely central direction. Lessons learned from contacts and site visits related to planning include the following key elements for success: (1) central planning in which

critical programmatic elements are outlined is foundational, (2) planning grants are critical to fiscal accountability (3) consensus on monitoring of outcomes is necessary, and (4) provincial authorities need to provide technical assistance to assist local agencies in planning and developing diversion services for persons with concurrent disorders.

*#3 Recommendation.* Policy frameworks be developed by the OMHLTC in which required elements of diversion for PCD are articulated and technical assistance be provided to facilitate their implementation.

*#4 Recommendation.* Consensus on the identification and definition of outcomes of pre-charge and post-charge diversion programs is required for research studies and for monitoring programs.

➤ **Background.** The OMHLTC's System Enhancement Funding found many agencies unable to expend new operating budgets in the immediate fiscal year due to a lack of planning capacity.

*#5. Recommendation.* That planning grants be established by the OMHLTC to enable local agencies to develop partnerships and that pre-established established criteria which include sustained evaluation activities be used to evaluate the grant applications.

➤ **Background.** With the implementation of the OMHLTC's Local Health Integration Network's (LHINs)'s new boundaries and devolved responsibilities, other ministerial boundaries may not be contiguous and this could have a direct negative impact on planning and delivery of diversion services for PCDs.

*#6. Recommendation.* That boundaries for local Human Services and Justice Coordinating Committees, regional forensic programs, court jurisdictions, police services, etc. should be reviewed and plans for alignment be developed in PCD diversion programming.

➤ **Background.** Failure to address cultural and gender-based needs in diversion programming leads to dropouts and recidivism.

*#7. Recommendation.* The OMHLTC CD diversion policy frameworks should include the constituent elements of culturally- and gender-based programming.

➤ **Background.** While the MOHLTC has commissioned reports on diversion of people with mental illness and diversion of people with concurrent disorders, several intercepts and sub-populations have not been addressed.

*#8. Recommendation.* That synthesis reports of diversion for people with concurrent disorders and personality disorders, in jails, probation and post-release, and diversion for juveniles be commissioned.

### ***Pre-arrest/Charge***

- **Background.** Three pre-arrest models for persons with mental illness have been developed, described and evaluated and can be adapted to include persons with substance abuse.

*#1. Recommendation.* That the capacity for community-based withdrawal management beds be addressed. Beds should be provided based on the assessment to ensure that police cells are not used for people with CD who are in withdrawal.

*#2. Recommendation.* That using planning grants, local police services or detachments and relevant community mental health agencies should be encouraged to develop jail diversion plans for people with CD; smaller detachments are encouraged to forge regional partnerships. Memoranda of agreements are required to formalize responsibilities, fiscal arrangements, monitoring, etc. between the partners.

*#3. Recommendation.* That police and established diversion partners be encouraged to have regular meetings for case conferences from a systems' improvement/enhancement viewpoint.

*#4. Recommendation.* That planning grants for the establishment of monitored safe beds with priority for police be required in each community. People with CD should be assessed, stabilized and linked with community services. The time that people with CD are allowed to stay in safe beds needs to be specified, e.g., 24-48 hours. Inclusion and exclusion criteria should be developed as well as staffing plans.

- **Background.** Application by a physician or an order by a judge for psychiatric assessment and apprehension by police officers involving Sections 15, 16 or 17 of the Ontario Mental Health Act is a type of diversion. Police are typically involved in the transport of PCD to a Schedule I facility and under Section 33 of the Act police "...shall remain at the facility and retain custody of the person until the facility takes custody of him or her in the prescribed manner."

*#5. Recommendation.* That changes to Section 33 of *The Mental Health Act* be made to allow deputizing of all hospital security personnel in Schedule I facilities for the purposes of retaining custody of persons with CD.

- **Background.** A US study (Janofsky & Tamburello, 2006) has found that findings of imminent dangerousness, which subsequently led to hospital admission, were less likely to be present in instances initiated by police than in instances initiated by a justice of the peace and a judge (under the equivalent of Sections 17, 16 and 21 of The Ontario Mental Health Act).

*#6. Recommendation:* That this study should be replicated in Canada as it may have implications for police training and the use of safe beds.

- **Background.** While police have recently had three hours of in-service education about mental illness, they lack specific information about PCD's

confidential information.

*#7. Recommendation.* The signing of Advanced Directives to consent to release of information in specific circumstances, pending changes to privacy legislation, by persons with CD should be encouraged so that sharing of information between health and criminal justice systems can be enhanced.

### ***Post-Charge: Court Diversion***

➤ **Background.** Ontario's court diversion program is a model for other jurisdictions. However, CD service providers, the legal profession and court personnel likely underutilize the program through lack of knowledge of the program and case ascertainment.

*#1. Recommendation.* That public records of arrests be released daily by local police services to community CD agencies who should review the list and when a client is identified the agency should immediately visit the client with a view to ascertaining whether the individual is eligible for court diversion.

*#2. Recommendation.* That active case finding be supported by ensuring that court support workers have access to collateral information such as records of arrest, synopsis of alleged offense and other court documents.

*#3. Recommendation.* That cross training of CD court and community staff be conducted about the eligibility criteria, and process for court diversion, and liaison with diversion personnel.

*#4. Recommendation.* That case finding by court support workers be encouraged by attendance at mental health docket bail hearings, through access to cells, liaison with duty and defence counsel, and liaison with remand centres, etc.

*#5. Recommendation.* That court diversion programs should develop bulletins/brochures that outline the court diversion program for people with CD (eligibility, services, etc.) and send them to all lawyers and relevant court personnel.

*#6. Recommendation.* That cross training for the legal profession and court personnel on symptoms of CDs and pre-screening procedures be conducted to enhance the case ascertainment of CDs eligible for diversion.

### ***Post-Charge: Mental Health Dockets/Courts***

➤ **Background.** It is unrealistic for all Judges and Justices of the Peace to have knowledge of CD, chronicity issues, medication compliance problems, etc. when such issues are raised within the context of bail applications and applications for psychiatric assessments further to Sections 15 and 16 of *The Ontario Mental Health Act* or motions for assessments of the medical condition of accused



persons under section 672.11 of the *Criminal Code of Canada* (Part XX:1. Mental Disorders).

*#1 Recommendation.* That planning grants and technical assistance be made available for courts to establish a mental health docket in which dedicated judges and justices of the peace preside, the frequency of which be based on volume of cases.

*#2. Recommendation.* That cross training in mental illness for dedicated judges, justices of the peace and court personnel be developed and delivered through basic workshops and web-based continuing education.

➤ **Background.** In Ontario, PCD who are charged with serious indictable offences are not eligible for court diversion. Sufficient preliminary evidence (prior to the McArthur Mental Health Court Evaluation now underway) exists in the literature to support the establishment of mental health courts for PCD.

*#3. Recommendation.* That the Ministry of the Attorney General develop a practice memorandum for the establishment of serious indictable offence felony mental health courts for PCD.

*#4. Recommendation.* That planning grants and technical assistance be provided to courts and agencies for the establishment of MH courts for PCD.

➤ **Background.** Currently the Toronto Drug Court does not screen for CDs. Drug Courts have a unique philosophical approach to offenders with substance abuse that could not easily incorporate integrated CP treatment.

*#5. Recommendation.* That all drug court clients be screened for CDs and those so diagnosed be referred to the Mental Health Court for integrated treatment of CDs.

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## Appendix B

### Literature Review Methodology

To recover peer-reviewed articles from the scholarly literature, free-text searches of the following databases were conducted: Web of Science, Medline, PubMed, PsychInfo, Sociological Abstracts, Cinahl, Criminal Justice Abstracts, Social Work Abstracts, Index to Legal Periodicals and Books, LegalTrac, ProQuest, Dissertation Abstracts International, LexisNexis and The Cochrane Library, among others. To ensure the broadest possible retrieval set and to accommodate variations in controlled vocabulary between databases, the following combinations of the following terms were employed: “diversion,” “diversion programs,” “mental health” “mental health courts,” “substance abuse,” “drug courts,” “dual diagnosis,” “co-occurring disorders,” and “concurrent disorders” using truncation and proximity operators as necessary. After retrieving and evaluating a substantial corpus of texts, their bibliographies were examined to locate relevant items that had not been identified in previous database searches. To recover gray literature, extensive searches of the Internet were conducted for electronically published documents and for references to unpublished items. In addition to search engines such as Google, Internet resources specifically designed to retrieve items from government and academic sites were used; these include Scirus, Infomine, Academic Info, and Teoma. Relevant documents were retrieved from Web sites associated with universities, advocacy groups, information clearinghouses and all levels of government, as well as existing mental health courts and diversion programs throughout English-speaking countries. Also, the project’s investigators drew on their professional backgrounds and knowledge of relevant literature to note additional items of importance, which were incorporated into the review. Finally, to ensure retrieval of the most current items, key Web sites and databases were monitored throughout the course of the project. Ultimately, we recovered 624 items (available in Reference Manager format).

## Appendix C

### Literature Appraisal Tool

<p>Ontario Mental Health Foundation          Ministry of Health And Long-term Care</p> <p><b>Diversion Programs for People with Concurrent Disorders</b></p> <p><b>Literature Review Table</b></p>
Reviewer's name:
Title, author(s) & year:
Country in which research was conducted:
Purpose:
Research method/design:
N(numbers) & measures used or sources of data and evidence:
Rank (assign a numerical value based on the Hierarch of Evidence):
Intercept Point:
Findings:
Best Practices/Recommendations:
Author's conclusions:
Reviewer's comments/contact information:

---

## Appendix D

### Interview Schedule

#### Interview Guide Diversion Project for People with Concurrent Disorders

Data will be collected through semi-structured interviews conducted onsite by the investigators. Consistent with most tenets of qualitative interviewing, the interview guide and questions may be refined or adjusted throughout the data collection phase of the study (Kuzel, 1992). At the beginning of the interview, we will ask basic questions about the program such as the number of persons with mental illness (PMI) diverted each year, and what proportion of these have concurrent disorders. Other specific areas of interest appear below, with examples of relevant questions.

#### Program History

How long has your program been in operation? What were the greatest challenges in implementing the program? How has it changed since its inception? Were concurrent disorders always a key element of the program? In retrospect, how would you have designed the program differently?

Please estimate how many clients with concurrent disorders the diversion program has dealt with in the last year.

Does your program serve any special populations? If yes, please identify them.

#### Program Staffing and Training

Please describe the members of the diversion team. Can you provide us with formal job descriptions for each member of the team? Has your program provided training in mental health issues for all members of the legal team? Has your program provided training in legal issues for all members of the mental health team? Do team members receive training in substance abuse/addiction issues? How many hours does training take? How often is training offered to your department's members? Is more training needed? Please describe the additional training needed.

#### Case Finding and Referral

How do clients become involved in the diversion program? What is the average wait time, from referral to acceptance? Are there times when this is exceeded?

#### Eligibility

Please explain the criteria used (either formal or informal) to determine whether an individual is an appropriate candidate for diversion. Who makes this decision?

Are there any criteria that clients must meet in order to participate in the diversion program?

#### Screening/Assessment

Does your program have any formal screening and/or assessment procedures? If yes, please provide details. How long does screening/assessment usually take? Does it include screening/assessment for both mental health and substance abuse? Who usually does this?

Does your diversion program have on-site psychiatrists, psychologists, or social workers to conduct fitness or competence assessments? To assess psychiatric diagnoses? To provide treatment and follow-up? What on-site services are provided to clients?

### **Relationships with other Agencies**

Does your program have any informal arrangements with other agencies, programs or services within your organization or community? Does your diversion program have formal agreements or memoranda of understanding with community agencies? Can you tell us about them? Can you provide us with copies of relevant policies or memoranda of understanding?

### **Treatment and Services**

What agencies/services are provided to your clients? Have these changed over time?

Should any other services be available? If yes, please explain.

Are your services based on evidence-based practices? If yes, which ones?

What is the average length of your program?

Do your program's diversion policies exist in written form? If yes, could we have a copy?

### **Monitoring**

Has the diversion program established a set of outcomes for clients? What are they?

How does the program monitor clients' outcomes? Could you provide us with copies of the data? What sanctions exist for non-compliance? How do you monitor program effectiveness?

### **Conclusion**

What are the program's key strengths? What are the program's key weaknesses? How might the program be improved? Can you think of any additional comments that might be helpful?

Would you like a copy of the final report, when available? (Please provide a business card so we can send it to you).

Yes

No

Name and address of recipient:

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Kuzel, A.J. 1992. Sampling in qualitative inquiry. In Crabtree, B.F. and W.L. Miller (eds.). *Doing Qualitative Research*. Newbury Park: Sage.

## Appendix E: Site Visits

### 1. San Antonio, Texas

Bexar County/City of San Antonio  
 Crisis Care Center and Diversion Initiatives  
 527 N Leona, 2nd Floor  
 San Antonio, Texas 78207  
 210.223.7233

<p>Leon Evans                  Executive Director                  The Center for Health Care Services                  3031 IH 10 West                  San Antonio, Texas 78201                  210.731.1300  <a href="mailto:L_evans@chcs.hhscn.org">L_evans@chcs.hhscn.org</a></p>	<p>Gilbert R. Gonzales                  Director, Crisis and Jail Diversion                  The Center for Health Care Services                  527 N. Leona, Suite A212                  San Antonio, TX 78207                  210.358.9804  <a href="mailto:ggonzales@chcs.hhscn.org">ggonzales@chcs.hhscn.org</a></p>
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### 2. New York, New York

Rikers Island  
 Bronx County (New York) Mental Health Court  
[http://consensusproject.org/programs/one?program\\_id=410](http://consensusproject.org/programs/one?program_id=410) . Retrieved September 20, 2006).

Brooklyn County (New York) Mental Health Court  
<http://consensusproject.org/mhcp/brooklyn-mhc-planning-outline.pdf> . Retrieved September 20, 2006).

New York State Centre for Court Innovation  
 Bronx Psychiatric Emergency Services  
 Bronx Treatment Alternatives to Street Crime Mental Health Court Project

<p>Lauren Almquist Council of State Governments 40 Broad Street, Suite 2050 New York, NY 10004 Phone: 212-482-2344 Fax: 212-482-2344 Email: <a href="mailto:lalmquist@csg.org">lalmquist@csg.org</a></p>	<p>Charles Amrhein, Clinical Director Bronx TASC Crime Mental Health Court Project 1000 Grand Concourse, Suite 1A Bronx, NY 10451 <a href="mailto:camrhein@nyctasc.org">camrhein@nyctasc.org</a></p>
<p>Nahama Broner, PhD Senior Research Psychologist Center for Crime, Violence and Justice Research RTI International 915 Broadway, Suite 1200 New York, NY 10010 212.353.0315 <a href="mailto:nbronner@rti.org">nbronner@rti.org</a></p>	<p>Judge J. Collins Bronx Mental Health Court <a href="mailto:jcollins@courts.state.ny.us">jcollins@courts.state.ny.us</a></p>
<p>Judge M. Demic Brooklyn Mental Health Court NYS Supreme Court-Kings County 320 Jay Street, Room 25.74 Brooklyn, NY 11201 <a href="mailto:mdemic@courts.state.ny.us">mdemic@courts.state.ny.us</a></p>	<p>Carol Fisler, Director, Mental Health Court Programs And Kelly O’Keefe, Senior Research Associate Center for Court Innovation 520 Eighth Avenue New York, NY 10018 212.373.1691 or 212.373.8095, respectively <a href="mailto:cfisler@courts.state.ny.us">cfisler@courts.state.ny.us</a> <a href="mailto:kmokeefe@courts.state.ny.us">kmokeefe@courts.state.ny.us</a></p>
<p>Lucille Jackson Project Director Brooklyn Mental Health Court</p>	<p>David Kelly, Assistant District Attorney Kings County District Attorneys’ Office, 350 Jay Street Brooklyn, NY 11201-2908 <a href="mailto:kellyd@brooklynda.org">kellyd@brooklynda.org</a></p>
<p>Elizabeth Nevins, Program Coordinator Criminal Justice Project Council of State Governments 100 Wall St, 20<sup>th</sup> Floor New York, NY, 1005 212-482-2320 <a href="mailto:enevins@csg.org">enevins@csg.org</a></p>	<p>Merrill R. Rotter, M.D. Bronx Psychiatric Center 1000 Waters Place Bronx, NY 10461 718.931.0600 Ext: 2264 <a href="mailto:brdomrr@omh.state.ny.us">brdomrr@omh.state.ny.us</a> or <a href="mailto:mrotter@omh.state.ny.us">mrotter@omh.state.ny.us</a></p>

### 3. San Francisco, California

San Francisco Behavioural Health Court  
 City-Wide Case Management Forensics  
 San Francisco’s Women’s Re-entry Centre  
 Women’s Integrated Skills and Health Project (WISH)  
 930 Bryant Street  
 City and County of San Francisco

Kathleen Connolly Lacey, LCSW Assistant Director Citywide Case Management Forensics 939 Market Street, 4 <sup>th</sup> Floor, San Francisco, CA 94103 415.597.8077 Kathleen.Connolly@ucsf.edu	Jennifer Johnson, J.D., Deputy Public Defender Behavioral Health Court Hall of Justice 850 Bryant Street San Francisco, CA 415.310.5512 <a href="mailto:Jennifer.Johnson@sfgov.org">Jennifer.Johnson@sfgov.org</a>
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### 4. Toronto, Ontario

Gladue (Aboriginal Persons) Court  
 Ontario Court of Justice  
 Old City Hall  
 Bay Street  
 Toronto, ON

Toronto Drug Treatment Court  
 Ontario Court of Justice  
 33 Russell Street  
 Toronto, ON M5S 2S1

Jonathan Rudin, LLB, LLM Program Director Aboriginal Legal Services of Toronto 803-415 Yonge Street Toronto, ON M5B 2E7 416.408.3967 x226 <a href="mailto:rudinj@lao.on.ca">rudinj@lao.on.ca</a>	Richard Coleman Coordinator, Toronto Drug Treatment Court 33 Russell St. Toronto, ON, M5S2S1 416.535.8501 x 6331 Richard_Coleman@camh.net
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## Appendix F

### CONTACTS

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<p>Christine Bois Concurrent Disorders Priority Lead Centre for Addiction and Mental Health 613.256.7625 <a href="mailto:csbois@ftn.net">csbois@ftn.net</a></p>	<p>Patrick E. Boyle, LISW, LICDC Director of Implementation Services Ohio SAMI CCOE 1708 Southpoint Drive, Cleveland, OH 44109-1911 216.398.3933 <a href="mailto:Patrick.boyle@case.edu">Patrick.boyle@case.edu</a></p>
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## Appendix G

### Review of Integrated Treatment

The essence of integration is that the same clinicians or teams of clinicians, working in one setting, provide coordinated mental health and SA interventions (Ridgely, Goldman & Willenbring, 1990). Integration is often accomplished through the use of multidisciplinary teams that include both mental health and SA specialists who share responsibility for treatment and cross-training (Carey 1996; Drake, Mercer-McFadden, Mueser, McHugo & Bond, 1998) and it must be supported and sustained by a common administrative structure as well as confluent funding streams (Mercer, Mueser & Drake, 1998). The result for the PCD, is that the services appear seamless, with a consistent approach, philosophy, and set of recommendations; the need for them to negotiate with separate systems, providers, or payers disappears (Mueser & Drake, 2000).

Integrated treatment involves modifications of traditional approaches to both mental health and SA disorder (Mueser, Drake & Miles, 1998). For example, skills training focuses on the need to develop meaningful relationships and to deal with social situations involving SA. Also pharmacotherapy takes into account not only the need to control symptoms but also the potential for abuse of some medications used in treatment. Lastly, SA interventions are modified in accordance with the vulnerability of PMI to confrontational interventions, their need for support, and their typical lack of motivation to pursue abstinence (Ziedonis & Trudeau, 1997).

Systematic planning of diversion programs is required as needs to be supported by planning grants. Boundary spanners are an intrinsic component to successful planning. Stakeholders involved in planning need to be involved in establishing the information and evaluation systems. Pre-booking clients have more functional impairment and less serious offences than post-booking clients. Early case finding is enhanced when: potential participants are familiar with the diversion program, communication of pertinent information occurs between the criminal justice and the mental health systems, cross-training in identification and assessment occurs, and integrated concurrent disorder treatment programs

#### *Elements of Effective Integration*

Numerous models for providing integrated treatment have evolved. Despite variations, programs that have demonstrated positive outcomes have several common service features, beyond the basic commitment to integration of organization and financing mechanisms (Drake, McHugo, Clark, Teague, Xie et al., 1998), as follows:

- They are almost always developed within outpatient mental health programs, primarily because adding SA treatment to the existing array of community support services already available for persons with SMI is more feasible than reproducing all of these services within a SA treatment context (Drake et al. 1998).
- Successful programs are aware that SA is integral to all aspects of the existing mental health program rather than isolated as a discrete intervention (Drake, McHugo & Noordsy, 1993). Treatment subcomponents such as case management, assessment, individual counseling, group interventions, family education, medication

management, money management, housing, and vocational rehabilitation incorporate special features that reflect awareness of concurrent disorders (Mercer-McFadden, Drake, Brown & Fox, 1997).

- They address the difficulty that PCD have in linking with services and maintaining treatment adherence by providing continuous out-reach and close monitoring techniques (Drake et al., 1998). These approaches enable patients to access services and to maintain needed relationships with a consistent program over months and years (Hellerstein, Rosenthal & Miner, 1995).
- Integrated programs recognize that recovery tends to occur over months or years in the community (Drake & Mueser, 1996). Since PCD do not develop stable remission quickly, even in intensive treatment programs but rather, they seem to develop stable remission over longer periods, with a cumulative percentage of approximately 10 to 15% attaining stable remissions per year, in conjunction with a consistent CD program. Successful programs therefore take a long-term, outpatient perspective (Drake et al., 1998).
- Many CD programs recognize that the majority of psychiatric patients have little readiness for abstinence-oriented SA treatments (Test et al., 1989; Carey 1996; Drake et al., 1998; Ziedonis & Trudeau, 1997). Instead these programs incorporate interventions designed to help patients who either do not recognize their SA or do not desire SA treatment become ready for more definitive interventions aimed at abstinence.

Research evidence suggests that integrated treatment programs are more effective than programs based on the sequential or parallel approaches. In a major review of 38 studies on the effectiveness of CD treatment, Drake et al. (1998) note that ten studies found that integrated programs are consistently able to engage PCD in services and to help them to reduce SA behaviors and attain stable remission. This study found that other outcomes related to hospital use, psychiatric symptoms, and quality of life scores were positive but less consistent. A second review in 2004 (Drake, Mueser, Brunette & McHugo) of 26 controlled studies again supported integrated treatment, noted that long-term residential treatment is helpful for PCD who do not respond to outpatient care and recommended research to evaluate tailored treatment and the mix of combinations. Indeed, a growing body of literature has examined the treatment outcomes of PCD in sequential or parallel treatment programs. In general, research has shown that these PCD in these programs have lower rates of completing treatment, shorter stays in treatment, and higher rates of relapse and rehospitalization after treatment as opposed to PCD in integrated programs (Brown, Ridgely, Pepper, Levine & Ryglewicz, 1998; Carroll, Power, Bryant & Rounsaville, 1993; Weisner, Matzger & Kaskutas, 2003; Compton, Cottler, Jacobs, Ben-Abdallah & Sptiznagel, 2003). Conversely, longer stays in residential treatment and participation in aftercare services, including outpatient mental health treatment, have been associated with better post-treatment functioning among PCD for up to five years after treatment (Ouimette, Gima, Moos & Finney, 1999; Ouimette, Moos & Finney, 2000; Ritsher, McKellar, Finney, Otilingam & Moos, 2002; Ray, Weisner, & Mertens, 2005; Ritsher, Moos & Finney, 2002). In summary, individuals who receive a greater number of comprehensive services while in treatment, particularly if the treatment is targeted to their specific needs, show improved outcomes (Marsh, Cao & D'Aunno, 2004; Marsh, D'Aunno & Smith, 2000). Identified components of effective integration are attached as Appendix G. Further, the Co-occurring Centre for Excellence in Ohio

(COCE) has been funded by SAMHSA to update consensus and evidenced-based practices across a variety of settings (including the criminal justice system), provide technical assistance and cross-training to enhance infrastructure development and clinical capacity and implement evaluation measures (Ronis & Lenkoski, 2004; Sacks, Osher, Klitzner & Urban, 2005).

### Components of Effective Integration

*Staged interventions.* Effective programs incorporate, implicitly or explicitly, the concept of stages of change (Prochaska, Velicer, DiClemente & Fava, 1988; Bird, Jinnett, Burnam, Koegel, Sullivan, Wenzel et al., 2002; Marsh, D'Aunno & Smith, 2000). In the simplest conceptualization, stages of change include helping PCD acquire skills and supports for controlling illnesses and pursuing goals, and helping PCD in stable remission develop and use strategies for maintaining recovery. These are predicated on the development of trusting therapeutic relationships. Nevertheless, the concept of stages has proved useful to program planners and clinicians because clients at different stages respond to stage specific interventions.

*Assertive Outreach.* Many PCD have difficulty linking with services and participating in treatment (Grella & Hser, 1997). Effective programs engage PCD and members of their support systems by providing assertive outreach, through some combination of intensive case management and meetings in the client's residence (Rounsaville, Kosten, Weissman & Kleber, 1986; Ray, Weisner & Mertens, 2005). For example, homeless PCD often benefit from outreach, help with housing, and time to develop a trusting relationship before participating in any formal treatment. These approaches enable PCD to gain access to services and maintain needed relationships with a consistent program over months and years (Young & Grella, 1998).

*Motivational Interventions.* Many PCD are not ready for abstinence-oriented treatment (Friedmann, Lemon, Durkin & D'Aunno, 2003). They may also lack motivation to manage psychiatric illness and to pursue employment or other goals. Effective programs therefore incorporate motivational interventions that are designed to help clients become ready for illness self-management (Havassy, Alvidrez & Owen, 2004; Bird, Jinnett, Burnam et al., 2002). Motivational interventions involve helping the individual identify his or her own goals and to recognize that not managing one's illnesses interferes with attaining those goals (Knudsen, Roman, Ducharme & Oser, 2003).

*Counselling.* Once PCD are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Effective programs provide some form of counselling that promotes cognitive and behavioral skills at this stage. The counselling takes different forms and formats, such as group, individual, or family therapy or a combination (Osher & Drake, 1996). One study found evidence that a cognitive-behavioral approach was superior to a 12-step approach (Moos et al., 2000).

*Social Support Interventions.* In addition to helping PCD build skills for managing their illness and pursuing goals, effective programs focus on strengthening the immediate social environment to help them modify their behavior. Activities, which recognize the

role of social networks in recovery from CD (Gil-Rivas & Grella, 2005), include social network or family interventions.

*Long-Term Perspective.* Recovery occurs over months or years in the community. PCD do not usually develop stability and functional improvements quickly, even in intensive treatment programs, unless they enter treatment at an advanced stage (Brown, Monti, Myers, Martin, Rivinus, Dubreuil et al., 1998). Instead, they tend to improve over months and years in conjunction with a consistent program for CD. Effective programs therefore take a long-term, community-based perspective that includes rehabilitation activities to prevent relapses and to enhance gains.

*Comprehensiveness.* Learning to lead a symptom-free lifestyle often requires transforming many aspects of one's life—for example, habits, stress management, friends, activities, and housing. Therefore, in effective programs attention to SA as well as mental illness is integrated into all aspects of the existing mental health program and service system rather than isolated as a discrete SA treatment intervention (Drake et al., 2001). Inpatient hospitalization, assessment, crisis intervention, medication management, money management, laboratory screening, housing, and vocational rehabilitation incorporate special features that are tailored specifically for PCD. For example, hospitalization is considered a component of the system that supports movement toward recovery by providing diagnosis, stabilization, and linkage with outpatient interventions during acute episodes (Grella, Gil-Rivas & Cooper, 2004).

*Cultural Competence.* Effective programs will recruit, retain and promote a diverse staff who are representative of the demographic characteristics of the population. Further staff should receive continuing education in culturally and linguistically appropriate service delivery. Special efforts should be made to engage PCD who may be unwilling or unable to accept available program models (Peters & Osher, 2004).

## Appendix H

### San Francisco's Women's Integrated Skills and Health (WISH) Project

Description: We selected one innovative program directed to the needs of female with CD involved with the criminal justice system for a site visit. The WISH project is associated with the County of San Francisco's Behavioral Health Court, a problem-solving, post-booking, pre-plea court whose primary goal is to divert PCD defendants from jail to appropriate treatment services. The WISH program is for women diagnosed with an Axis I mental health disorder in need of intensive mental health treatment. The program also accepts women CDs; in particular, WISH targets women who have substance misuse disorders combined with major depression, generalized anxiety disorder, and PTSD. Clients who have been placed on probation are also accepted. All participants in the WISH program are monitored by the Behavioral Health Court and must make regular court appearances. The WISH program is funded by a three-year SAMHSA grant that includes a strong evaluation component. It was developed with consumer input and has a low client-to-case manager ratio, 13:1. The start-up phase that began in October 2006 will enroll 26 clients in year 1, and 10 clients in years 2 and 3. In conjunction with San Francisco's Citywide Case Management Forensic Unit (which provides three dedicated case managers), the WISH Project offers the following services: (1) assessment and treatment planning; (2) discharge and re-entry planning; (3) crisis intervention including gender-based trauma services; (4) individual therapy; (5) life skills and parenting training; (6) medication prescription and monitoring; (7) employment skills training; (8) support for activities of daily living; (9) social, interpersonal and leisure time skill training; (10) education and support for clients' families; and (11) links to other support services such as Children of Incarcerated Parents Program.

#### (With Permission) Women's Integrated Skills and Health Project (WISH Project)

930 Bryant Street  
City and County of San Francisco

### THE WISH PROJECT ELIGIBILITY GUIDELINES

#### Mission Statement

The mission of the WISH project is to ensure that women offenders with co occurring disorders are diverted from jail and provided with access to high quality, culturally appropriate integrated mental health and substance abuse treatment. Women who qualify for treatment in the WISH project will be closely monitored by Behavioral Health Court in a therapeutic courtroom setting. Once clients have consistently and successfully engaged in mental health and substance abuse treatment and have strong ties to the community mental health system, WISH project clients will be able to resolve the criminal matter and graduate from the program.

#### Project Description

The WISH Project is for women diagnosed with an Axis I mental health disorder (as defined in the *Diagnostic and Statistical Manual of Mental Disorders IV-TR*) who are in need of intensive mental health treatment. The program will also address substance abuse issues that

often accompany serious mental illness. In most cases, women in WISH have pending criminal cases that have not yet been adjudicated. WISH will also accept clients who were previously placed on felony probation. The grant will allow for two clinical social workers from Citywide Case Management to provide intensive case management to this population.

WISH will also address the needs of a group of women who are dually diagnosed but are higher functioning and thus, are not prioritized for services. This particular population usually suffers from disorders such as Major Depression, Generalized Anxiety Disorder, Post-Traumatic Stress Disorder that do not necessarily cause functional complications that accompany diagnoses such as Schizophrenia and Bipolar Disorder. While the co-occurring substance abuse disorder complicates the clinical picture, these women are more likely to be able to make individual therapy appointments, manage their own medications, and maintain their living situations. Women who require less outreach will be served by this grant through a case manager dedicated to linking women to community mental health and bridging the gaps between different agencies within San Francisco's community mental health system.

All of the women in WISH, regardless of the intensity of the need for services will participate in Behavioral Health Court and attend regular court appearances. If clients are successful in mental health treatment, the criminal case will be resolved in a way that takes into account both the seriousness of the mental illness, and the seriousness of the charges.

The WISH Project is not a statutory right, nor is it a diversion program which guarantees a dismissal of charges after successful completion of the program. Every client who participates in the WISH Project does so voluntarily. At any time, a client can opt out of participation and return to the traditional criminal process. Each client's progress will be monitored by the court, and by the treatment team. Because of the individualized assessment of each client "successful completion" of the program is determined on a case by case basis.

### **Eligibility Criteria**

Eligibility for WISH is based on three factors: (1) psychiatric diagnosis; (2) seriousness of the criminal charges; and (3) amenability to treatment in the community mental health system. In addition to those factors, the court looks carefully at the nexus between the mental illness and the behavior that led to the arrest when considering a client for admission. For each case presented to the court, the Behavioral Health Court team reviews the underlying facts and makes an individual determination. The following criteria are intended as guidelines. In certain limited circumstances, clients who fall outside of the guidelines are admitted into Behavioral Health Court by agreement of the public defender, the district attorney and the judge.

#### **(1) Diagnostic Criteria**

The majority of clients in the WISH Project will be diagnosed with an Axis I disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders IV-TR. Most clients will have a persistent mental illness such as schizophrenia, schizoaffective disorder, bi-polar disorder, major depression or post-traumatic stress disorder and co occurring substance abuse disorder. Clients referred to the Linkage case manager may suffer less severe symptoms but require dual diagnosis treatment as well.

Clients with an Axis II diagnosis of mental retardation or other developmental disability are diagnostically appropriate for Behavioral Health Court and will be accepted if appropriate services are provided in the community mental health system. The WISH Project will also

consider clients with an Axis II Borderline Personality Disorder if the illness is substantially compromising the client's functioning. Citywide provides Dialectical Behavior Therapy at the clinic and can accept a small number of women who fall into this category.

## **(2) Criminal Charges**

Behavioral Health Court will not accept the following clients absent extenuating circumstances:

### A. Current Charges

1. Felony or misdemeanor sex crimes including failure to register
2. Felony or misdemeanor domestic violence offenses
3. Murder, attempted murder, voluntary manslaughter
4. Felony or misdemeanor weapons offenses
5. Assault resulting in great bodily injury
6. Felony arson
7. Any offense defined as a "serious felony" listed in PC 1192.7

### B. Prior Convictions

1. Murder, attempted murder, voluntary manslaughter
2. Forcible sex offenses
3. Felony or misdemeanor sex offenses involving a child
4. Torture
5. Kidnapping
6. Felony Arson
7. Mayhem

## **(3) Amenability to Community Mental Health Treatment**

Beyond the diagnostic criteria and the criminal charges, the court assesses the appropriateness of Behavioral Health Court as a solution in each case based on the client's amenability to community mental health treatment. The court will consider the following factors:

- A. Primary diagnosis of major mental illness and psychiatric stability
- B. Motivation for treatment and for BHC
- C. Assessment of the benefit that BHC will have to the client
  1. Will the client benefit from the therapeutic environment of the court setting?
  2. Will the court's sensitivity to the mental illness improve compliance?
  3. Will participation in BHC versus a traditional court reduce recidivism?
- D. History of treatment in the community including compliance
- E. Review of Jail Psychiatric Services treatment history, including assessment conducted at the time of arrest
- F. Risk assessment by a psychiatrist or psychologist ordered by the court pursuant to 730/1017 in exceptional circumstances



## Appendix I

### Brooklyn Mental Health Court Description (Used with permission)

<p style="text-align: center;">B R O O K L Y N M E N T A L H E A L T H C O U R T</p>	<p><b>FACT SHEET</b></p>
<p>360 Adams Street Brooklyn, New York 11201 718.643.5503 fax 718.643.8724</p>	<p><b>Brooklyn Mental Health Court</b></p> <p>The Brooklyn Mental Health Court is a specialized court part that seeks to craft a meaningful response to the problems posed by defendants with mental illness in the criminal justice system. Addressing both the treatment needs of defendants with mental illness and the public safety concerns of the community, the Brooklyn Mental Health Court links defendants with serious and persistent mental illnesses (such as schizophrenia and bipolar disorder) who would ordinarily be jail- or prison-bound to long-term treatment as an alternative to incarceration.</p> <p><b>Goals</b></p> <ul style="list-style-type: none"> <li>• Improve the court’s ability to identify, assess, evaluate and monitor offenders with mental illness;</li> <li>• Use the authority of the court to:             <ul style="list-style-type: none"> <li>Link offenders with mental illness to appropriate mental health treatment and supports;</li> <li>Ensure that participants receive high quality community-based services;</li> <li>Engage participants in treatment;</li> <li>Hold participants accountable for their actions;</li> </ul> </li> <li>• Create effective linkages between the criminal justice and the mental health systems; and</li> <li>• Improve public safety by reducing recidivism of offenders with mental illness.</li> </ul> <p><b>Key principles</b></p> <p>To achieve these goals, the Brooklyn Mental Health Court has adapted several operating principles that have proven successful at other problem-solving courts:</p> <ul style="list-style-type: none"> <li>• Detailed screening and assessment to create individualized treatment plans;</li> <li>• Frequent judicial monitoring to keep the judge engaged with the defendant and emphasize for the defendant the seriousness of the process;</li> <li>• Accountability of the defendant for his or her actions; and</li> <li>• Coordination of services with a broad network of government and not-for-profit service providers to address interrelated problems that defendants face, including substance abuse, homelessness, joblessness, and serious health problems.</li> </ul> <p><b>Criminal justice eligibility</b></p> <ul style="list-style-type: none"> <li>• Felonies: All nonviolent felonies are eligible. Felonies involving assault, robbery and burglary are considered on a case-by-case basis. Other violent felonies are presumed ineligible.</li> <li>• Misdemeanors: All offenses are eligible, but the court is not intended for offenders who would spend only a short amount of time in jail. Misdemeanor offenders must be willing to accept a 12-month treatment mandate and a potential jail sentence of up to one year.</li> </ul> <p><b>Mental health eligibility</b></p> <ul style="list-style-type: none"> <li>• Offender must have a major mental illness such as schizophrenia, bipolar disorder, major depression or schizoaffective disorder;</li> <li>• Evaluation must indicate that offender’s mental illness contributed to criminal activity; offender is willing to enter treatment; treatment may help the offender lead a crime-free life in the community;</li> <li>• Offender may have, but does not need to have, an alcohol or substance abuse disorder;</li> <li>• Offender with a personality disorder but without a major mental illness is ineligible;</li> </ul> <p style="text-align: right;"><b>MORE</b></p>

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	<ul style="list-style-type: none"> <li>• Conditions such as cognitive impairment, mental retardation, developmental disabilities, brain damage and dementia are not eligible unless there is also a major mental illness;</li> <li>• Offender must be 18 or older;</li> <li>• Offender who refuses to enter into treatment, cooperate in the assessment process or cooperate in interviews with service providers may be found ineligible.</li> </ul> <p><b>Screening process</b></p> <p>A social worker on the court's clinical team conducts a psychosocial assessment and a consulting psychiatrist conducts a psychiatric evaluation, resulting in two narrative reports that give a detailed description of the candidate, including the nature of his or her mental illness, family history, education and employment experience, substance abuse history, history of treatment, and key elements of a proposed treatment plan. Mental health eligibility is determined by the court's clinical director, a licensed social worker.</p> <p><b>Identification of potential cases</b></p> <p>Cases are referred by judges, defense attorneys, and the prosecutor. Cases where competency to stand trial has been questioned are calendared in the court once the defendant has been found fit for trial.</p> <p><b>Decision to participate</b></p> <p>Participation is entirely voluntary for the offender. The prosecutor has a right to deny participation to any eligible candidate. Final decision is made by the judge.</p> <p><b>Program structure</b></p> <ul style="list-style-type: none"> <li>• <i>Treatment mandate:</i> Misdemeanor offenders: 12 months; first-time felony offenders: 12-18 months; predicate felons: 18-24 months. Individualized treatment can include mental health treatment, substance abuse treatment, intensive community-based case management services and supported housing.</li> <li>• <i>Plea:</i> A guilty plea is required to participate, but the plea can be vacated upon successful completion.</li> <li>• <i>Graduation:</i> Participant must comply with treatment mandate and cannot commit any new offenses. Misdemeanants and first-time nonviolent felony offenders: guilty plea vacated and all charges dismissed. Predicate felons and first-time violent felony offenders: felony guilty plea vacated with misdemeanor plea remaining in place; violent offenders will receive probation.</li> <li>• <i>Jail/prison alternative for program failure:</i> Sentences are determined on case-by-case basis at the time guilty plea is taken and program participation begins.</li> <li>• <i>Clinical and judicial monitoring during program participation:</i> All participants appear in court every two weeks for the first three months, then monthly thereafter. More frequent court appearances are required for noncompliant participants. The clinical staff meets with participants on every court date and more frequently as needed. The clinical staff communicates with all service providers at least weekly; providers give written monthly reports as well. The clinical team summarizes all input from providers in written summary reports at every court appearance.</li> <li>• <i>Rewards, sanctions and clinical responses:</i> Compliance is rewarded with praise from the judge, less frequent court appearances and certificates for completing quarterly phases. Noncompliance may result in clinical responses (such as a change in treatment or other services), admonitions from the judge, more frequent court appearances and other sanctions that the judge feels may help motivate compliance. Short stays in jail are possible.</li> </ul> <p>The Brooklyn Mental Health Court is a joint project of the New York State Office of Mental Health, the New York State Unified Court System and the Center for Court Innovation.</p>