FINAL-STAGE DIVERSION

A Safety Net for Offenders With Mental Disorders

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Diversion programs for offenders with mental disorders typically focus on early intervention as the ideal avenue for redirecting individuals from the criminal justice system. Although this approach is advantageous in many respects, sentenced offenders on probation have few available options for the intensive treatment provided by such programs. ATLAS, a mental health court in Dallas, Texas, adopts a reverse approach in selecting individuals on the brink of probation revocation. When compared to a matched sample, ATLAS participants had lower rates of rearrest within 12 and 24 months of their intake, supporting the efficacy of final-stage diversion programs as a pragmatic alternative to early interventions.

Keywords: diversion; mental health court; offenders with mental disorders

A grave but unintended effect of deinstitutionalization is that thousands of individuals with mental disorders, formerly treated in the mental health system, have been relegated to the criminal justice system. According to Althouse (2010), the availability of state hospital beds shrank dramatically from 600,000 in the 1960s to fewer than 40,000 today. The dearth of inpatient and community-based mental health services contributes to the criminalization of these individuals with the use of jails and prisons as de facto treatment facilities (American Psychiatric Association [APA], 2004; Lamb & Weinberger, 2005). Because the criminal courts are poorly equipped to effectively manage this population, specialized programs were developed for offenders with mental disorders. Among the interventions, diversion programs were implemented to redirect offenders with severe Axis I disorders from or coordinate efforts within the criminal justice system.

Munetz and Griffin (2006) detailed the sequential intercept model as a conceptual framework for understanding the stages at which mental health and other social interventions could be introduced. From an early intervention perspective, they described preventive, community-based care as the "ultimate intercept"; at-risk individuals would be identified and provided treatment *before* their involvement in the criminal justice system. The sequential intercept model places a heavy emphasis on early intercepts to minimize involvement of persons with mental disorders in the criminal justice system and to attain

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more "bang for the buck" (Munetz & Griffin, 2006, p. 548). Diversion programs at these early stages typically include mobile crisis teams equipped to respond to individuals with mental disorders and pretrial diversion to community-based treatment.

Diversion can also occur after formal involvement with the criminal justice systems with the twin goals of an alternative to incarceration for persons with mental disorders and minimizing their future involvement with criminal activities and consequent arrests. Among the most publicized diversion programs, mental health courts (MHCs) usually operate as a midstage intercept and generally include court- and jail-based services. Finally, late-stage intercepts focus on reentry into and maintenance within the community of persons with mental disorders. These programs include specialty probation caseloads and Forensic Assertive Community Treatment programs. Although many articles have been published noting these programs' effectiveness over the past few decades (see, e.g., Case, Steadman, Dupuis, & Morris, 2009; Christy, Poythress, Boothroyd, Petrila, & Mehra, 2005; Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Herinckx, Swart, Ama, Dolezal, & King, 2005; Lamberti, Weisman, & Faden, 2004; Moore & Hiday, 2006; Skeem & Eno Louden, 2006), research has just recently begun looking at the mechanisms through which this change occurs (Case et al., 2009; Skeem & Eno Louden, 2006).

Mid- and late-stage diversion programs have come under fire for failing to address the root of the problem. For example, Seltzer (2005) argued that the reactive goals of these programs redirect treatment and resources away from the community needs to those "'lucky' enough to become involved with the criminal justice system" (p. 581). Although it is true that many community mental health programs are underfunded, this zero-sum-game argument appears tenuous because additional funding is being provided at the state and federal levels to support initiatives using jail diversion and reentry programs to reduce incarceration of individuals with mental disorders (Council of State Governments, 2010). Examples include the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 and its reauthorization (Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008). Furthermore, as observed by Lamb and Weinberger (2005), midstage diversion programs save substantial costs for incarceration and rearrests, thereby making better use of money spent upfront. In light of the criticisms, we submit that effective diversion programs at any stage are warranted on economic and humanitarian grounds (also see Miller & Perelman, 2009). Nonetheless, we acknowledge Seltzer's "lucky" argument. The Bureau of Justice Statistics (BJS) reported 4.3 million individuals on probation in 2008 (Glaze & Bonczar, 2009). Based on previous BJS research, Ditton (1999) estimated that the prevalence of mental disorders among probationers is 16%. Assuming a stable prevalence rate, approximately 688,000 probationers have mental disorders. As of November 2010, the Consensus Project's local program database identified 101 programs dealing with adults with mental disorders. Imposing a maximum caseload of 40 clients (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006), an upper-bound estimate yields approximately 4,000 diversion opportunities for 688,000 with severe mental illnesses. Therefore, the opportunity for diversion is likely to be affected by chance (i.e., 1 in 172) simply because of very limited availability.[1]

Another criticism levied at mid- and late-stage diversion programs involves the voluntariness of this option. It has been argued that the Fourteenth Amendment requires that everyone receive equal protection from the laws with no specific subgroups being singled

out for different treatment (Redlich, Hoover, Summers, & Steadman, 2010). However, the U.S. Supreme Court has clearly held that specific subgroups, such as sexually violent predators (*United States v. Comstock*, 2010), can be identified and treated differently based on their clinical status. The Court has also singled out certain groups by extending the Eighth Amendment safeguard against cruel and unusual punishment to prohibit the execution of individuals with mental retardation (*Atkins v. Virginia*, 2002) and juveniles (*Roper v. Simmons*, 2005); individuals with severe mental disorders, if unable to understand the nature of and reason for execution, are also excluded from the death penalty (*Ford v. Wainwright*, 1986). As a more compelling argument, Litschge and Vaughn (2009) noted that pleading guilty is a common prerequisite for most diversion programs and that defendants with mental disorders may have diminished capacities (Redlich, 2005) to make rational decisions. From a clinical perspective, this issue must be clearly addressed within the context of informed consent.

Given the already staggering numbers of inmates with mental disorders—approximately 310,000 in 2000 (Lamb & Weinberger, 2005)—and that probationers with mental disorders are more likely to be rearrested or revoked than probationers without (Dauphinot, 1997), late-stage interventions constitute a useful and cost-effective alternative for diverting high-risk probationers from high-cost incarceration (APA, 2004). Miller and Perelman (2009) provide strong support for the use of MHCs and diversion programs as "partial relief" (p. 123) for the problems facing offenders with mental disorders.

MHCs have transitioned in objectives and populations, marking a chasm between what have been characterized as the first and second generations (Griffin, Steadman, & Petrila, 2002). The first generation MHCs focused on minor offenses by offenders with mental disorders; they mostly served preadjudication misdemeanants and relied on community-based supervision (Redlich, Steadman, Monahan, Petrila, & Griffin, 2005). The second generation, stimulated by federal funding from the Bureau of Justice Assistance, shifted focus to major offenses; they typically served postplea offenders (misdemeanants and felons) with both court- and community-based supervision (Redlich et al., 2005). The final-stage diversion program—described in this article—could be conceptualized as a third generation or, alternatively, a conceptually flawed approach (i.e., waiting too long to provide the needed treatment). The first two generations addressed their respective goals of (a) keeping "noncriminal" persons with mental disorders *outside* the criminal justice system and (b) managing serious criminals with mental disorders more effectively *within* the system. In contrast, the final-stage model, described herein as the ATLAS program, was established for *failed* probationers with mental disorders. Given the resources available, these probationers had already received some combination of mental health services, intensified probation, or, occasionally, formal involvement in a midstage diversion program. Because of their multiple failures to meet the conditions of probation, these probationers were taken into custody and faced the revocation of their probation with subsequent incarceration.

The most pressing issue is whether the final-stage model can be justified on conceptual and ethical grounds. When first approached about the project, our initial impression was negative. Waiting for repeated failures to provide the necessary interventions seemed wrongheaded and even cruel. Moreover, it is reasonable to ask whether these probationers failed to use available resources or whether the available resources failed these probationers.

Our reflections during the last 24 months have led us to a different perspective. In most large municipalities, court-ordered community mental health resources for offenders with mental disorders are stretched far beyond their capacities. It often makes little sense to fault mental health services, which have virtually no budgetary control over their resources. It often makes little sense to fault probationers with mental disorders for not "getting better" based on the available services. The final-stage model is a triage approach offering the most intensive services to probationers with mental disorders in the greatest need. However, these services are available to only a small minority of those with mental disorders likely to be revoked and incarcerated. Still, intensive treatment for even a small number of individuals represents an ethical imperative.

ATLAS, A FINAL-STAGE PROGRAM

ATLAS provides intensive supervision and support in the context of a final-stage program by combining the resources of court staff, designated probation officers, mental health treatment providers, and other ATLAS participants. The most unique feature of ATLAS is its safety net approach: These individuals have failed repeatedly to comply with the orders and conditions of probation. On the brink of revocation, they are referred to ATLAS for intensive supervision and a final opportunity to avoid incarceration. ATLAS, short for "Achieving True Liberty and Success," accepts felony probationers with mental disorders. Described further in the method section, ATLAS differs from many diversion programs by the intensity rather than type of provided services. During the initial intervention, weekly court appearances oversee multiple weekly contacts with mental health providers and probation staff.

The original ATLAS program was initiated for felony probationers with mental disorders in 2004. After creating a partnership with a service provider network in 2006, an enhanced ATLAS program (i.e., the current program described above) was implemented with its own dedicated case managers. All participants must pass a 30-day probationary period in which the judge and treatment team assess individuals' suitability for the court and motivation to follow treatment recommendations. Participants who did not complete this 30-day period were not eligible to participate in the ATLAS program.

An important feature of the ATLAS program is its integrated approach to treatment interventions. On a weekly basis, the judge reviews with the treatment team (e.g., mental health case managers and probation officers) each participant's progress with a strong emphasis on early success. During the initial phases of treatment, participants appear in court weekly with members of their treatment team to acknowledge successes and provide constructive approaches to problematic issues. In addition, ATLAS offers peer support groups for its participants.

ATLAS focuses primarily on rewarding positive behavior within a supportive group environment. Improvements are rewarded by decreased reporting and fewer drug screens. Substantial successes carry very tangible rewards affecting their original sentences, such as reductions in community service hours, court fees, and fines. From a role model perspective, the most successful participants serve as mentors to other participants. In addition, participants are provided with certificates of achievement for certain milestones and, on completion, recognized in a special graduation ceremony. Like all diversion programs,

sanctions are sometimes necessary (e.g., detention in jail), but the primary emphasis is increased services to meet clinical (e.g., therapy) and compliance (e.g., home visit) needs.

A final-stage diversion program can constitute a rational and ethical model of intervention for failed probationers likely to be incarcerated. However, a pivotal issue—as with all intervention programs—is its efficacy. Therefore, the primary purpose of this study was to investigate the effectiveness of the ATLAS program, when compared to a matched sample of probationers. As an archival study, we focused on rearrests at both 12 and 24 months intervals, extending the interval used in most MHC outcome studies. In addition, we compared ATLAS graduates with failures as an important step in establishing the effectiveness of an MHC (Moore & Hiday, 2006).

METHOD

Archival data on ATLAS participants included those admitted to the program from February 2006 to June 2008. The 2006 date was chosen to ensure that all participants were involved in the enhanced program. At the time of data collection in July 2009, nearly half ($n = 42$) of ATLAS participants had graduated from the program (hereafter, the "graduate group"), with 14 remaining current ("ongoing group") and 37 having been unsuccessfully discharged ("failure group"). Reasons for discharge can include absconding, probation revocation, or transfer to substance abuse or mental health facilities.[2]

Demographic and criminal information was obtained from state databases by staff at the Dallas County Community Supervision and Corrections Department. Health care information was obtained from ValueOptions, a behavioral health organization under contract with ATLAS to provide mental health and substance use treatment. According to procedures approved by the University of North Texas Institutional Review Board, no names or personal identifiers were recorded.

The current investigation used a contrasted groups design with matched samples. The ATLAS group was matched to a traditional criminal court (TCC) group on variables composed of demographic, mental health, and arrest histories. This information was used to ensure that participants in the matched sample were also provided with mental health and substance abuse services while on felony probation in Dallas County during the same period of time. Importantly, that both ATLAS and the TCC group had access to similar resources in the community (Wolff & Pogorzelski, 2005) because of their enrollment in ValueOptions.

Risk and needs scores were calculated using the Texas Case Classification and Risk Assessment Tool (11 weighted questions from the Wisconsin Risk/Needs Assessment, normed on the Texas community supervision population). Although research was not available on the Needs scale, the Risk scale has demonstrated strong predictive validity among felony offenders (Bryl, Fabelo, & Nagy, 2006). Risk scores are based on 8-point categories to establish minimum (0–7), medium (8–14), and maximum (≥15) levels of risk. In contrast, needs scores utilize 15-point categories for minimum (0–14), medium (15–29), and maximum (≥30) levels of need.

With one exception, participants were matched exactly on Axis I diagnosis, gender, and ethnicity and closely on age (±5 years).[3] After diagnosis and demographic variables, we matched participants on the same level for risk scores and within one level on needs scores.

TABLE 1: Descriptive Data of the ATLAS and Traditional Criminal Court (TCC) Samples

		ATLAS		*TCC*				
Characteristic	*Criterion*	M	SD	M	SD	t	p	*Cohen's* d
Age	±5 years	33.12	9.08	32.42	9.22	0.52	.60	0.08
Risk[a,b]	Same level	22.09	7.36	21.19	6.57	0.87	.39	0.13
Treatment need[a,b]	±1 level	32.02	8.25	27.78	8.14	3.49	.001	0.52

a. Risk and Need scores were obtained with Texas Case Classification and Risk Assessment Tool (based on Wisconsin Risk/Needs Assessment). For risk, scores of 0–7 are minimum, 8–14 are medium, and 15+ are maximum. For need, scores of 0–14 are minimum, 15–29 are medium, and 30+ are maximum.
b. Risk and need scores were missing for 4 ATLAS participants.

However, four ATLAS participants lacked risk and needs scores and were matched on the other variables. Health care claims were used to ensure TCC participants had been utilizing mental health resources during the same timeframe as ATLAS participants.

An unavoidable limitation of the matching involved final-stage comparisons. Clearly, the most appropriate match would include TCC offenders who had been revoked. However, relevant outcome data would not be available. Therefore, probationers with similar probation violation histories were chosen to parallel ATLAS participants (Wolff & Pogorzelski, 2005). If anything, this limitation may militate against significant findings, given that the TCC sample had not yet reached the revocation stage.

RESULTS

Each sample was predominantly male (55 of 93, or 59.1% both samples) and African American (ATLAS, 62.4%; TCC, 61.3%) felons, with smaller percentages of European Americans (ATLAS, 31.2%; TCC, 32.3%) and Hispanic Americans (6.5% both samples). Both samples were identically matched for Axis I diagnoses: bipolar disorder (39 or 41.9%), major depressive disorder (24 or 25.8%), schizophrenia (15 or 16.1%), and schizoaffective disorder (15 or 16.1%). Risk scores were comparable between the groups with less than a 1-point difference (see Table 1). For needs scores, the ATLAS sample was substantially higher ($d = 0.52$) than their TCC counterparts. This difference resulted in a higher percentage of ATLAS than TCC being classified in the maximum needs group (60.2% and 45.2%, respectively), $\chi^2(2, N = 182) = 5.97$, $p = .05$.

Although other dependent variables could be considered (e.g., gainful employment, clinical outcomes), a primary consideration of diversion programs is rates of arrests at 12- and 24-month intervals. Further consideration of mechanisms of change or alternative outcomes was limited by the archival design. Unless otherwise noted, assumptions of all statistical tests were met. We also examined differences between the ATLAS graduate group ($n = 42$) and the ATLAS failure group ($n = 37$), who did not complete the program. The ongoing group ($n = 14$) of participants still in treatment was excluded from these comparisons.

REARRESTS

At the 12-month interval, the odds ratio of 1.79 suggested that the TCC sample (22.6%) was more likely than the overall ATLAS sample (14.0%) to be arrested on new charges;

TABLE 2: Differences in Rearrest for ATLAS and Traditional Criminal Court (TCC) Samples at 12- and 24-Month Intervals

	Proportions Rearrested				
Comparison	*Group 1*	*Group 2*	χ^2	p	*OR*
12 months					
Overall: ATLAS vs. TCC	14.0% of 93	22.6% of 93	2.30	.065	1.79
ATLAS: Graduates vs. failures	9.5% of 42	24.3% of 37	3.13	.039	3.05
Graduates: ATLAS vs. TCC	9.5% of 42	23.8% of 42	3.09	.040	2.97
24 months					
Overall: ATLAS vs. TCC	28.2% of 39	42.9% of 42	1.89	.085	1.91
ATLAS: Graduates vs. failures	18.2% of 22	46.7% of 15	3.46	.032	3.94
Graduates: ATLAS vs. TCC	18.2% of 22	42.1% of 19	2.82	.047	3.27

Note. OR = odds ratio. For all comparisons, Group 1 is the first group listed. Based on our prediction that ATLAS would reduce rearrests, one-tailed *p* values are provided.

however, the χ^2 was nonsignificant (see Table 2). A more relevant analysis involves whether the ATLAS graduate group produced a substantial and significant reduction in rearrests (9.5%) when compared to the ATLAS failure group (24.3%) and their TCC counterparts (23.8%). As summarized in Table 2, very large and similar effects were observed, with odds ratios of 3.05 and 2.97, respectively.

A crucial issue is whether treatment gains constitute only a temporary gain. Two trends were observed when extending the observation period to 24 months (see Table 2). First, rearrests increased substantially for both the ATLAS (14.0% to 28.2%) and TCC (22.6% to 42.9%) samples. Second, the ATLAS graduate group maintained a much lower rate of rearrests (18.2%), which produced large odds ratios when compared to the ATLAS failure group (46.7%, OR = 3.94) and their TCC counterparts (42.1%, OR = 3.27). Despite this largely positive finding, the increase from 12 to 24 months in the percentage of rearrests for the ATLAS graduate group is concerning.

An important consideration is the amount of time before rearrest. With their intensive treatment and heightened scrutiny, ATLAS participants appear to have front-loaded their rearrests. Although both groups evidenced similar rearrest rates within 3 months ($n_{ATLAS} = 5$ and $n_{TCC} = 6$), these early reoffenders accounted for a greater proportion of those eventually rearrested at 12 months within ATLAS than within TCC (38.5% of 13 for ATLAS; 28.6% of 21 for TCC). In addition, ATLAS participants were rearrested sooner than their counterparts. At the 12-month interval, the 13 ATLAS participants ($M = 136.62$ days, $SD = 83.90$) were rearrested approximately 6 weeks earlier than the 21 TCC participants ($M = 178.00$ days, $SD = 123.52$). Because the assumption of homogeneity of variance was not met, Welch's *t* tests were used, which yielded a nonsignificant difference with a moderate effect size, Welch's $t(31.63) = -1.16$, $p = .25$, $d = 0.38$. The difference in time before arrest became more pronounced though still not significant when the ATLAS graduate group ($M = 63.25$ days, $SD = 42.91$ days) was compared to their TCC counterparts ($M = 166.30$ days, $SD = 137.90$ days), Welch's $t(11.81) = -2.12$, $p = .06$, $d = 0.85$. This difference may be reflective of the increased supervision received by ATLAS participants within the program and a diminished ability to slip through the cracks.

TABLE 3: Identifying Successful Graduates in ATLAS

Predictor	B	SE	*Wald*	df	p	*OR*
Time in ATLAS	–0.002	0.001	1.20	1	.27	1.00
Needs	–0.08	0.05	2.75	1	.10	0.93
Risk	–0.06	0.05	1.23	1	.27	0.94
Age at intake	0.003	0.03	0.01	1	.93	1.00
Male	0.30	0.55	0.30	1	.58	1.35
Psychotic disorder	0.49	0.58	0.70	1	.40	1.63

Note. OR = odds ratio. Reference categories for gender and diagnosis were female and mood disorder, respectively.

SUCCESSFUL GRADUATES

For the purposes of this study, *successful graduates* were defined as graduates from ATLAS without any rearrests at the 12-month interval ($n = 38$). Cognizant of the modest sample, we explored the use of potential predictors, entered simultaneously into logistic regression. They included background (age, gender, and time in ATLAS) and clinical variables (mood vs. psychotic disorder, risk score, and needs score). The successful graduates group was composed of 38 participants that were compared to 35 in the failed group (2 failed participants were excluded from analyses because of missing risk and needs scores). Although the full model was significant compared to the constant-only model, $\chi^2(6, N = 73) = 13.96$, $p = .03$, Nagelkerke $R^2 = .23$, its overall success rate of 72.4% was modest. Moreover, none of the independent variables were demonstrably predictive on their own (see Table 3). Because of the limited availability of other data (e.g., severity of impairment, treatment readiness, and comorbid substance abuse), the modest success is not surprising. The absence of a psychotic disorder appears to be potentially predictive for successful graduates (OR = 1.63), although it did not achieve significance.

DISCUSSION

Archival MHC studies are a far cry from randomized clinical trials with their random assignment of carefully assessed participants to rigorously designed treatment protocols. Despite our efforts to match samples, the study is limited by (a) available assessment measures to ascertain treatment readiness (e.g., the transtheoretical model; Prochaska & DiClemente, 1982), (b) archival design, and (c) a single, albeit important outcome variable (rearrests). With these limitations, we are unable to evaluate what components of the ATLAS programs were the most effective. As happened with psychotherapy research (Kazdin, 2005; Kopta, 2003; Latessa, Cullen, & Gendreau, 2002), researchers are beginning to identify "what works" in effective diversion programs (see, e.g., Redlich, Steadman, et al., 2010).

TREATMENT EFFECTIVENESS

Despite the study limitations, graduates of this final-stage model achieved major reductions in rearrests. Rather than a random assignment to experimental and treatment-as-usual groups, the current investigation utilized ATLAS as an experimental group that had already failed the treatment-as-usual condition and was on the brink of probation revocation and

TABLE 4: Two-Year Rearrest Rates of Felony Offenders in Travis and Dallas Counties

	Travis County	*Dallas County*			
Risk Level	*Combined*	*Combined*	*ATLAS*	*TCC*	*Logit d*[a]
Minimum	.22	—	—	—	—
Medium	.29	.36	.00	.57	–0.18
Maximum	.46	.36	.32	.40	0.23

Note. TCC = traditional criminal court. Too few minimum offenders are included in the Dallas County sample to get representative rearrest rates. Travis County data are from Bryl, Fabelo, and Nagy (2006).
a. Logit *d* = logged odds ratio, comparing Travis County and combined Dallas County.

incarceration. An argument could be made that success for the ATLAS program should be measured against the 100% failure rate for the treatment-as-usual condition. From this perspective, 18 of 39 (46.2%) ATLAS participants had graduated from the program and had not been rearrested in 24 months.

The ATLAS program appears to reduce rearrests when compared to the matched treatment-as-usual group (12-month OR = 1.79, 24-month OR = 1.91), although the χ^2 values indicate only a nonsignificant trend. Interestingly, the rearrest rates of both ATLAS and TCC groups compare favorably to 12-month outcomes in traditional MHCs including Clark County, Washington (46%), and Broward County, Florida (48%), although these first-generation programs dealt only with misdemeanants (Christy et al., 2005; Herinckx et al., 2005). As noted by Fisler (2005), the aims of felony MHCs differ from misdemeanant MHCs. When compared to felony offenders in nearby Travis County, Texas (see Bryl et al., 2006), the 2-year rearrest rates of medium- and maximum-risk individuals seem comparable (see Table 4).

An important difference between the current study and past investigations is that mental health and/or substance use interventions were being utilized by both the experimental and treatment-as-usual groups from the same health care provider (i.e., ValueOptions). Whether treatment-as-usual groups receive any behavioral health interventions is unaddressed in the majority of MHC outcome studies (e.g., Christy et al., 2005; McNiel & Binder, 2007; Moore & Hiday, 2006). Because of the intensity of the ATLAS supervision, however, it is possible that their participants were referred more frequently for clinical services. Rather than seeing any increase in services as a potential confound, we would submit that it represents an important feature of the ATLAS program.

ATLAS graduates are less likely to be rearrested than ATLAS failures or the TCC treatment-as-usual group. Although the rates of rearrests are lower, they parallel Moore and Hiday's (2006) rates for MHC completers (26.9%) and noncompleters (70.0%). On one hand, the current comparison between graduates and failures is unfair. The TCC group is not afforded the same opportunities to eliminate its "bad actors" who are failing through a lack of compliance with or benefit from available treatment. On the other hand, all intervention programs must be allowed an opportunity to eliminate individuals deemed inappropriate for treatment. It is important that graduates of the ATLAS program maintained their much lower rates of rearrests for an extended period of 24 months.

THE ATLAS PROGRAM

This final-stage, essentially "last-chance" ATLAS program provides a highly integrated approach to both court-based management and community-based supervision. The weekly

treatment team meetings involve updates on progress for each individual on the docket, with collaborative decision making regarding participants' status and advancement in the program. The intensive supervision, reward-based model, and graduation ceremony are more akin to treatment programs than TCC, while maintaining the supervisory oversight and sanctions inherent in community supervision.

The first 3 months of the ATLAS program constitutes a critical stage in its treatment intervention. A disproportionate number of arrests (38.5% of arrests within 1 year, compared to 28.6% for TCC) occur during this period. However, ATLAS participants who succeed in the first 3 months have a 90.9% likelihood of not being arrested at 12 months. Although intensive supervision and services are provided throughout involvement in the ATLAS program, these percentages suggest that possibly more interventions may be warranted during the initial months. This approach parallels the treatment of high-risk or in-crisis therapy clients, with intensive treatment giving way to supportive care once stability has been achieved.

Most MHC research (e.g., Christy et al., 2005; Cosden et al., 2003; Herinckx et al., 2005; Moore & Hiday, 2006) utilizes a 12-month outcome in evaluating the success of their interventions. The limited data on the ATLAS program raises concerns about whether 12-month follow-ups are sufficient. The rates of rearrests nearly doubled for the second 12-month period for the overall ATLAS program (14.0% to 28.2%) and the ATLAS graduate group (9.5% to 18.2%). To minimize recidivism, diversion programs might consider relapse prevention or continued care following discharge. For example, on completion of ATLAS, participants whose probation has not ended are transferred to probation officers carrying a specialty caseload of offenders with mental or developmental disorders. Because the intensity of treatment appears to be a factor in reducing recidivism, maintaining a high level of treatment is likely to be protective in the months and years following discharge.

The current study suggests further research using risk scores and other variables to identify felony probationers at great risk of failure. However, we recommend the use of multiple risk measures (e.g., actuarial and structured) with an examination of their relative usefulness (see, e.g., Mokros, Stadtland, Osterheider, & Nedopil, 2010). At present, the 30-day trial period appears to have merit in testing participants' investment in treatment and determining whether sufficient resources are available. In addition, diversion programs could consider the incorporation of therapeutic alliance measures to evaluate treatment amenability. Although such measures are not always successful in predicting high-risk offenders' treatment progress (e.g., Polaschek & Ross, 2010), their measurement may assist in tailoring treatment to specific offender programs (Skeem, Eno Louden, Polaschek, & Camp, 2007; Tatman & Love, 2010). Clearly, treatment methods should consider offenders' readiness for change (Jordan, Rogers, & Neumann, 2009).

CONCLUDING REMARKS

Prevention and early intervention programs are often heralded as the preferred treatment models, especially with troubled youth (Loeber & Farrington, 2000; Munetz & Griffin, 2006). In stark contrast, many offenders with mental disorders have lengthy psychiatric and legal histories (James & Glaze, 2006) often beginning in late childhood and early adolescence.

At some point, the concept of early intervention loses its meaning when addressing chronic disorders and extensive criminality.

Implicitly, the ATLAS program acknowledges the too-frequent failures of public mental health services and the limits of criminal justice interventions. It is designed to work with felony probationers whose recognized failures at treatment are presumably linked to their failures at probation. As with all single-site MHC studies, it is difficult to ascertain whether its success (a) demonstrates the efficacy of the program's broad principles and specific interventions or (b) reflects on the personal and professional investments of a cadre of skilled professionals. In our view, both play instrumental roles.

Other MHC programs may wish to consider the third-generation diversion model that is applied to known failures. In the current study, the intensity of its services and the investment of professionals provided considerable success in terms of both the other option (revocation and incarceration) and a matched group in a treatment-as-usual condition. For this challenging population, we suspect intensive treatment is essential—especially in the early phases of treatment—by providing a safety net through multiple weekly contacts with a trained staff and weekly court appearances, both of which limit disengagement and decompensation. The safety net is augmented by immediate interventions that are closely coordinated by the court.

NOTES

1. These estimates highlight the dearth of diversion program opportunities available for offenders with mental disorders, a seeming contrast to their growing popularity in psychological research.

2. These transfers are considered failures of the ATLAS program to effectively manage participants' clinical issues with available outpatient resources and intensive community supervision.

3. One African American from the ATLAS group was matched on everything but ethnicity; a European American was selected as the closest match on other variables.

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