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ARRESTED ADULTS AWAITING ARRAIGNMENT: MENTAL HEALTH, SUBSTANCE ABUSE, AND CRIMINAL JUSTICE CHARACTERISTICS AND NEEDS

Nahama Broner,* Stacy S. Lamon,**
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INTRODUCTION

The incarceration rate among the general population in the United States is less than one percent,[1] yet the rate of incarceration among the mentally ill population is higher.[2] The involvement of psychiatric clients with the criminal justice system has been described in studies of family members, police intervention with the mentally ill, civilly committed and general psychiatric inpatients, and those in incarcerated settings.[3] While the risk of violence in this population is believed to be primarily, though not solely, driven by substance use rather than mental illness,[4] medication

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1. U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, 2000 CENSUS 2 (2001), *available at* http://www.census.gov/prod/2002pubs/c2kprof00_us.pdf (last visited Jan. 15, 2003).

2. Judith F. Cox et al., *A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems: Implications for Service Planning*, 28 J. BEHAV. HEALTH SERV. & RES. 177, 181 (2001); Marjorie Rock & Gerald Landsberg, *County Mental Health Directors' Perspective on Forensic Mental Health Developments in New York State*, 25 ADMIN. & POL'Y MENTAL HEALTH 327, 327 (1998); Linda A. Teplin, *Psychiatric and Substance Abuse Disorders Among Male Urban Jail Detainees*, 84 AM. J. PUB. HEALTH 292, 292-93 (1994).

3. *See* Nahama Broner et al., *A Review of Screening Instruments for Co-Occurring Mental Illness and Substance Use in Criminal Justice Programs, in* SERVING MENTALLY ILL OFFENDERS AND THEIR VICTIMS: CHALLENGES AND OPPORTUNITIES FOR MENTAL HEALTH PROFESSIONALS 289, 290 (Gerald Landsberg et al. eds., 2002) [hereinafter SERVING MENTALLY ILL OFFENDERS]; *see also* E. Glenn Schellenberg et al., *A Review of Arrests Among Psychiatric Patients*, 15 INT'L J.L. PSYCHIATRY 251, 252-62 (1992).

4. *See* John Monahan, *Clinical and Actuarial Predictions of Violence, in* 1 MODERN SCIENCE EVIDENCE: THE LAW AND SCIENCE OF EXPERT WITNESS TESTIMONY 58, 62 (David J. Faigman et al. eds., pocket pt. 2000); Henry J. Steadman et al., *Violence*

non-compliance significantly increases the risk for violence[5] and triples the risk for arrest.[6] Additionally, research has shown that those with mental illness are both more likely to be arrested when compared to those without mental illness,[7] and may be more likely to recidivate than non-mentally ill offenders if treatment is not received.[8] Comparative rates of recidivism for the mentally ill and non-mentally ill may be more aptly explained by the type of monitoring received[9] or other factors. Research has also demonstrated that jail and prison populations tend to have higher rates of mental illness and substance abuse than the population at large.[10] And while the rates of mental illness and substance abuse are generally well estimated for a number of criminal justice populations, like community corrections, jails, and prisons,[11] this is not the case for the post-arrested, but the pre-arraignment population. As this pre-arraignment population has been overlooked in previous studies, the relatively high rates of mental illness documented for jails and prisons may underestimate the true extent of the problem. Al-

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by People Discharged From Acute Psychiatric Inpatient Facilities and By Others in the Same Neighborhoods, 55 ARCH. GEN. PSYCHIATRY 393, 398 (1998).

5. Marvin S. Swartz et al., *Can Voluntary Outpatient Commitment Reduce Hospital Recidivism? Findings From a Randomized Controlled Trial in Severely Mentally Ill Individuals,* 156 AM. J. PSYCHIATRY 1968, 1973-74 (1999); Marvin S. Swartz et al., *Violence and Severe Mental Illness: The Effects of Substance Abuse and Nonadherence to Medication,* 155 AM. J. PSYCHIATRY 226, 227 (1998).

6. Randy Borum et al., *Substance Abuse, Violent Behavior and Police Encounters Among Persons with Severe Mental Disorder,* 13 J. CONTEMP. CRIM. JUST. 236, 245 (1997).

7. Linda A. Teplin, *The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees,* 80 AM. J. PUB. HEALTH 663, 664-65 (1990).

8. RENYI LIU, CAL. DEP'T OF CORR., SERIOUSLY MENTALLY DISORDERED OFFENDERS AND RECIDIVISM: EFFECT OF POC TREATMENT ON REDUCING SMD OFFENDERS' RETURN TO CUSTODY RATE 2 (1999).

9. Phyllis Solomon & Jeffrey Draine, *Jail Recidivism in a Forensic Case Management Program,* 30 HEALTH & SOC. WORK 167, 168 (1995).

10. *See* Gilles Cote & Sheilagh Hodgins, *Co-Occurring Mental Disorders Among Criminal Offenders,* 18 BULL. AM. ACAD. PSYCHIATRY & L. 271, 281 (1990); H. Richard Lamb & Robert W. Grant, *The Mentally Ill in an Urban County Jail,* 39 ARCH. GEN. PSYCHIATRY 17, 17 (1982); Henry J. Steadman & Bonita M. Veysey, U.S. DEP'T OF JUSTICE, *Providing Services for Jail Inmates with Mental Disorders,* NATIONAL INSTITUTE OF JUSTICE RESEARCH IN BRIEF, Jan. 1997, at 1, *available at* http://www.ncjrs. org/pdffiles/162207.pdf (last visited Jan. 15, 2003); Linda A. Teplin, *The Criminalization of the Mentally Ill: Speculation in Search of Data,* 94 PSYCHOL. BULL. 54, 57 (1983); Teplin, *supra* note 7, at 664-65.

11. *See* PAMELA M. DITTON, U.S. DEP'T OF JUSITCE, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 1 (1999), *available at* http://www.ojp. usdoj.gov/bjs/pub/pdf/mhtip.pdf (last visited Jan. 15, 2003); Jeffrey L. Metzner et al., *Treatment in Jails and Prisons, in* TREATMENT OF OFFENDERS WITH MENTAL DISORDERS 211, 230-31 (Robert M. Wettstein ed., 1998).

though the primary literature on diversion suggests that intervention at this earlier stage may produce the most beneficial outcomes for the target population,[12] little empirical attention has focused on the needs of the pre-arraignment population, whose needs are complicated by the fact that arraignment is both a gateway to incarceration and a reentry point directly back to the community.

This Study is one of the first to look at this unique population at this specific point in the criminal justice process. Yet studies of pre-arraignment populations are crucial because it is at this point in the system that something of a "bottle-neck" occurs: arrested individuals are taken from neighborhoods, collected in the precincts, and funneled through the booking process to the arraignment court. This is where the sorting process begins, as some individuals go to jail and others return to the community (and others, not studied here, are hospitalized). Consequently, this bottle-neck is an excellent place to identify individuals with mental health and substance abuse problems, to examine those problems, to consider legal interventions, such as diversion or routing to specialized courts, for instance, drug and mental health courts, and to plan for community mental health, substance abuse, health, and social service interventions. Following a brief review of the literature on rates of substance abuse and mental health problems for criminal justice populations, the process from arrest to arraignment in Kings County (Brooklyn) is described. This Study concludes with a discussion of the implication of results for practice, criminal justice intervention, and policy.

I. MENTAL HEALTH AND SUBSTANCE ABUSE IN CRIMINAL JUSTICE INVOLVED POPULATIONS

A. Review of Relevant Studies

In 2000, there were 11.64 million arrests of adults eighteen years of age and older in the United States,[13] and as of midyear 2001, almost two million individuals were incarcerated in jails and prisons.[14] Research has consistently demonstrated that a significant

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12. *See* Henry J. Steadman et al., *The Diversion of Mentally Ill Persons from Jails to Community-Based Program: A Profile of Programs*, 85 AM. J. PUB. HEALTH 1630, 1633 (1995).

13. FED. BUREAU INVESTIGATION, U.S. DEP'T OF JUSTICE, UNIFORM CRIME REPORTS: CRIME IN THE UNITED STATES 2000, at 5 (2000), *available at* http://www.fbi.gov/ucr/cius_00/00crime2.pdf (last visited Jan. 15, 2003).

14. Allen J. Beck et al., *Prison and Jail Inmates at Midyear 2001*, BUREAU JUST. STAT. BULL., Apr. 2002, at 1, *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim01.pdf (last visited Jan. 15, 2003).

portion of the population entering the criminal justice system has moderate to serious mental health problems, and, accordingly, it is estimated that approximately 700,000 adults with criminal justice contact are believed to have serious mental illness.[15] In New York City, approximately 15,000 people identified with mental health problems are confined and released each year, representing over ten percent of the annual jail census.[16]

Overall lifetime prevalence for serious mental illness has been estimated to be between 6.7 percent (for prisoners) and 9.5 percent (for male jail detainees), approximately twice the rate of the general community in the United States.[17] It has been suggested, however, that epidemiological rates underestimate the true prevalence of mental illness, which should be considered when describing or comparing community and criminal justice involved samples.[18] In fact, a recent survey noted rates of seven percent in an adult community sample (nine percent for women versus six percent for men).[19] In a series of studies, Dr. Linda Teplin reported that rates of specific serious lifetime psychiatric disorders among incarcerated male and female populations range from three percent to seventeen percent (increasing to thirty-four percent when posttraumatic stress disorder ("PTSD") is included),[20] and reach as high as thirty-five percent for any current disorder, with the exception of antisocial personality disorder.[21] A review of studies on jail and prison inmates notes that generally ten to fifteen percent of these populations have serious mental illness;[22] the range in estimates is related to the different methodologies used, definitions for

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15. Henry J. Steadman et al., *A SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons*, 50 PSYCHIATRIC SERV. 1620, 1620 (1999).

16. Stacy S. Lamon et al., *New York City's System of Criminal Justice Mental Health Services*, *in* SERVING MENTALLY ILL OFFENDERS, *supra* note 3, at 145.

17. *See* LEE N. ROBINS & DORREL A. REGIER, PSYCHIATRIC DISORDERS IN AMERICA: THE EPIDEMIOLOGIC CATCHMENT AREA STUDY 78 (1991); Linda A. Teplin, *Detecting Disorder: The Treatment of Mental Illness Among Jail Detainees*, 58 J. CONSULTING & CLINICAL PSYCHOL. 233, 234 (1990).

18. *See* Ronald C. Kessler et al., *Psychiatric Epidemiology: Recent Advances and Future Directions*, *in* MENTAL HEALTH, UNITED STATES, 2000, at 29, 32 (Ronald N. Manderscheid & Marilyn J. Henderson eds., 2001).

19. 1 OFFICE OF APPLIED STUDIES, U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2001 HOUSEHOLD SURVEY ON DRUG ABUSE 69 (2001).

20. Teplin, *supra* note 17, at 233-36; Teplin, *supra* note 2, at 292-93; Linda A. Teplin et al., *Prevalence of Psychiatric Disorders Among Incarcerated Women: I. Pretrial Jail Detainees*, 53 ARCH. GEN. PSYCHIATRY 505, 505-08 (1996).

21. Teplin, *supra* note 2, at 292-93.

22. H. Richard Lamb & Linda E. Weinberger, *Persons With Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERV. 483, 484 (1998).

what constitutes mental illness, and perhaps the different settings (for example, jails and prisons) reflected in the studies reported. In community supervised and institutional correctional populations, in the United States, sixteen percent or over a quarter of a million incarcerated inmates and half a million community supervised offenders self-report current mental health pioblems (ten percent) or past psychiatric treatment (six percent).[23]

Mental illness is especially prevalent among women entering the correctional system, and upwards of sixty percent are estimated to have a mental disorder.[24] Incarcerated women are particularly likely to suffer from PTSD and other anxiety disorders.[25] Accordingly, incarcerated women have been found to have higher overall rates of mental illness than men (eighteen percent to ten percent),[26] and have at least three times the risk for suicidal ideation and behavior when compared to the general community population.[27] Seventeen percent of women in jails and twenty-three percent of women in prisons receive psychiatric medication.[28]

In terms of substance abuse, studies estimate that approximately sixty percent of people arrested in major cities in the United States used drugs at the time of arrest.[29] In 1999, from a sample of 556 male arrestees in New York City, forty-six percent tested positive for cocaine (and "crack" cocaine), forty percent for marijuana, and twenty-two percent for opiates.[30] Overall, in this New York City

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23. DITTON, *supra* note 11, at 2.

24. Shaun Parsons et al., *Prevalence of Mental Disorder in Female Remand Prisons*, 12 J. FORENSIC PSYCHIATRY 194, 196 (2001); Mark I. Singer et al., *The Psychosocial Issues of Women Serving Time in Jail*, 40 SOC. WORK 103, 107 (1995).

25. Thomas W. Haywood et al., *Characteristics of Women in Jail and Treatment Orientations: A Review*, 24 BEHAV. MODIFICATION 307, 310 (2000); Teplin et al., *supra* note 20, at 511.

26. Emil R. Pinta, *The Prevalence of Serious Mental Disorders Among U.S. Prisoners*, *in* FORENSIC MENTAL HEALTH: WORKING WITH OFFENDERS WITH MENTAL ILLNESS 12-1, 12-6 (Gerald Landsberg & Amy Smiley eds., 2001).

27. Devon R. Charles et al., *Suicidal Ideation and Behavior Among Women in Jail*, 19 J. CONTEMP. CRIM. JUST. 65, 75 (2003).

28. LAWRENCE A. GREENFIELD & TRACY L. SNELL, U.S. DEP'T OF JUSTICE, SPECIAL REPORT: WOMEN OFFENDERS 8 (1999), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/wo.pdf (last visited Jan. 15, 2003).

29. ARRESTEE DRUG ABUSE MONITORING PROGRAM, U.S. DEP'T OF JUSTICE, 1999 ANNUAL REPORT ON DRUG USE AMONG ADULT AND JUVENILE ARRESTEES 9 (2000), *available at* http://www.ncjrs.org/pdffiles1/nij/181426.pdf (last visited Jan. 15, 2003); DITTON, *supra* note 11, at 1.

30. BRUCE G. TAYLOR ET AL., U.S. DEP'T OF JUSTICE, ADAM PRELIMINARY 2000 FINDINGS ON DRUG USE AND DRUG MARKETS: ADULT MALE ARRESTEES 7-13 (2001), *available at* http://www.ncjrs.org/pdffiles1/nij/189101.pdf (last visited Jan. 15, 2003).

sample, seventy-nine percent tested positive for any of the measured drugs,[31] forty-one percent were at risk for drug dependence,[32] and twenty-three percent were at risk for alcohol dependence based on heavy usages (including binge drinking).[33] When studies include drug charges and/or regular use prior to the alleged offense, nationally, close to seventy percent of inmates are considered substance-dependent.[34] A survey of inmates being transferred from Ohio jails to state prisons found that fifty-eight percent had a lifetime history of drug dependence, and that fifty-one percent were dependent upon drugs at the time of transfer.[35] Similarly, sixty-one percent of inmates in a low-security federal prison screened positive for alcohol problems.[36] Substance abuse rates may be even higher for women.[37] According to the National Institute of Justice, sixty-seven percent of women admitted to jails in the United States test positive for drugs (eighty-one percent in New York City).[38]

Just as studies have shown that rates of mental illness and substance abuse are quite high in incarcerated populations, other studies have shown that the two problems are frequently co-occurring. In contrast to the general population in the United States, where twenty percent of adults with serious mental illness have a co-occurring substance abuse problem,[39] Dr. Karen Abram and Dr. Linda Teplin found that almost three quarters of inmates with mental health diagnoses have co-occurring alcohol and drug abuse

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31. *Id.* at 5.

32. *Id.* at 18.

33. *Id.* at 16.

34. *See* Doris James Wilson, *Drug Use, Testing, and Treatment in Jails*, NAT'L INST. JUST. RES. IN BRIEF, May 2002, at 3, *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/duttj.pdf (last visited Jan. 15, 2003).

35. Celia C. Lo & Richard C. Stephens, *Drugs and Prisoners: Treatment Needs Upon Entering Prison*, 26 AM. J. DRUG & ALCOHOL ABUSE 229, 242 (2001).

36. Robert J. White et al., *Self-Identified Alcohol Abusers in a Low-Security Federal Prison: Characterisitcs and Treatment Implications*, 45 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 214, 219 (2001).

37. *See* Kathleen Jordan et al., *Prevalence of Psychiatric Disorders Among Incarcerated Women: II. Convicted Felons Entering Prison*, 53 ARCH. GEN. PSYCHIATRY 513, 514 (1996); Teplin et al., *supra* note 20, at 507.

38. ARRESTEE DRUG ABUSE MONITORING PROGRAM, U.S. DEP'T OF JUSTICE, 1998 ANNUAL REPORT ON DRUG USE AMONG ADULT AND JUVENILE ARRESTEES 1 (1998), *available at* http://www.ncjrs.org/pdffiles1/175656.pdf (last visited Jan. 15, 2003).

39. OFFICE OF APPLIED STUDIES, *supra* note 19, at 72.

problems.[40] This holds true among inmates with diagnoses of schizophrenia (fifty-eight percent of whom were drinking and fifty-two percent of whom were using drugs at the time of arrest), those diagnosed with a bipolar disorder (fifty-eight percent using drugs and thirty-three percent using alcohol), and for those diagnosed with a depressive disorder (fifty-four percent using drugs and forty percent using alcohol). Dr. Mark Munetz, Mr. Thomas Grande, and Ms. Margaret Chambers found that seventy percent of inmates with serious mental illness were actively abusing substances at the time of incarceration.[41] These rates are significantly higher than rates found among those without a serious mental health diagnosis. For inmates without a serious mental health diagnoses, Abram and Teplin found that thirty-two percent were drinking at the time of arrest, and twenty-seven percent were using drugs at the time of arrest.[42]

Beyond legal problems, the mentally ill have many additional documented social service needs. This is particularly true for individuals with co-occurring disorders. Several reviews of the research literature found that the negative consequences of co-occurring disorders in the general population include the following: the inability to manage finances, greater stress and demands on family, increased risk of homelessness, increased vulnerability to infectious diseases such as HIV and hepatitis, increased risk for suicide, and higher rates of hospitalization and other service utilization.[43] In effect, the mentally ill, substance abusing subset of the criminal justice population, set apart from others in the criminal justice system by the highly varied and complex nature of their problems, is rich in medical, social, and behavioral pathology.

There have been relatively few studies specifically assessing rates of service needs of incarcerated populations. It is easy, however, to extrapolate the preponderance of medical, psychosocial, housing, treatment, and other needs from the above findings. Studies that

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40. Karen M. Abram & Linda A. Teplin, *Co-Occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy*, 46 AM. PSYCHOLOGIST 1036, 1039, 1044 (1991).

41. Mark R. Munetz et al., *The Incarceration of Individuals with Severe Mental Disorders*, 34 CMTY. MENTAL HEALTH J. 361, 369 (2001).

42. Abram & Teplin, *supra* note 40, at 1039.

43. *See* Robert E. Drake et al., *Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders*, 24 SCHIZOPHRENIA BULL. 589, 601-03 (1998); John F. Edens et al., *Treating Prison Inmates with Co-Occurring Disorders: An Integrative Review of Existing Programs*, 15 BEHAV. SCI. & L. 439, 440 (1997); Jill RachBeisel et al., *Co-Occurring Severe Mental Illness and Substance Use Disorders: A Review of Recent Research*, 50 PSYCHIATRIC SERV. 1427, 1430-31 (1999).

have focused on the needs of the criminal justice populations describe homelessness, sexually transmitted diseases, employment, and education issues. In this regard, one study estimated rates of homelessness among mentally ill prisoners at thirty-one percent, with the most severely mentally ill inmates at the most risk.[44] A study of women prisoners found that posttraumatic stress disorder was correlated with risky sexual behaviors and increased risk for HIV.[45] Other studies have noted the educational and employment issues for those with a multi-faceted constellation of co-morbid health and psychiatric disorders.[46] These findings suggest that this population has many other social needs above and beyond its documented mental health and substance abuse treatment needs, and that these needs are often unaddressed.

II. THE PROCESS OF ARREST THROUGH ARRAIGNMENT IN NEW YORK CITY

Virtually every criminal case begins with an arraignment in the criminal court. While the arraignment marks the beginning of the court process, it also marks the end of a process that began with the arrest. This "arrest to arraignment process" can be thought of as the gateway to the criminal justice system. In New York City, this arraignment process occurs within twenty-four hours.[47] The following is a description of this process gleaned from research staff observation, focus groups with arrestees and police, and judicial and court staff experience.

A. Police "Booking"

After a police officer makes an arrest, most detainees are brought to a police stationhouse where a supervising officer reviews the case and either approves the arrest or releases the individual.[48] If an arrest is approved, the police determine what

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44. Phyllis L. Solomon et al., *Homelessness in a Mentally Ill Urban Jail Population*, 43 HOSP. & CMTY. PSYCHIATRY 169, 170 (1992).

45. Heidi E. Hutton et al., *HIV Risk Behaviors and Their Relationship to Posttraumatic Stress Disorder Among Women Prisoners*, 52 PSYCHIATRIC SERV. 508, 510-11 (2001).

46. Singer et al., *supra* note 24, at 109-11.

47. Roundtree v. Brown, 570 N.E.2d 223, 225 (1991).

48. Detainees who are classified as "Emotionally Disturbed Persons" ("EDPs") at the time of arrest may be brought to an emergency room prior to booking. Those EDPs who are brought to the stationhouse are assigned one-on-one observation until arraignment. EDPs fall within a category of "special" cases (including elderly, pregnant, and physically ill detainees) and their experiences may differ from those described here.

charges are appropriate. The accused is fingerprinted and permitted to make a telephone call before being sent to a holding cell to wait while the paperwork is prepared.

B. Post-booking to Arraignment

In Brooklyn, the detainee is transported by the police department to pre-arraignment gaols, the "holding cells" or "pens," in the sub-basements of the criminal court building. Each defendant is put through a mental detector, searched, and photographed prior to being placed in a holding pen. There are no social or treatment services offered during this process. While in these holding areas, representatives of the Criminal Justice Agency ("CJA") conduct interviews with each detainee to obtain information about employment, residence, and family ties. This information is reported to the judge and used to assist in bail determination. Health care workers briefly interview detainees, individually or in groups, to screen for communicable diseases, such as tuberculosis. There is no screening for mental health and substance abuse problems or history.

In some jurisdictions, the court holding pens may be modernized and newly renovated, but in others, renovations have not occurred for many years and decrepit conditions exist. Male and female adults (aged sixteen and older) are housed separately in large cells with ten to forty people in a cell at any one time. An open toilet is located in the cell where meals are eaten and arrestees often sleep on the floor. A public telephone is available. Privacy does not exist.

In these cells, many arrestees are still under the influence of the drugs or alcohol that they consumed prior to arrest. Some may be in the process of withdrawal from drugs or Methadone, both of which are not available to them. Others who are mentally ill or have other special medical needs, but have not been identified as such by police, are housed in these cells with the general population. Some may have their conditions exacerbated by the lack of medication and the stressful and disorienting environment as they progress through the post-booking and pre-arraignment process.

There is little incentive for someone with substance abuse or mental health problems to raise these issues at this point in the process, because delaying the arraignment is feared. For individuals who take prescribed medication for either a medical or psychiatric disorder, they may be well aware that notifying the police of their need for medication after their medication has been confis-

cated[49] will result in an interruption and delay of the arraignment process while they are transferred to the hospital or interviewed. If they hope to be released soon, they keep quiet. They are also concerned about revealing their physical or psychiatric ailments, because doing so is likely to make them vulnerable to other arrestees who may prey on them while they await transportation to the hospital.

Furthermore, many individuals with substance abuse and/or mental health problems and their attorneys are concerned about raising these issues prior to or during arraignment for fear that there will be a negative impact on bail and detention determination. They are concerned that they will be stigmatized by the criminal justice system and held in custody because they may be viewed as at risk for losing control, being dangerous, or being more likely to get needed treatment in jail than in the community. Therefore, often with the support of their defense counsel, they do not self-identify mental health or substance abuse problems. During this Study, many participants also expressed dissatisfaction with previous community mental health and substance abuse treatment services and were reluctant to return to that system either voluntarily or through a conditional sentence. This reluctance may change later in the process when substance abuse and mental health problems can be used as leverage for alternative sentencing or as part of other defense strategies such as competency to stand trial or pleading not guilty by reason of insanity.

In addition to confusion regarding the arrest and arraignment process, the impact of the arraignment environment and the complications of psychiatric or physical conditions, a primary stressor is the ambiguity and uncertainty of when or whether they will be released. The majority of arrestees interviewed voiced an urgency to return to their lives. They feared that they would jeopardize their jobs, living situations, familial stability, or leave their children or an elderly relative unsupervised. The idea of "beating the system" seemed rare in this first stage of criminal justice processing. Rather, such a view was held by a minority of individuals who had become institutionalized in the criminal justice process and, like the legal players, were focused on maneuvering through the sys-

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49. During the course of this Study, a policy remained in effect that required police officers to remove all medications at booking. There was no procedure to relay that information or to address needs, other than those needs resulting from an acute reaction to the lack of medication later in the process.

tem. This distinction is important in understanding the tension that steadily rises as the individual reaches the judge.

While the detainee waits in the holding cell, the arresting officer informs the Office of the District Attorney of the case. The District Attorney's Office reviews the facts of the case and, in most instances, drafts an accusatory instrument. The district attorney is not bound by the booking charges or any decision previously made by the police and can substitute appropriate charges. If it is determined that no viable charges can be brought, the detainee is released. If not released, fingerprint records and booking charges are sent by fax to Albany, where the New York State Division of Criminal Justice Services ("DCJS") uses the fingerprints to determine whether the individual has a criminal history. When the fingerprint records have been researched, the New York State Identification ("NYSID") report, commonly referred to as a "rap sheet," is sent by fax to the police collating room in the courthouse where it is incorporated into the court files. The rap sheet lists all prior New York State convictions, pending New York State cases, outstanding warrants, and may include out-of-state and federal information.

Once all necessary records have been compiled, the court clerk distributes copies to the court, defense, and prosecution. The filing of the charges with the court clerk marks the formal beginning of the criminal action and the person under arrest becomes a defendant in the criminal case. As the paperwork arrives in the courtroom, police officers of the court division bring the defendant to cells near the attorney interview booths. In Brooklyn, arrestees progress through the various sub-basement levels up to court, where, often toward the end of their twenty-four hours, they briefly meet with an attorney, usually court appointed, for only a few minutes and for the first time. The defense attorney reviews the charges, discusses the case with the defendant, and notifies the court. The defendant, accompanied by the attorney, is then called before the court and the court officer reads the charges.

The expectation or hope of the majority of arrestees, even for those charged with serious crimes and those familiar with the system, is their imminent release, which is consistent with the fact that over three-quarters of this population are released at arraignment.[50] This mix of anxiety, anticipation, and expectation, combined with the concerns of the consequences of further detention

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50. WAYNE R. LAFAVE ET AL., CRIMINAL PROCEDURE 18 (3d ed., 2000).

on their immediate life circumstances, can lead to explosions in the courtroom if remanded to correction custody or if bail is set above the ability to pay.

C.   Arraignment

Arraignment is defined as the first court appearance in a criminal case.[51] When the case is called, the defendant has the right to have the criminal charges read in open court and is advised of her rights as a criminal defendant.[52] The defendant then has an opportunity to enter a plea of guilty or not guilty. In the fast-moving criminal court proceeding, in which every defendant either has an attorney or is assigned one by the court, the reading of the charges and rights are routinely waived and a "not guilty" plea is entered. The arraignment process usually takes less than five minutes.

If the charges are all misdemeanors or lesser offenses,[53] the court can dispose of the case at the arraignment hearing[54] in one of three ways. The court may take a plea of guilty and the judge can impose a sentence at that point. With the consent of the prosecutor, the court can also adjourn a case for a period of six months or one year, on the understanding that the case will be dismissed at the end of that time period ("adjournment in contemplation of dismissal" or "ACD"), with the prosecutor retaining the ability to restore

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51. *Id.* at 993.

52. These rights include the right to trial, in some cases, the right to trial by jury, and the right to be represented by an attorney at every stage of the proceeding.

53. The criminal court has initial jurisdiction over all offenses. Criminal Court of the City of N.Y., General Information, Jurisdiction, *at* http://www.courts.state.ny.us/ NYCCriminalGeneralInfo.html#JURISDICTION (last visited Jan. 15, 2003). Offenses include crimes and lesser matters such as violations and traffic infractions. *Id.* Crimes are divided into two categories: misdemeanors and felonies. WAYNE R. LAFAVE ET AL., CRIMINAL PROCEDURE CRIMINAL PRACTICE SERIES 343 (2d ed., 1999). Misdemeanors are crimes in which the maximum sentence is one year. *Id.* Felonies are crimes in which the sentence can exceed one year. *Id.* A great number of offenses have been made returnable to administrative agencies, such as traffic court, for most traffic infractions. But some traffic infractions wind up in criminal court. Some of these violations and traffic infractions carry short jail sentences that usually do not exceed fifteen days. In most cases in which an offense is charged, the defendant is given a ticket and a date on which to appear voluntarily in court. The police have the discretion to make an arrest on a violation or traffic infraction. With the crackdown on "quality of life" offenses, more people have been put through the system on these minor offenses.

54. If one or more of the charges is a felony, the court does not have jurisdiction to accept a plea of guilty. All felony cases that are not dismissed outright result in a bail decision at arraignment. Pleas may be made only following an indictment brought by a grand jury.

the case at any time prior to that dismissal.[55] If appropriate, the court can also dismiss a case outright. If the case is not disposed in one of these three ways, then a bail decision is made. The court can either set bail or release the defendant on her own recognizance ("ROR"). If bail is set but not posted, a defendant will be transferred to the custody of the New York City Department of Corrections and remain in jail as the trial process continues.

Thus, arraignment is one of the most potentially volatile and dangerous junctures for arrestees, as well as for the police who are in charge of them until arraignment, the court officers and other personnel who are present during arraignment, and, if remanded to jail, the corrections officers. For the arrestee, arraignment is a key time in the criminal justice process, not only a point of high stress and anxiety, but also a decisive moment that determines the individual's fate. The negative impact of going through this process for those with psychiatric disorders, whether immediately released to the community or incarcerated, was anecdotally described by participants in this Study as potentially devastating. Depending on their state of functioning at the time, participants described past and current arrest experiences as activating previous trauma and exacerbating symptoms.

III. Methods

A. Procedure

The Study took place in Brooklyn (Kings County), New York, in the criminal court building's sub-basement intake and staging level pens, in the evening and nights during August and September 1999, and during November 1999, through early February 2000, for a total of fourteen weeks. Brooklyn is New York City's most populous borough with a population of 2,425,980.[56] According to the Kings County District Attorney's Office, in 2000, there were a total of 98,668 arrests in Kings County; approximately forty percent occurred in the evening or night.[57]

Four hundred ninety-five arrestees from the general "pens" population (excluding those designated "emotionally disturbed persons" who were housed in a special room) were randomly selected from their "booking/arrest" sheets and approached for informed

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55. N.Y. CRIM. PRO. LAW § 170.55 (McKinney 2002).

56. U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, 2001 SUPPLEMENTARY CENSUS (2001), *available at* http://www.census.gov/acs/www/products/profiles/single/2001/SS01/tabular/060/06000US36047100221.htm (last visited Jan. 15, 2003).

57. Interview with Kings County District Attorney's Office (May 2001).

consent procedures.[58] Those identified as "emotionally disturbed persons" participated in a larger study, but their results were not included here.[59] Arrestees were not compensated for participation in this Study, which was a screening phase for a larger study. All arrestees who were approached were given a resource sheet for local borough treatment, medical, housing, legal, food, and family services. All were post-arrest and pre-arraignment, waiting to meet with their lawyers and the judge. Some had been under arrest for a few hours, others for almost a day.

Of those approached, 160 refused to participate in the Study (thirty-two percent refusal rate). Additionally, twenty-six arrestees were excluded prior to interviewing (five percent), including nine who did not respond when called, eight clients who were unable to speak English or Spanish well enough to participate in the interview, five who were in acute withdrawal from alcohol or drugs, two who were called to court after completing the consent process, but prior to beginning the interview, and two who were too psychotic to participate in informed consent. These cases were logged as refusals or exclusions, but basic demographic information from public records was recorded (for example, age, gender, race/ethnicity, charge, criminal justice history, and prospective recidivism data). The remaining 307 detainees were enrolled in the Study. These participants were comparable to the 186 who refused or were excluded at the time of intake in terms of racial/ethnic composition and arrest charge. Those who refused or were excluded, were significantly more likely to be female, χ^2 (1, $n=496$)= 4.335, $p<.05$, and were significantly older, averaging thirty-three years old, rather than twenty-eight years old on average, $t(300.631)= -4.026$, $p<.001$. For purposes of the analyses, twenty-six individuals who had not completed the structured diagnostic interview ("DIS-IV") were excluded, for a final study sample of 281 subjects (see below).

Participants in the Study sample ($n=307$) were interviewed for approximately one hour either while in their holding cell (primarily

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58. This Study, part of a larger study, was approved by the New York University and the New York City Department of Health and Mental Hygiene Institute Review Boards and the United States Department of Health and Human Services through the Certificate of Confidentiality process.

59. Since the purpose of this current Study is to examine the arraignment process for the general population, EDPs are not included. They will be included as part of a larger study that is being analyzed. As expected, preliminary analysis of EDPs in this larger study indicates that rates of mental illness, substance abuse, co-morbidity, and related variables are higher than those found in the general pre-arraignment population.

for males) or in an interview booth (primarily for females). Interviews were conducted in Spanish, if requested. The interview included a psychosocial questionnaire and standardized mental health and substance abuse instruments. In order to place the findings into context, brief interviews were held with the arrestees, where questions were asked about the arraignment process, priority of needs, and ideas for interventions. Participants were also systematically asked about the potential impact of the arraignment process on their immediate disposition and case outcome if substance abuse and mental health problems were voiced. Answers were notated by research staff, discussed during group supervision, and themes extracted. Needs were coded along with research staff impressions. Three focus groups were held with men and one with women at different staging levels. Participants were volunteers that were not systematically selected, but included those identified with mental health problems, substance abuse problems, as well as those that identified themselves as not having such issues. Police officers and court staff were also asked about the population (characteristics, needs, ideal program interventions) and the process. Collateral criminal justice records and psychiatric records (when available) were reviewed, prospective twelve-month data was collected for arrests and incarcerations, and, for non-sealed records, legal case outcomes were collected.

The interviewers in this Study held either a Master's degree in forensic psychology or social work and had completed outpatient and inpatient clinical externships, or were pursuing a doctoral degree in school or clinical psychology. Interviewers were trained in the administration of the Diagnostic Interview Schedule[60] and the Brief Psychiatric Rating Scale ("BPRS"),[61] reaching ninety-six percent inter-rater reliability for coded tapes of like-subjects, were supervised and observed weekly on site, and attended bi-weekly half-day group supervision.

B. Subjects

The Study sample was culled from an original base sample of 307 subjects. All subjects who did not complete the DIS-IV, the Michigan Alcohol Screening Test ("MAST"), and the Drug Abuse

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60. *See* Lee N. Robins et al., *National Institute of Mental Health Diagnostic Interview Schedule: Its History, Characteristics, and Validity*, 38 ARCH. GEN. PSYCHIATRY 381, 383-85 (1981).

61. *See* John E. Overall & Donald R. Gorham, *The Brief Psychiatric Rating Scale*, 10 PSYCHOL. REP. 799, 799-802 (1988).

Screening Test ("DAST") were excluded for the purposes of these analyses. Of these study exclusions, thirteen subjects withdrew during the course of the interview, twelve were called to court before finishing the interview, and one was incomplete due to a field interviewer error, for a final study sample of 281 subjects.

Of the 281 participants included in this Study (see Tables 3 and 7), the majority of participants were male (seventy-one percent) and reflected Brooklyn's overall criminal justice jail population in terms of race and ethnicity (sixty-seven percent African-American, twenty-two percent Latino, and eleven percent white). They ranged in age from sixteen to sixty-three years, with a mean of twenty-eight years. On average, participants had completed eleven years of education. Seventy-three percent of the sample self-described as single, nineteen percent reported being either married or living with a partner, and eight percent were divorced, widowed, or separated. Twenty-nine percent of the sample reported a history of homelessness, with ten percent reporting current homelessness, and twenty-one percent reporting having lived in a shelter at some point. Fifty-one percent of the sample was employed either full or part-time, and all but seven percent (*n*=19) had some history of employment.

C. Measures

A psychosocial questionnaire, used by local court projects, systematically recorded self-report demographic, criminal justice, psychosocial, and past service use information, and five standardized instruments were used to assess drug and alcohol use, and psychiatric diagnosis and symptoms.

Five modules from the DIS-IV[62] were administered to assess major psychiatric disorders, including those considered "severe" and two "moderate" disorders that had been reported as common to the criminal justice population: depression (with dysthymia), mania, psychosis, post-traumatic stress disorder, and generalized anxiety disorder. The DIS has been used in the study of diagnostic prevalence for the pre-sentenced and convicted jail populations.[63] Studies of previous versions of the DIS have found good to excellent consistency, and have concluded that the DIS is reliable for assessment of diagnoses based on the Diagnostic and Statistical

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62. Robins et al., *supra* note 60, at 383-85.
63. *See* Jordan et al., *supra* note 37, at 514; Teplin et al., *supra* note 20, at 506.

Manual of Mental Disorders, Third Edition, Revised ("DSM-III-R").[64]

Two self-report scales were used to assess probable alcohol and drug abuse or dependence and cut-off scores that correlated with dependence were also used. One was the Michigan Alcohol Screening Test,[65] which has been extensively evaluated,[66] and used for screening and assessment with forensic, substance using, and psychiatric populations.[67] The other, based upon the MAST, was the Drug Abuse Screening Test.[68] It is also widely used and found to have sound psychometric properties in psychiatric populations.[69]

In order to measure severity/frequency of use, the Drug/Alcohol 6-month Follow-Back Calendar,[70] adapted for a three-month time frame, was used. Although not scored or formally validated, it assists in forming a more complete impression of overall substance use patterns and severity. The reliability and validity of the time-line follow-back approach has been documented among psychiatric outpatients.[71]

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64. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 27-358 (3d ed. revised 1987); Hans-Ulrich Wittchen, *Reliability and Validity Studies of the WHO-Composite International Diagnostic Interview (CIDI): A Critical Review*, 28 J. PSYCHIATRIC RES. 57, 69 (1994).

65. *See* Melvin Selzer, *The Michigan Alcoholism Screening Test: The Quest for a New Diagnostic Instrument*, 127 AM. J. PSYCHIATRY 1653, 1654 (1971) (explaining the purpose and structure of the MAST).

66. *See* Robert R. Saltstone et al., *A Multivariate Evaluation of the Michigan Alcoholism Screening Test and the Drug Abuse Screening Test in a Female Offender Population*, 19 ADDICTIVE BEHAV. 455, 455 (1994).

67. L. David Blevins et al., *Using the Michigan Alcoholism Screening Test to Identify Problem Drinkers Under Federal Supervision*, 60 FED. PROBATION 38, 38-40 (1996); Phillip Firestone et al., *Recidivism in Convicted Rapists*, 26 J. AM. ACAD. PSYCHIATRY & L. 185, 190 (1998); Saltstone et al., *supra* note 66, at 455; John S. Searles et al., *The Detection of Alcoholism in Hospitalized Schizophrenics: A Comparison of the MAST and the MAC*, 14 ALCOHOLISM: CLINICAL & EXPERIMENTAL RES. 557, 557-58 (1990).

68. *See* Harvey A. Skinner, *Center for Addiction and Mental Health 1999 Resources, Drug Abuse Screening Test*, 7 ADDICTIVE BEHAV. 363 (1982).

69. Karen M. Cocco & Kate B. Carey, *Psychometric Properties of the Drug Abuse Screening Test in Psychiatric Outpatients*, 10 PSYCHOL. ASSESSMENT 408, 408 (1998); *see* Douglas Staley & Nady El Guebaly, *Psychometric Properties of the Drug Abuse Screening Test in a Psychiatric Patient Population*, 15 ADDICTIVE BEHAV. 257, 262-63 (1990) (reporting a study done that concluded that the DAST has strong psychometic properties in psychiatric populations).

70. N.H.-DARTMOUTH PSYCHIATRIC RESEARCH CTR., DRUG/ ALCOHOL 6-MONTH FOLLOW BACK CALENDAR (2001), *available at* http://www.Dartmouth.edu/dms/psychrc/pdf_files/webADTLFB.pdf (last visited Jan. 15, 2003).

71. *See, e.g.*, Kate B. Carey, *Reliability and Validity of the Time-Line Follow-Back Interview Among Psychiatric Outpatients: A Preliminary Report*, 11 PSYCHOL. ADDICTIVE BEHAV. 26, 27 (1997).

The Brief Psychiatric Rating Scale ("BPRS")[72] evaluates eighteen psychiatric symptoms on a seven-point scale per rater observed behavior and direct questions.[73] Inter-rater reliabilities for the individual items and the total score have been evaluated and reported in many studies within different patient populations,[74] and the BPRS is viewed as valid for the comprehensive assessment of psychiatric symptoms.[75]

Additional criminal justice data was collected from police, court, and correction records.[76] Full arrest histories were taken from arrest "rap" sheets following arrest, including number and type of arrests, number and type of convictions, and warrant histories. Arraignment disposition information and current case outcomes were gathered from the city's CRIMS computer database. Finally, in conjunction with the New York City Department of Correction, all re-arrest and incarceration data was gathered for a twelve-month period following intake.

D.   Statistical Methods[77]

Analyses of dichotomous and categorical variables were performed using chi-square tests, and analyses of continuous variables were performed using t-tests and one-way analysis of variance tests. In the examination of the differences among the four diagnostic groups, analyses of dichotomous and categorical variables were performed using chi-square tests corrected for statistical significance using Bonferroni's method. Analyses of continuous vari-

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72. *See* Overall & Gorham, *supra* note 61, at 799.

73. William O. Faustman & John E. Overall, *Brief Psychiatric Rating Scale, in* THE USE OF PSYCHOLOGICAL TESTING FOR TREATMENT PLANNING AND OUTCOMES ASSESSMENT 791, 792 (Mark E. Maruish ed., 1999).

74. *See* James L. Hedlund & Bruce W. Vieweg, *The Brief Psychiatric Rating Scale (BPRS): A Comprehensive Review*, 11 J. OPERATIONAL PSYCHIATRY 48, 56 (1980).

75. *See* Kristine K. Morlan & Siang-Yang Tan, *Comparison of the Brief Psychiatric Rating Scale and the Brief Symptom Inventory*, 54 J. CLINICAL PSYCHOL. 885, 891 (1998).

76. Self-report data, per a questionnaire developed for the Substance Abuse & Mental Health Services Administration's ("SAMHSA") multi-site Criminal Justice Diversion Initiative, was also collected, but only client responses regarding having served any incarceration time was used for the current analyses.

77. Chi-square tests, t-tests, and one-way analysis of varience are simple non-parametric and parametric statistical tests that are generally used to understand whether results are distributed according to prediction, whether there is a difference between group means, or a relationship between variables that occurs beyond chance. *See, e.g.,* FRED N. KERLINGER, FOUNDATIONS OF BEHAVIORAL RESEARCH: EDUCATIONAL AND PSYCHOLOGICAL INQUIRY 257-60 (1964).

ables were performed using one-way analysis of variance tests and post-hoc Tukey tests.

Psychiatric diagnoses used in analyses were based on the standardized instrument diagnoses from the DIS-IV. Substance abuse/dependence diagnoses were probable rather than absolute, as they were derived from the MAST and DAST. Subjects were considered to have a "lifetime" DIS-IV diagnosis if they met all criteria with no possible exclusions for other disorders. Those with diagnostic exclusions were not included as having a lifetime diagnosis,[78] and thus were analyzed as having no lifetime or, if no current diagnosis, no mental health diagnosis. Lifetime diagnoses included information from throughout the individual's life up to the past twelve months. Subjects were considered to have a "current" diagnosis if they had an active disorder in the past twelve months. Individuals in recovery, partial recovery, or with symptoms that did not reach full diagnostic criteria per the DIS-IV were not classified as currently ill. A score of five or above on the MAST or DAST was considered as a probable diagnosis for substance abuse/dependence, and a score of thirty-four on the BPRS was considered symptomatic of acute psychiatric disorder, consistent with Hart and Hemphill's findings as used in pre-trial populations.[79] Self-report drug and alcohol use, per the Drug/Alcohol 6-month Follow-Back (adapted), was analyzed for the first full month prior to intake for this Study.

IV. RESULTS

A. Characteristics of a Pre-Arraignment Population

1. *Rates of Mental Illness and Substance Abuse*

Table 1 shows the rates of mental disorders (both "lifetime" and "current"—within the past twelve months only) per DIS-IV responses and probable alcohol and drug abuse/dependence rates per the MAST and the DAST. Eighteen and one-half percent of the sample presented with a current diagnosis of serious mental illness, categorized as major depressive, bipolar, or schizophrenic disorder.

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78. For lifetime diagnosis, nine clients with a probable diagnosis were excluded: one with probable major depressive disorder, two with probable post-traumatic stress disorder, one with probable dysthymia, and five with probable generalized anxiety disorder.

79. *See* Patricia A. Zapf et al., *An Examination of the Relationship of Homelessness to Mental Disorder, Criminal Behavior, and Health Care in a Pretrial Jail Population*, 41 CAN. J. PSYCHIATRY 435, 437 (1996) (noting that study used a BPRS score of thirty-four, in line with Hart and Hemphill's recommendation).

Further, an overlapping seven percent (three percent discrete) endorsed a "moderate" mental health diagnosis, such as post-traumatic stress, dysthymia, or generalized anxiety. Thus, at the time of the interview, twenty-two percent of interviewees reached psychiatric diagnosis for one of the measured mental health disorders within the previous year: schizophrenia/schizophreniform, bipolar disorder, major depressive disorder (single or recurrent), dysthymia, generalized anxiety, or post-traumatic stress disorder. Neither a measure of functionality nor criteria for a previous psychiatric hospital episode, however, was included in the analyses. Rather, these are simply rates for reaching diagnostic criteria, not necessarily the rate of those in need of intervention. As a proxy for need for psychiatric intervention, BPRS ratings were used to assess the presence of current psychiatric symptoms. Thirteen percent overall (approximately one third or thirty-two percent of those with a DIS-IV current diagnosis) demonstrated serious symptoms, comparable to hospitalized patients.

Consistent with the literature, when lifetime rates for psychiatric diagnosis were examined, higher rates were found.[80] Overall, thirty-one percent of the sample endorsed some lifetime psychiatric diagnosis of those assessed, twenty-five percent had some lifetime diagnosis of a serious disorder, and an overlapping fifteen percent (six percent discrete) were diagnosed with a history of moderate psychiatric disorder.

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80. Jordan et al., *supra* note 37, at 515; Teplin et al., *supra* note 20, at 508.

TABLE 1 RATES OF MENTAL ILLNESS AND SUBSTANCE ABUSE IN THE GENERAL SAMPLE (*n*=281)		
Disorder	Current (12 months)	Lifetime
Severe Diagnosis (DIS-IV)	18.5% (*n*=52)	24.9% (*n*=70)
Major Depressive Disorder	16.4% (*n*=46)	14.9% (*n*=42)
Bipolar Disorder	7.8% (*n*=22)	7.5% (*n*=21)
Schizophrenia Disorder	1.8% (*n*=5)	2.5% (*n*=7)
Moderate Mental Health Diagnosis (DIS-IV)	7.1% (*n*=20)	14.9% (*n*=42)
Post-Traumatic Stress Disorder	6.0% (*n*=17)	10.3% (*n*=29)
Dysthymia	0.7% (*n*=2)	0.4% (*n*=1)
Generalized Anxiety Disorder	0.7% (*n*=2)	4.6% (*n*=13)
Any Mental Health Diagnosis (DIS-IV)	22.1% (*n*=62)	31.0% (*n*=87)
Probable Substance Abuse/Dependence Diagnosis (MAST/DAST)	44.5% (*n*=125)	
Alcohol Disorder (MAST)	32.4% (*n*=90)	
Drug Disorder (DAST)	34.9% (*n*=98)	
Co-Occurring Mental Health & Substance Abuse Diagnoses	15.3% (*n*=43)	20.6% (*n*=58)
Of Those with a Mental Health Disorder (*n*=62 current, 87 lifetime)	69.4%	66.7%
Of Those with a Substance Use Disorder (*n*=125)	34.4%	46.4%

Overall, forty-five percent of the sample was likely to be dependent upon or abusing drugs or alcohol (Table 1). The analyses suggest that forty-five percent is most likely a "floor effect" in terms of substance abuse. As further attributes indicative of substance abuse were taken into consideration, the percentage of drug users climbed steadily. For instance, forty-six percent of the overall sample (irrespective of substance abuse diagnosis) reported using illegal drugs in the previous month. Although individuals with a probable substance use diagnosis used alcohol or drugs for a significantly greater number of days than those without a probable diagnosis ($t(138.538)=-7.501$, p<.001 for alcohol; $t(233.576)=-5.780$, *p*<.001 for drugs), drug and/or alcohol use was reported among

both populations. Not surprisingly, the sample also had high rates of drug-related contact with the criminal justice system. Thirty-five percent were awaiting arraignment on a drug offense and fifty-four percent reported a history of being arrested for drug offenses. Overall, when combining daily use, diagnosis, and drug possession or sale charge, eighty percent of the population had some sort of historical or current involvement with drugs or alcohol. For those with a probable drug or alcohol disorder, thirty-four (current psychiatric diagnosis) to forty-six percent (lifetime psychiatric diagnosis) had co-occurring psychiatric diagnoses. Among those with a mental health diagnosis, the rate of substance abuse was much higher. Approximately sixty-seven percent (lifetime) to sixty-nine percent (current) of those with a psychiatric diagnosis had a probable co-occurring substance abuse or dependence diagnosis. Given the likely underestimate of the probable substance abuse/dependence diagnoses, these co-occurring rates, while consistent with the literature reviewed, are likely low.

2. *Current Versus Lifetime Mental Health Problems*

For analysis purposes, those with a psychiatric diagnosis were classified as any individual with either a lifetime or a current diagnosis. There was significant overlap between the two groups. Sixty-nine percent (*n*=60) of those with a lifetime diagnosis also had a current diagnosis, while ninety-seven percent of those with a current diagnosis also had a lifetime diagnosis. Two cases were excluded when individuals with current diagnoses were compared to those with lifetime only diagnoses, but were included for the fuller analyses below. One was an individual with a current depressive episode who had not met criteria for major depressive disorder, while the other had a current diagnosis of dysthymia and a probable lifetime diagnosis of both generalized anxiety disorder and dysthymia, who had not been counted as mentally ill according to coding procedures as outlined above.

Table 2 compares those individuals with a current (preceding twelve-months prior to interview) psychiatric diagnosis, of whom ninety-seven percent had a lifetime diagnosis, to those who only had a lifetime diagnosis, on a number of variables representative of the issues explored in this Study. As these groups ostensibly overlap, it is consistent that those with lifetime only and those with current diagnoses did not differ significantly in most respects, with the exception that those with a current diagnosis (plus lifetime) were more likely to have been arrested previously than those with a life-

time diagnosis only, possibly indicating chronicity. Rates of substance abuse, homelessness, unemployment, childhood trauma, and use of mental health and substance abuse services (see below) are high both for those with a lifetime and current diagnosis and for those without a current diagnosis.

TABLE 2 COMPARISON OF ARRESTEES WITH LIFETIME ONLY VERSUS CURRENT DIAGNOSIS		
Variable	Lifetime Diagnosis Only ($n=27$)	Current and Lifetime Diagnosis ($n=62$)
Gender		
Male	52% ($n=14$)	69% ($n=43$)
Female	48% ($n=13$)	31% ($n=19$)
Race\Ethnicity		
African-American	52% ($n=14$)	59% ($n=36$)
White	7% ($n=2$)	15% ($n=9$)
Latino	41% ($n=11$)	26% ($n=16$)
Age *M(SD)* Range	29(8) 19-55	29(10) 17-55
Education*M(SD)* Range	12(3) 6-16	11(2) 8-16
Diagnostic Severity		
Moderate Only	30% ($n=8$)	15% ($n=9$)
Severe Only	52% ($n=14$)	53% ($n=33$)
Both Moderate and Severe	18% ($n=5$)	32% ($n=20$)
Substance Abuse Diagnosis	63% ($n=17$)	69% ($n=43$)
Used Alcohol or Drugs, One Month Before Arrest	59% ($n=16$)	79% ($n=48$)
Index Offense Charge Severity		
Felony	52% ($n=13$)	39% ($n=23$)
Misdemeanor	48% ($n=12$)	61% ($n=36$)
Previously Arrested*[81]	60% ($n=15$)	85% ($n=51$)
Previously Convicted	48% ($n=12$)	59% ($n=35$)
Unemployed at Arrest	44% ($n=12$)	59% ($n=34$)
History of Homelessness	33% ($n=9$)	47% ($n=29$)
History of Trauma	52% ($n=14$)	53% ($n=33$)
History of Mental Health or Substance Abuse Treatment	59% ($n=16$)	66% ($n=41$)

* $p<.05$

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81. $\chi^2=6.355$, df=1, p<.05.

3. *Differential Populations by Arraignment Disposition*

Nineteen percent of the sample was admitted to the New York City Department of Correction as a result of their index offense. All but one of these cases were admitted directly from arraignment. This is an underestimate of the overall number of those detained from the arraignment. When examining the full collected sample, including those who refused or were excluded (N=495), that rate rose to twenty-two percent of those arraigned and detained in jail, which is approximately equivalent to current New York City Department of Correction admission rates. Because the Study's results indicate that seventy-five to eighty percent of the sample were being returned directly to the community without incarceration, a number of analyses were conducted to determine how those going to jail were similar to or different from those going back to the community, in terms of demographic characteristics, criminal justice offenses, psychiatric and substance abuse diagnoses, homelessness, employment, trauma history, and past service use.

The mentally ill were significantly more likely to be incarcerated as a result of their index offense, whether their diagnosis was lifetime, $\chi^2(1, N$=495)=11.336, p<.01, or current, $\chi^2(1, N$=495)=11.004, p<.01. Fully half of those incarcerated had a lifetime psychiatric diagnosis, and thirty-nine percent had a current psychiatric diagnosis. This discrepancy held true for those with a serious diagnosis, lifetime, $\chi^2(1, N$=495)=8.955, p<.01, or current, $\chi^2(1, N$=495)=9.746, p<.01, but not for those with a moderate diagnosis. Sixty-three percent of the incarcerated group had a positive substance abuse diagnosis, $\chi^2(1, N$=495)=9.243, p<.01.

Additionally, thirty-nine percent of those incarcerated on their index offense had a history of mental health treatment, $\chi^2(1, N$=495)=5.342, p<.05, forty-one percent had a history of substance abuse treatment, $\chi^2(1, N$=495)=8.143, p<.01, and sixty-one percent had a history of either type of treatment, $\chi^2(1, N$=495)=8.520, p<.01. Study participants with a history of homelessness were also more likely to be found among those that were incarcerated following arraignment. Forty-three percent of the incarcerated group had a history of homelessness, $\chi^2(1, N$=495)=6.547, p<.05.

Eighty-seven percent of those incarcerated were men, significantly more than the thirteen percent of women, $\chi^2(1, N$=495)=8.823, p<.01. These figures are similar to the ten percent annual estimates for women housed in New York City jail facilities. Those with a prior arrest history, ninety-two percent of those incar-

cerated, $\chi^2(1, N=495)=13,443, p<.001$, and those arrested on a felony charge were more likely to be incarcerated following arraignment (fifty-three percent of those incarcerated), $\chi^2(1, N=495)=7.180, p<.01$. There were no significant differences in race, age, marital status, educational level, unemployment, current homelessness, index offense charge, drug use, alcohol use, or trauma history between those who were incarcerated and those who were not. While significant differences do exist between those released at arraignment and those detained, being that this Study is descriptive rather than explicative, causality is not implied. The analyses used do not account for particular factors (for example, substance abuse, mental illness, charge, homelessness, past treatment, or some combination of factors) that may impact incarceration rates.

B. Demographic, Criminal Justice, and Service Use Differences by Diagnostic Group

Given that three quarters of the sample with lifetime diagnoses also had current diagnoses, and that those with lifetime diagnoses did not differ greatly from those with current diagnoses (Table 2), lifetime and current diagnosis were combined to give a broader picture of psychiatric illness in the pre-arraignment population. Accordingly, the two cases that had current diagnoses, but no lifetime diagnosis were included. One of the purposes of this research is to describe the arraignment population in order to shed light on potential needed service interventions; therefore a comparison of diagnostic subpopulations was undertaken. The sample was divided into four groups based on psychiatric and substance abuse diagnoses: twenty-nine individuals with a psychiatric diagnosis and no substance abuse diagnosis ("MI"), sixty individuals with both a psychiatric and probable substance abuse or dependence diagnosis ("MICA"), sixty-five individuals with a probable substance abuse or dependence diagnosis but no psychiatric diagnosis ("SA"), and 127 individuals whose symptoms or substance use did not reach diagnostic criteria or who had no symptoms or use ("None").

Having divided the sample into differing groups by presence, absence, or co-occurrence of mental health and substance disorders, the four groups were analyzed to determine how else these populations differed. The groups were compared on a number of demographic variables. To describe the severity of the sample's psychiatric and substance abuse problems, the Study analyzed the groups in terms of psychiatric symptoms and substance use pat-

terns. The differences between groups were examined in terms of criminal justice history, index offense, criminal justice outcomes, and recidivism to see whether individuals with different needs were also having different experiences with the criminal justice system. Finally, a number of different potential areas of needs for this population were examined based on self-reported homelessness, employment, financial support, family and living situation, and trauma history. Medical, mental health, and substance abuse treatment patterns were also examined.

1. *Demographics*

Table 3 shows how the four groups differ on key demographic variables, as well as statistical significance and parameters (as do other tables). No significant differences between groups emerged from the analyses, with the exception of age. MICA arrestees were significantly older than None arrestees, and SA arrestees were significantly older than those with no substance abuse diagnosis.[82] The sample did not differ in terms of gender, race, educational background, marital status, or parental status. Approximately fifty-five percent of the sample had children, even though only about half of those with children had children living with them who were under the age of eighteen (fifty-one percent, $n=78$). Six arrestees (two percent) were veterans, and it was not possible to perform analyses with this variable due to the small number of cases.

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82. "No substance abuse diagnosis" includes both the MI and the None groups.

TABLE 3 DEMOGRAPHIC DIFFERENCES AMONG GROUPS						
Variable		(A) MI (*n*=29)	(B) MICA (*n*=60)	(C) SA (*n*=65)	(D) None (*n*=127)	Total Sample (*n*=281)
Gender	Male	59% (*n*=17)	67% (*n*=40)	82% (*n*=53)	69% (*n*=88)	71% (*n*=198)
	Female	41% (*n*=12)	33% (*n*=20)	18% (*n*=12)	31% (*n*=39)	29% (*n*=83)
Race/ Ethnicity	African-American	65% (*n*=19)	53% (*n*=31)	65% (*n*=42)	76% (*n*=92)	67% (*n*=184)
	White	7% (*n*=2)	15% (*n*=9)	14% (*n*=9)	9% (*n*=11)	11% (*n*=31)
	Latino	28% (*n*=8)	32% (*n*=19)	21% (*n*=14)	15% (*n*=18)	22% (*n*=59)
Married/ Common-law		21% (*n*=6)	23% (*n*=14)	19% (*n*=12)	18% (*n*=22)	19% (*n*=54)
Have Children		48% (*n*=14)	65% (*n*=39)	52% (*n*=34)	53% (*n*=67)	55% (*n*=154)
Age***[83] *M(SD)*		26(8) 17-51	31(9) 17-55	31(10) 18-63	26(8) 16-49	28(9) 16-63
Education Level *M(SD)*		12(2) 9-16	11(2) 6-16	11(2) 6-16	12(2) 6-16	11(2) 6-16

*** $p<.001$

2. *Psychiatric Symptomatology and Substance Use Patterns*

The analyses of symptomatology and use patterns lent further support to the classification by diagnosis. Table 4 indicates levels of psychiatric distress as measured by the BPRS. Individuals in the MI and MICA groups had significantly higher scores on the BPRS than those without any diagnosis (None). Those in the MICA group also had significantly higher scores than those with a psychiatric diagnosis only (MI) and those with only a substance abuse diagnosis (SA). Further analyses showed elevated symptoms for the MICA group as opposed to those with no disorders (None) on four of the five BPRS subscales (anxiety-depression, thought disturbance, activation, and hostile-suspiciousness). Individuals in the MICA group had higher scores than those in the MI group on the anxiety-depression and thought disturbance subscales, and were

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83. $F=7.260$, $df=3$, 277, $p<.001$ (B>D, C>A, C>D, by one-way ANOVA).

significantly more likely to reach an acute cutoff score of thirty-four, $\chi^2(3, n=127)=41.464$, $p<.001$. There was no difference among groups on the anergia (lack of energy) subscale. Those in the MI group had significantly higher scores than those with no diagnosis (None) on the anxiety-depression scale.

TABLE 4
PSYCHIATRIC SYMPTOMATOLOGY ON THE
BPRS BY DIAGNOSTIC GROUP

BPRS Scale		(A) MI (n=29)	(B) MICA (n=60)	(C) SA (n=65)	(D) None (n=127)
Sum Score***[84] (n=271)	M	25.607	30.707	22.918	21.284
	SD	7.455	9.413	5.478	4.917
	Range	18-48	18-58	18-44	18-42
Anxiety/ Depression Scale***[85] (n=271)	M	1.929	2.444	1.504	1.256
	SD	0.805	1.009	0.633	0.475
	Range	1.00-3.50	1.00-4.75	1.00-3.50	1.00-3.50
Anergia Scale (n=271)	M	1.250	1.306	1.303	1.248
	SD	0.366	0.459	0.477	0.612
	Range	1.00-2.25	1.00-2.75	1.00-2.50	1.00-3.75
Thought Disturbance Scale***[86] (n=271)	M	1.170	1.547	1.103	1.055
	SD	0.354	0.829	0.286	0.258
	Range	1.00-2.50	1.00-4.75	1.00-2.75	1.00-3.50
Activation Scale***[87] (n=271)	M	1.310	1.379	1.115	1.081
	SD	0.725	0.745	1.257	0.265
	Range	1.00-4.33	1.00-5.33	1.00-2.00	1.00-2.67
Hostile-Suspiciousness Scale***[88] (n=271)	M	1.429	1.816	1.317	1.268 .
	SD	0.753	0.929	0.582	0.600
	Range	1.00-3.67	1.00-5.33	1.00-3.33	1.00-4.00

*** $p<.001$

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84. F=29.123, df=3, 270, p<.001 (B>A, B>C, B>D, A>D).

85. F=41.956, df=3, 270, p<.001 (B>A, B>C, B>D, A>C, A>D).

86. F=16.404, df=3, 270, p<.001 (B>A, B>C, B>D).

87. F=6.541, df=3, 270, p<.001 (B>C, B>D).

88. F=8.766, df=3, 270, p<.001 (B>C, B>D).

An analysis of substance use patterns, described in Table 5, found that those in the MICA and SA groups were significantly more likely to have used alcohol, drugs, or both in the month prior to their arrest than those without a substance abuse diagnosis (None and MI groups). Interestingly, twenty-eight percent of the MI group and thirty-percent of the None group reported illegal drug use in that month, although only two MI arrestees and one None arrestee used any illegal drug harder than marijuana. The use of "harder" drugs such as cocaine, opiates, stimulants, and sedatives was generally confined to the MICA and SA groups. While SA and MICA groups drank alcohol in significantly more days in the previous month than those without a substance abuse diagnosis, those in the MICA group used drugs significantly more frequently than any other group (SA, MI, and None). Those in the SA group used drugs more frequently than those in the None group, and all four groups reported some illicit substance use in the previous month.

Individuals with mental health and substance use diagnoses (MICA) and probable substance use diagnosis (SA) began drinking at an earlier age than those in the None group, although the average age of first drug use did not vary significantly by group (see Table 5). MICA and SA arrestees were also more likely to have drunk beer or used cocaine or crack than those with no substance abuse diagnosis (MI and None). Additionally, MICA arrestees were more likely to have drunk hard liquor than those in the None group. No differences emerged in use patterns of wine or marijuana. As the occurrence of drugs used in the month prior to arrest was low, the sample size did not allow for comparative group analyses of opiates or "other drugs" used.

TABLE 5 DRUG AND ALCOHOL USE BY GROUP					
Variable		MI ($n=29$)	MICA ($n=60$)	SA ($n=65$)	None ($n=127$)
Used Alcohol Month Before Arrest***[89]		34.5% ($n=10$)	69.5% ($n=41$)	67.7% ($n=44$)	40.2% ($n=51$)
	Beer/Malt Liquor***[90]	24.1% ($n=7$)	60.0% ($n=36$)	61.5% ($n=40$)	26.0% ($n=33$)
	Wine	6.9% ($n=2$)	10.0% ($n=6$)	10.8% ($n=7$)	7.1% ($n=9$)
	Hard Liquor**[91]	17.2% ($n=5$)	40.7% ($n=24$)	27.7% ($n=18$)	18.1% ($n=23$)
Used Drugs Month Before Arrest***[92]		27.6% ($n=8$)	75.0% ($n=45$)	58.5% ($n=38$)	29.9% ($n=38$)
	Marijuana	27.6% ($n=8$)	45.0% ($n=27$)	40.0% ($n=26$)	29.1% ($n=37$)
	Cocaine/Crack***[93]	3.4% ($n=1$)	28.3% ($n=17$)	27.7% ($n=18$)	0.8% ($n=1$)
	Opiates^	0.0% ($n=0$)	10.0% ($n=6$)	9.2% ($n=6$)	0.8% ($n=1$)
	Other Drugs^[94]	3.4% ($n=1$)	15.0% ($n=9$)	4.6% ($n=3$)	0.0% ($n=0$)
Used Either Month Before Arrest***[95]		51.7% ($n=15$)	83.1% ($n=49$)	86.2% ($n=56$)	55.9% ($n=71$)
Age of First Drink***[96] ($n=248$)	*M*	15.17	14.09	13.70	16.67
	SD	3.62	4.16	3.28	3.78
	Range	7-21	2-27	6-20	5-32
Age of First Drug Use	*M*	15.41	15.68	15.24	16.46
	SD	2.79	5.23	3.87	4.05

89. $\chi^2=24.349$, df=3, p<.001 (B>A, B>D, C>A, C>D, by Bonferroni-corrected χ^2 test).

90. $\chi^2=35.453$, df=3, p<.001 (B>A, B>D, C>A, C>D, by Bonferroni-corrected χ^2 test).

91. $\chi^2=12.132$, df=3, p<.01 (B>D, by Bonferroni-corrected χ^2 test).

92. $\chi^2=41.565$, df=3, p<.001 (B>A, B>D, C>A, C>D, by Bonferroni-corrected χ^2 test).

93. $\chi^2=43.484$, df=3, p<. .001 (B>A, B>D, C>A, C>D, by Bonferroni-corrected χ^2 test).

94. "Other drugs" include sedatives, stimulants, psychedelic, and inhalant drugs.

95. $\chi^2=28.149$, df=3, p<.001 (B>A, B>D, C>A, C>D, by Bonferroni-corrected χ^2 test).

96. F=10.471; df=3, 245; p<.001 (D>B; D>C).

(*n*=208)	Range	10-21	9-35	5-28	9-35
Number of Days	*M*	1.55	8.54	9.29	1.54
Drinking	*SD*	3.18	10.26	11.06	2.97
Alcohol, Last Month***[97]	Range	0-12	0-31	0-31	0-15
Number of Days	*M*	4.55	16.95	10.77	5.57
Using Drugs,	*SD*	9.90	12.71	12.96	10.62
Last Month***[98]	Range	0-31	0-31	0-31	0-31

** *p*<.01   *** *p*<.001 ^expected cell frequencies too low to permit crosstab analysis

3. *Criminal Justice Contact*

Based on collateral criminal justice data collected from police records, court records, and correctional records, individuals in the four groups varied in their contact with the criminal justice system. The variations depended on whether analyses used retrospective data, the current index offense, or prospective data for the twelve-months following study intake at arraignment (Table 6). A review of arrest records found that MICA and SA arrestees were more likely to have been arrested previously than those in the None group. SA arrestees were more likely to have an arrest history than MI arrestees, though over half of the individuals within each of the four groups, and seventy-two percent overall, had some prior arrest record. When past convictions were divided into felony and misdemeanor offenses, MICA and SA arrestees were more likely to have a history of being convicted of a misdemeanor $\chi^2(3, n=171)=25.548, p<.001$, a felony $\chi^2(3, n=100)=21.098, p<.001$, or either type of offense category $\chi^2(3, n=271)=29.008, p<.001$, as compared to those in the None group. Those in the MICA and SA groups also were more likely to have had a warrant issued for their arrest at some point in their lifetime than those in the None group. Overall, forty-two percent of those in the sample self-reported a history of "doing time." Again, those in the MICA and SA groups had significantly higher rates for self-reported incarceration than those in the None group. While the Study did not look at ways in which drug offenses may be driving some of these differences in arrest and conviction rates, a review of arrest records revealed that MICA and SA arrestees were also more likely to have a history of being arrested, $\chi^2(3, n=193)=38.031, p<.001$, and/or convicted, $\chi^2(3, n=131)=21.625, p<.001$ for a drug offense than those in the None

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97. F=22.789; df=3, 276; p<.001 (B>A; B>D; C>A; C>D).
98. F=15.019; df=3, 277; p<.001 (B>A; B>C; B>D; C>D).

category. SA arrestees were also more likely to have a drug arrest on their record than MI arrestees.

The groups also were compared based on their experience with the criminal justice system at the time of their arrest (their index or intake offense). In contrast to the differences that emerged between groups for past criminal justice history variables (for example, retrospective longitudinal data), when data from a single point in time, arraignment for the index offense, was analyzed (for example, cross-sectional data), few differences between groups were found. Overall, twenty-two percent were arrested for a violent offense, thirty-six percent for a drug offense, eleven percent for a property offense, and thirty-one percent for a public disorder offense (see Table 6).[99] There were no significant differences among the groups in terms of the type of offense with which they were charged, or in terms of the severity of that offense (felony or misdemeanor).[100] When examining whether the intake offense was violent, both by New York State statute (fourteen percent overall), and by common criminal justice practice (twenty-four percent overall), there were no significant differences among the groups.[101]

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99. For analysis purposes, crimes were grouped into the following categories: violent (robbery, assault, and sexual assault); drug (sale and possession); property (burglary, grand larceny, and fraud); and public disorder offenses which included quality of life crimes (trespassing, theft of services, prostitution, vandalism, and petit larceny), procedural offenses (resisting arrest, criminal contempt, and obstruction), and administrative violations (open container, public urination, and driving without a license). Eleven cases originally classified as "other crimes against persons" were excluded in order to allow for meaningful analyses; these offenses included criminal possession of a weapon, reckless endangerment, and endangering the welfare of a child. While some studies have looked at possession of a weapon as a violent offense, as it was not possible to determine whether the weapon in question was a gun, knife, or something less menacing, it was decided not to classify them as violent as such. The analyses of violent crime rates by statute and practice reflect these cases, however, which explains the differing rates of "violent" offenses.

100. Administrative code violations (i.e., open container; $n=6$) were excluded for these analyses.

101. "Violent by common practice" was determined through interviews with judges, prosecutors, and defense attorneys in Brooklyn and the Bronx. At the time of this Study, charges that were not considered violent by statute, but were treated as violent charges by common practice included third degree assault, vehicular assault, menacing, reckless endangerment, second and third degree rape and sexual abuse, and endangering the welfare of a child.

TABLE 6				
CRIMINAL JUSTICE INVOLVEMENT BY GROUP				
Variable	(A) MI (*n=29*)	(B) MICA (*n=60*)	(C) SA (*n=65*)	(D) None (*n=127*)	Total Sample (*n=281*)
Arrest and Conviction History					
Any Prior Arrests (*n=269***)[102]	62% (*n=16*)	85% (*n=50*)	92% (*n=60*)	56% (*n=67*)	72% (*n=193*)
Any Prior Convictions (*n=262*)***[103]	42% (*n=11*)	62% (*n=36*)	73% (*n=45*)	34% (*n=39*)	50% (*n=131*)
Any Prior Warrants (*n=262*)***[104]	31% (*n=8*)	53% (*n=30*)	59% (*n=37*)	22% (*n=26*)	39% (*n=101*)
Any Prior Time Served (Self-Report) (*n=270*)***[105]	43% (n=12)	54% (*n=30*)	61% (*n=38*)	27% (*n=33*)	42% (*n=113*)
Index Offense					
Offense Type					
Violent	24% (*n=6*)	15% (*n=9*)	15% (*n=10*)	28% (*n=33*)	22% (*n=58*)
Drug	20% (*n=5*)	40% (*n=23*)	42% (*n=27*)	35% (*n=42*)	36% (*n=97*)
Property	12% (*n=3*)	17% (*n=10*)	9% (*n=6*)	9% (*n=11*)	11% (*n=30*)
Public Order	44% (*n=11*)	28% (*n=16*)	34% (*n=22*)	28% (*n=34*)	31% (*n=83*)
Violent Offense					
By NYS Statute	25% (*n=7*)	13% (*n=8*)	9% (*n=6*)	15% (*n=19*)	14% (*n=40*)
By Common Practice	25% (*n=7*)	18% (*n=11*)	16% (*n=10*)	30% (*n=37*)	24% (*n=65*)
Offense Severity					
Felony	42% (*n=11*)	43% (*n=25*)	32% (*n=20*)	35% (*n=44*)	37% (*n=100*)

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102. χ^2=33.814, df=3, p<.001 (B>D, C>D, C>A).
103. χ^2=29.088, df=3, p<.001 (B>D, C>D).
104. χ^2=29.016, df=3, p<.001 (B>D, C>D).
105. χ^2=24.631, df=3, p<.001 (B>D, C>D).

Misdemeanor	58% (n=15)	57% (n=33)	68% (n=42)	65% (n=81)	63% (n=171)
Incarcerated as Result of Index Offense***[106]	28% (n=8)	32% (n=19)	23% (n=15)	9% (n=12)	19% (n=54)
Criminal Justice Recidivism and Incarceration Patterns					
Rearrested, 12 Months**[107]	48% (n=14)	47% (n=28)	52% (n=34)	29% (n=37)	40% (n=113)
Number of Rearrests, 12 Months M(SD) Range	2(3) 0-9	2(2) 0-7	2(2) 0-10	2(3) 0-20	2(2) 0-20
Number of Re-incarcerations, 12 Months M(SD) Range	1(1) 0-3	1(1) 0-4	1(2) 0-7	1(2) 0-12	1(1) 0-12
Days Incarcerated on Index Offense***[108] M(SD) Range	3(7) 0-30	22(62) 0-308	13(31) 0-159	2(7) 0-55	8(29) 0-275
Days Incarcerated on Sub-sequent Offenses M(SD) Range	17(41) 0-164	17(54) 0-233	14(36) 0-205	12(52) 0-365	15(51) 0-365
Total Days Incarcerated, 12 Months*[109] M(SD) Range	20(43) 0-164	·39(79) 0-308	27(55) 0-364	13(53) 0-365	23(61) 0-365

$*p<.05$ ** $p<.01$ *** $p<.001$

The four groups experienced the criminal justice system in signif-
icantly different ways after their arrest and arraignment. When
looking prospectively, MICA arrestees were more likely to be in-
carcerated as a result of their index offense than those in the None

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106. χ^2=15.729, df=3, p<.001 (B>D).
107. χ^2=12.262, df=3, p<.01 (C>D).
108. F=5.779, df=3, 277, p<.01 (B>D).
109. F=2.743, df=3, 277, p<.05 (B>D).

group, and spent significantly more time in jail or prison as a result of their index arrest than did those in the None group (see Table 6). A prospective analysis of case outcomes (n=148) revealed that eighty-six percent of the index offense cases resulted in a conviction. This result does not include cases whose outcomes were pending one year after the original arrest or those whose outcomes are unknown. This latter group includes those whose records were expunged from the system or sealed, biasing these results toward a greater conviction rate. The overall rate of conviction is much lower.[110] Due to the high rate of conviction (the ceiling effect), it was not possible to analyze this variable across groups.

The four groups did not differ significantly in terms of frequency of re-arrest or re-incarceration over the year following the arrest and arraignment on the index offense, but SA arrestees were more likely to have been re-arrested at least once compared to those in the None group (see Table 6). While MICA group participants spent more days incarcerated overall and on the index arrest than those in the None group, there were no differences between groups in the number of days spent incarcerated on subsequent re-arrests in the twelve months following their arraignment. Overall, MICA arrestees spent more time incarcerated during the one year follow-up than did the None arrestees, $F(3,277)=2.743$, $p<.05$, spending more time in jail, $F(3,277)=2.710$, $p<.05$, but not in prison. When looking at those who were jailed at least once over the course of the following year (either from the index offense or from a subsequent arrest), those in a group with a diagnosis (MI, MICA, or SA) were significantly more likely to have been jailed at least once than those in the None group, $\chi^2(3, n=113)=19.878$, $p<.001$. Time at risk was not controlled, thus limiting the conclusions that may be drawn in terms of group differences and re-offending rates. Also, the small number of individuals in the MI group relative to the other groups (MI=29, MICA=60, SA=65, and None=127) may have prevented detection of differences between the MI group and other groups.

4. *Service Use Patterns and Needs*

In addition to its demonstrated psychiatric and substance abuse/dependence treatment needs, the pre-arraignment population also

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110. Interview with Kings County District Attorney's Office, *supra* note 57. Of the total number of arrests in 2000 in Kings County, forty-seven percent were later convicted and thirty-three percent of those convicted received a jail or prison sentence. *Id.*

has other potential needs and issues that may benefit from intervention and that vary between groups. In terms of these issues (see Table 7), the analyses focused on employment and financial difficulties, difficulties inherent in the arrestee's family or living situation, trauma history, and health-related problems. In terms of service use patterns (see Table 8), self-reported use of psychiatric and substance abuse hospital in-patient treatment, outpatient treatment, detoxification, and medication were examined.

Although ninety-three percent reported a history of employment, thirty-four percent ($n=87$) had never held a position for longer than one year. Forty-nine percent of the sample was unemployed at the time of arrest, with rates that differed significantly overall but not between any two groups in particular (see Table 7). About one-third of those employed (thirty-five percent, $n=49$) had only a part-time job. Fifty-five percent of the sample ($n=140$) earned below ten thousand dollars per year and three-quarters (seventy-six, $n=194$) earned below twenty thousand dollars. Fewer than half the sample supported themselves primarily through salary or odd jobs, with many depending on family, friends, government programs, or illegal activities for support. Surprisingly, although the bulk of the sample was living on very little money and thus potentially eligible to receive government benefits, few individuals reported receiving them. Only sixteen percent ($n=44$) of the sample reported receiving public assistance. Among these, twelve percent ($n=33$) reported receiving Supplemental Security Income ("SSI") or Social Security Disability Insuance ("SSD"), thirty-six percent ($n=101$) reported receiving Medicare or Medicaid, and fourteen percent ($n=38$) reported receiving food stamps. There were no significant differences among the four groups in terms of employment and financial support, although it was not possible to analyze either income or means of support due to small sample size.

Many of the arrestees studied faced additional difficulties in their living situations. Foremost was the absence of stability. Overall, nearly thirty percent reported a history of homelessness, while ten percent reported homelessness at the time of arrest (see Table 7). Those in the MICA and SA groups were more likely than those in the None group to have experienced homelessness, and those in the MICA group were more likely than those in the None group to be homeless at the time of arrest. Current homelessness statistics may be somewhat suppressed, as twenty-one percent ($n=59$) of the sample reported having lived in a shelter at some

time in their lives. Further, exit interviews and focus groups supported the idea that current and even past homelessness, may have been under-reported in the sample, as those who were living in a shelter, or those that had a bed to sleep in the night prior to or the night following arraignment considered themselves to be domiciled. Further, defendants in focus groups noted that they believed that noting that one had a place to live (even if transient) would increase the chance of release.

Individuals who did have a stable living situation frequently had roommates, partners, or family members with problems that mirrored their own (see Table 7). Eighteen percent of the sample lived with a substance abuser. That number rose to thirty-seven percent among MICA arrestees and twenty-five percent among SA arrestees, a significant increase when compared to None arrestees. The groups differed significantly overall, but not between groups, with respect to living with someone who had gone through detoxification. Likewise, thirty-percent of the MICA group reported having a family member with a history of mental health treatment, a percentage significantly higher than when compared to those without a psychiatric diagnosis (SA and None). As the number of cases for those who specifically endorsed having family members who had experienced their treatment through a psychiatric hospitalization was small, significance testing between groups could not be done. Those in the MI group were more likely than those in the None group to live with someone who had been incarcerated for thirty days or more.

Given the instability of living situations described above, in terms of living arrangements and types of partner/family problems, that a third of the sample had also experienced childhood abuse (see below) and that over half of the sample endorsed having had children, the potential impact on parental status and abuse resulting in the involvement of child welfare is described. As shown in Table 7, seventeen percent (n=25) of those with children reported Administration for Children's Services ("ACS") involvement in their families at some time in their children's life (there were no significant differences between groups); eight percent (n=12) reported an ACS involvement at the time of arrest. Ten percent (n=15) reported having lost custody of their children, and five percent (n=7) reported having had their parental rights terminated. Due to small sample size, these last three variables could not be tested for potential group differences.

This pre-arraignment population also reported high rates of past trauma experiences, as described in Table 7. Fully one third of the sample reported some kind of abuse history (sexual, physical, or emotional), with those in the MI and MICA groups more likely than those without a psychiatric diagnosis to have a history of abuse. Twenty-five percent of the sample reported a history of emotional abuse, with MICA arrestees more likely than the SA or None arrestees to report a history of emotional abuse. Eighteen percent reported a history of physical abuse, significant overall, but not among groups. Overall, nine percent reported a history of sexual abuse, with MI arrestees significantly more likely to have experienced sexual abuse than those in the None group. Percentages of childhood trauma experiences described may under-report prevalence within this population; this data was attained through direct questioning, rather than through a standardized instrument or collateral data, which in the area of trauma is known to lead to under-reporting. Overall, in addition to childhood trauma, an overlapping thirty-six percent reported that they had been victims of a violent crime. Although the groups differed significantly overall in terms of violent victimization, they did not differ specifically among each other.

TABLE 7				
PARTICIPANTS' NEEDS AND SITUATIONAL FACTORS				
Variable	(A) MI (*n*=29)	(B) MICA (*n*=60)	(C) SA (*n*=65)	(D) None (*n*=127)	Total Sample (*n*=281)
Employment/Financial Situation					
Unemployed at Arrest[111]	33% (*n*=9)	64% (*n*=37)	49% (*n*=31)	45% (*n*=55)	49% (*n*=132)
*Primary Means of Support^*					
Salary/Odd Jobs	55% (*n*=16)	37% (*n*=22)	35% (*n*=23)	48% (*n*=61)	44% (*n*=122)
Family/ Friends	17% (*n*=5)	22% (*n*=13)	31% (*n*=20)	31% (*n*=39)	28% (*n*=77)
Government	28% (*n*=8)	29% (*n*=17)	20% (*n*=13)	17% (*n*=21)	21% (*n*=59)
Hustling/ Illegal Acts/Other	0% (*n*=0)	9% (*n*=5)	11% (*n*=7)	5% (*n*=6)	6% (*n*=18)
None	0% (*n*=0)	3% (*n*=2)	3% (*n*=2)	0% (*n*=0)	1% (*n*=4)
Family and Living Situation					
Homelessness					
Ever***[112]	28% (*n*=8)	50% (*n*=30)	34% (*n*=22)	16% (*n*=20)	29% (*n*=80)
Current**[113]	3% (*n*=1)	20% (*n*=12)	14% (*n*=9)	6% (*n*=7)	10% (*n*=29)
Live with Drug/Alcohol Abuser***[114]	15% (*n*=4)	37% (*n*=20)	25% (*n*=15)	6% (*n*=7)	18% (*n*=46)
Live with Detoxee*[115]	8% (*n*=2)	19% (*n*=10)	17% (*n*=10)	5% (*n*=6)	11% (*n*=28)

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111. χ^2=8.481, df=3, p<.05 (Bonferroni-corrected χ^2 test returned no pairs significant at the .008 level).

112. χ^2=24.684, df=3, p<.001 (B>D, C>D).

113. χ^2=11.886, df=3, p<.01 (B>D).

114. χ^2=27.761, df=3, p<.001 (B>D, C>D).

115. χ^2=9.758, df=3, p<.05 (Bonferroni-corrected χ^2 test returned no pairs significant at the .008 level).

Family Member Treated for Mental Health***[116]	20% (*n*=5)	30% (*n*=17)	8% (*n*=4)	7% (*n*=8)	14% (*n*=34)
Family Member Hospitalized for Mental Health^	4% (*n*=1)	17% (*n*=9)	6% (*n*=3)	5% (*n*=5)	8% (*n*=18)
Live with Someone Incarcerated 30+ Days**[117]	31% (*n*=8)	24% (*n*=13)	12% (*n*=7)	9% (*n*=11)	15% (*n*=39)
ACS Involvement (Of Those with Children, n=154)					
Ever	15% (*n*=2)	26% (*n*=10)	21% (*n*=7)	9% (*n*=6)	17% (*n*=25)
Current^	8% (*n*=1)	18% (*n*=7)	13% (*n*=4)	0% (*n*=0)	8% (*n*=12)
Trauma					
Victim of a Violent Crime*[118]	48% (*n*=14)	48% (*n*=29)	33% (*n*=21)	29% (*n*=37)	36% (*n*=101)
Abuse History					
Sexual**[119]	21% (*n*=6)	15% (*n*=9)	6% (*n*=4)	4% (*n*=5)	9% (*n*=24)
Physical*[120]	31% (*n*=9)	27% (*n*=16)	11% (*n*=7)	14% (*n*=18)	18% (*n*=50)
Emotional***[121]	38% (*n*=11)	48% (*n*=29)	14% (*n*=9)	17% (*n*=21)	25% (*n*=70)
Any Childhood Abuse***[122]	52% (*n*=15)	53% (*n*=32)	22% (*n*=14)	25% (*n*=32)	33% (*n*=93)

*$p<.05$** $p<.01$*** $p<.001$

^expected cell frequencies too low to permit crosstab analysis

In terms of medical health and physical well-being, thirty-one percent of the sample reported a medical problem or physical disa-

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116. χ^2=18.523, df=3, p<.001 (B>C, B>D).

117. χ^2=11.798, df=3, p<.01 (A>D).

118. χ^2=8.731, df=3, p<.05 (Bonferroni-corrected χ^2 test returns no pairs significant at .008 level).

119. χ^2=12.647, df=3, p<.01 (A>D).

120. χ^2=9.872, df=3, p<.05 (Bonferroni-corrected χ^2 test returns no pairs significant at .008 level).

121. χ^2=28.945, df=3, p<.001 (B>C, B>D).

122. χ^2=23.142, df=3, p<.001 (A>C, A>D, B>C, B>D).

bility,[123] with MICA and SA arrestees significantly less healthy as compared to those in the None group (see Table 8). Thirty-six percent overall and fifty percent of the MICA group reported a hospitalization for a physical health problem within the past five years, with those in the MICA group significantly more likely than those in the None group to have been hospitalized. Additionally, ten percent of the sample self-reported that they had attempted suicide and thirty-one percent, overall, had considered it. Those rates were significantly higher for MICA classified participants (twenty-eight percent attempt and sixty-nine percent ideation, respectively) than for either those classified as SA (six percent attempt and eighteen percent ideation), or None (two percent attempt and fourteen percent ideation). Rates for attempted suicide and suicidal ideation for those classified as MI (eighteen percent attempt and fifty percent ideation), were only significantly higher when compared to those in the None group and were not significantly different than those in the MICA or SA groups.

Finally, this pre-arraignment population has an extensive history of treatment for psychiatric and substance abuse problems (see Table 8). MICA classified participants were more likely to have received psychiatric counseling or to have been hospitalized for psychiatric reasons than None group participants, while MI arrestees were more likely to have been hospitalized than those classified as not having a diagnosis (None group). All three groups with a diagnosis (MI, MICA, and SA) were more likely than those without a diagnosis (None group) to have taken psychiatric medication. MICA classified participants were more likely than those without a psychiatric diagnosis to have received some mental health treatment over the course of their lifetime. Overall, more than one-quarter of the sample, including twenty-five percent of the SA group and fourteen percent of the None group (neither groups' participants endorsed symptoms at a level to reach a psychiatric diagnosis) reported some type of mental health treatment

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123. Forty-two arrestees (fifteen percent) reported asthma, bronchitis, or some other respiratory ailment; nineteen (seven percent) reported hypertension or a heart condition; ten (four percent) had a serious infectious disease (tuberculosis, HIV/AIDS, or hepatitis); seven (three percent) had a seizure disorder; five (two percent) had diabetes; and thirty-six (thirteen percent) had some other condition (including weapon wounds, arthritis, ulcers, back pain, allergies, skin conditions, hearing problems, missing digits, narcolepsy, migraines, dental problems, "tremors," or a serious internal problem, such as kidney failure). Of these conditions, due to the small number of cases in each medical category, it was only possible to analyze respiratory ailments, which were found not to vary significantly by group.

history. Potential group differences in current rates of counseling, medication, and previous experience of forced treatment were not analyzed due to the small number of responses for each of these variables.

In terms of substance abuse treatment, MICA and SA groups were more likely than those without a substance abuse diagnosis to have undergone substance abuse counseling and to have completed detoxification (see Table 8). Overall, twenty-six percent reported a history of substance abuse treatment and over half of the MICA and SA groups reported some kind of treatment, significantly more than those without a substance abuse diagnosis. Forty-three percent of the sample reported some substance abuse or psychiatric service use over the course of their lifetime, with the MICA (seventy-eight percent) and SA (sixty-five percent) groups significantly more likely to have used services than either the MI (thirty-five percent) or None (eighteen percent) groups.

TABLE 8				
HEALTH NEEDS AND TREATMENT HISTORY				
Variable	(A) MI (*n*=29)	(B) MICA (*n*=60)	(C) SA (*n*=65)	(D) None (*n*=127)	Total Sample (*n*=281)
Medical/Health Problem**[124]	36% (*n*=10)	42% (*n*=25)	40% (*n*=26)	21% (*n*=26)	31% (*n*=87)
Hospitalized for Medical Condition, Past 5 Years**[125]	37% (*n*=10)	52% (n=31)	40% (*n*=25)	26% (*n*=32)	36% (*n*=98)
Suicide					
Attempted***[126]	18% (*n*=5)	28% (*n*=17)	6% (*n*=4)	2% (*n*=3)	10% (*n*=29)
Considered ***[127]	50% (*n*=7)	69% (*n*=27)	18% (*n*=7)	14% (*n*=10)	31% (*n*=51)
MH Treatment History					
Counseling***[128]	36% (*n*=10)	47% (*n*=28)	25% (*n*=16)	13% (*n*=16)	25% (*n*=70)
Hospitalization ***[129]	21% (*n*=6)	20% (*n*=12)	5% (*n*=3)	3% (*n*=4)	9% (*n*=25)
Medication***[130]	19% (*n*=5)	27% (*n*=16)	11% (*n*=7)	2% (*n*=2)	11% (*n*=30)
Any***[131]	36% (*n*=10)	50% (*n*=30)	25% (*n*=16)	14% (*n*=18)	26% (*n*=74)
SA Treatment History					
Counseling ***[132]	3% (*n*=1)	52% (*n*=31)	48% (*n*=31)	3% (*n*=4)	24% (*n*=67)
Detoxification ***[133]	0% (*n*=0)	27% (*n*=16)	33% (*n*=21)	0% (*n*=0)	13% (*n*=37)

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124. χ^2=12.508, df=3, p<.01 (B>D, C>D).
125. χ^2=12.684, df=3, p<.01 (B>D).
126. χ^2=32.560, df=3, p<.001 (A>D, B>C, B>D).
127. χ^2=42.469, df=3, p<.001 (A>D, B>C, B>D).
128. χ^2=27.159, df=3, p<.001 (B>D).
129. χ^2=20.821, df=3, p<.001 (A>D, B>D).
130. χ^2=28.797, df=3, p<.001 (A>D, B>D, C>D).
131. χ^2=28.307, df=3, p<.001 (B>C, B>D).
132. χ^2=82.533, df=3, p<.001 (B>A, B>D, C>A, C>D).
133. χ^2=53.702, df=3, p<.001 (B>A, B>D, C>A, C>D).

Any***[134]	4% (*n*=1)	52% (*n*=31)	54% (*n*=35)	5% (*n*=4)	26% (*n*=71)
Any MH or SA Treatment***[135]	35% (*n*=10)	78% (*n*=47)	65% (*n*=42)	18% (*n*=23)	43% (*n*=122)

$$** \ P<.01 \ *** \ P<.001$$

When arrestees were asked whether they wanted help with any social service needs, their responses confirmed their desires for certain services, but the majority did not view themselves as needing mental health or substance abuse treatment (Table 9). Eleven percent described the need for substance abuse treatment, with MICA and SA arrestees more likely to request than those without a substance abuse diagnosis (MI and None). Eight percent endorsed the need for mental health treatment, but the number of cases was too low to allow for comparison among the four groups. Overall, sixty-one percent of participants requested help with some social service need. Those in the MICA and SA groups were more likely to endorse a need for services in general as compared to those in the None group. Eighty-three percent of those in the MICA group noted the need for help in accessing services. Thirty-two percent requested assistance finding housing, with those in the MI (forty-eight percent), MICA (forty-five percent), and SA (thirty-eight percent) groups more likely to note a need for housing than those in the None group (nineteen percent). Twenty-nine percent of the total sample noted the need for some form of educational assistance, with no differences between groups. Twenty-one percent of sample respondents endorsed a need for assistance in finding medical care, ten percent requested assistance with basic necessities such as food and clothing, and ten percent requested family support services. For all three of these needs categories, MICA and SA arrestees were more likely to note a need for assistance in these areas than those in the None group. Thirty-six percent endorsed a need for vocational or employment assistance, while ten percent expressed the need for public assistance, with MICA respondents in both cases more likely to ask for these items than those classified as None group participants. Thirteen percent requested legal assistance, with MICA classified group members more likely than those without a diagnosis to request such assistance. Five percent described the need for day care or child care services, seven percent

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134. χ^2=88.834, df=3, p<.001 (B>A, B>D, C>A, C>D).
135. χ^2=75.716, df=3, p<.001 (B>A, B>D, C>A, C>D).

endorsed the need for health care for their children, and three percent requested domestic violence intervention. The sample sizes within each of the four groups were too small to permit analysis of group differences for these last three variables.

TABLE 9 ARRESTEE REQUESTS FOR ASSISTANCE IN ACCESSING SPECIFIC SERVICES					
Variable	(A) MI (n=29)	(B) MICA (n=60)	(C) SA (n=65)	(D) None (n=127)	Total Sample (n=281)
Need Employment Assistance**[136]	41% (n=12)	48% (n=29)	42% (n=27)	25% (n=32)	36% (n=100)
Need Housing***[137]	48% (n=14)	45% (n=27)	38% (n=24)	19% (n=24)	32% (n=89)
Need Education	35% (n=10)	33% (n=20)	33% (n=21)	23% (n=29)	29% (n=80)
Need Medical Care**[138]	14% (n=4)	30% (n=18)	31% (n=20)	13% (n=16)	21% (n=58)
Need Legal Assistance ***[139]	17% (n=5)	30% (n=18)	8% (n=5)	6% (n=8)	13% (n=36)
Need Substance Abuse Treatment ***[140]	0% (n=0)	22% (n=13)	26% (n=16)	1% (n=1)	11% (n=30)
Need Family Support Services**[141]	14% (n=4)	20% (n=12)	16% (n=10)	3% (n=4)	11% (n=30)
Need Public Assistance**[142]	3% (n=1)	22% (n=13)	11% (n=7)	6% (n=8)	10% (n=29)
Need Basics (Food, Clothing)***[143]	3% (n=1)	22% (n=13)	16% (n=10)	3% (n=4)	10% (n=28)

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136. χ^2=11.557, df=3, p<.01 (B>D).
137. χ^2=18.824, df=3, p<.001 (A>D, B>D, C>D).
138. χ^2=13.016, df=3, p<.01 (B>D, C>D).
139. χ^2=22.383, df=3, p<.001 (B>C, B>D).
140. χ^2=38.134, df=3, p<.001 (B>A, B>D, C>A, C>D).
141. χ^2=14.749, df=3, p<.01 (B>D, C>D).
142. χ^2=11.922, df=3, p<.01 (B>D).
143. χ^2=19.168, df=3, p<.001 (B>D, C>D).

Need Mental Health Treatment^	7% (*n*=2)	22% (*n*=13)	9% (*n*=6)	2% (*n*=2)	8% (*n*=23)
Need Health Care for Children^	7% (*n*=2)	7% (*n*=4)	9% (*n*=6)	6% (*n*=8)	7% (*n*=20)
Need Child Care^	7% (*n*=2)	12% (*n*=7)	0% (*n*=0)	5% (*n*=6)	5% (*n*=15)
Need Domestic Violence Assistance^	7% (*n*=2)	5% (*n*=3)	3% (*n*=2)	2% (*n*=2)	3% (*n*=9)
Any Social Service Need***[144]	59% (*n*=17)	83% (*n*=49)	68% (*n*=43)	47% (*n*=59)	61% (*n*=168)

** *P*<.01   *** *P*<.001

^ = expected cell frequencies too low to permit crosstab analysis

V.   STUDY LIMITATIONS AND SUMMARY

This Study's findings are neither surprising nor dramatic, but rather confirm what has been previously proposed. Rates of mental illness and substance abuse are likely elevated in pre-arraignment populations compared to other criminal justice populations, and those detainees who have both mental health and/or substance abuse problems have significantly different problems and needs than others in the arraignment process. While these findings may be expected, previous studies have not provided information on the problems and needs of pre-arraignment populations.

A.   Limitations

One limitation to this Study was the number of arrestees (160, thirty-two percent) who refused to participate. Those that refused were, on average, older individuals and more likely to be female than those interviewed; otherwise those that refused and those that were interviewed were comparable on race/ethnicity, criminal justice history, and current offense and prospective criminal justice recidivism. Lack of privacy for interviewing, chaotic, dangerous working conditions in the pens (to a great extent overcome by dili-

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144. χ^2=24.072, df=3, p<.001 (B>D, C>D).

gent research workers with the aid of cooperative and welcoming police and court staff), and changes in the housing for women during the beginning of the Study may have contributed to the refusal rates for participation and influenced responses. Further, a few individuals (seven) were excluded[145] because they were experiencing withdrawal from drugs or alcohol or were too psychotic to be interviewed. Those excluded, however, represented a relatively small portion of those studied (two percent) and they would not have made a meaningful difference in overall results. A second consideration in comparing these results to those of other jurisdictions is the potential differences between the demographic composition of this sample, along with arrest and charge practices in Brooklyn.

A third limitation is the reliance on self-report information. With the exception of the collateral criminal justice information, most information was self-reported and not verifiable. While several standardized instruments were included and have been used in other studies of criminal justice populations,[146] each instrument has limitations.[147] Finally, as described in the results section, the statistics employed were descriptive and thus causality, or which factors contribute to rates of incarceration or other issues of interest, can not inferred.

B. Summary of Findings

Of the general population of individuals awaiting arraignment in Brooklyn, more than half (fifty-five percent) have mental health problems, substance abuse problems, or both. Of these, one-fifth have mental health problems only, almost two-fifths have substance abuse problems only, and over two-fifths have both mental health and substance abuse problems. Of those who reached criteria for a disorder, more than half have problems that may be considered serious. The rate of drug use for those with substance abuse problems is three times, and the rate of drinking is five times that of the others awaiting arraignment.

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145. *See supra* Part III.

146. *See* Broner et al., *supra* note 3, at 295-316 (providing a review of various screening instruments for mental illness and substance abuse).

147. NAHAMA BRONER ET AL., N.Y. UNIV. INST. AGAINST VIOLENCE, SCREENING AND ASSESSMENT FOR CO-OCCURRING MENTAL ILLNESS & SUBSTANCE USE IN COURT-BASED DIVERSION PROGRAMS: A BEST PRACTICES REVIEW 19-34 (2000); Robert G. Malgady et al., *Issues of Validity in the Diagnostic Interview Schedule*, 26 J. PSYCHIATRIC RES. 59, 61-84 (1992); Carol S. North et al., *A Comparison of Clinical and Structured Interview Diagnoses in a Homeless Mental Health Clinic*, 135 CMTY. MENTAL HEALTH J. 531, 538 (1997); Wittchen, *supra* note 64, at 75-79.

When symptoms, rather than disorders, were assessed, rates were one in eight, or thirteen percent, of sample participants demonstrated serious psychiatric symptoms consistent with hospitalized patients. While this study focuses on those with disorders, it is important to note that the rate of those demonstrating a certain level of symptoms rather than presence or absence of diagnosis may be more useful for determining need when prioritizing intervention. Raymond R. Corrado and his colleagues found that disorder-based definitions (for example, DIS) and symptom-based definitions (for example, BPRS) were not closely related (as also found in this Study, in which only thirty-two percent of those with DIS-IV disorder diagnoses also had significant symptoms as measured by the BPRS), and that symptom-based classification may be more strongly related to the potential need for treatment intervention.[148]

When mental health and substance abuse are examined in the general arraignment population, two distinct groups emerge: those with significant problems and those without. The problems experienced by these groups, however, exceed mental illness and substance abuse. Individuals with substance abuse problems were homeless more often than those without any substance abuse or mental health problems, and when housed, often lived with a drug or alcohol abuser. Those with substance use problems also reported twice as many medical and physical problems as did those without substance abuse/dependence or mental health problems. Individuals with mental health problems reported childhood abuse more often than those without. They also reported contemplating and attempting suicide more often than those without substance abuse or mental health problems. Not surprisingly, those with mental health problems reported psychiatric hospitalizations and the use of psychiatric medication more often than those without substance abuse or mental health problems. Additionally, those with substance abuse problems reported more experience with past substance abuse counseling and detoxification than did others.

When asked if they needed specific social service assistance, individuals with mental health and/or substance abuse problems, espoused a greater need for assistance with housing, medical care, family support services, and obtaining food and clothing. Those with co-occurring mental health and substance abuse problems also

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148. Raymond R. Corrado et al., *Diagnosing Mental Disorders in Offenders: Conceptual and Methodological Issues*, 10 CRIM. BEHAV. & MENTAL HEALTH 29, 36-37 (2000).

asked for legal assistance, vocational and employment assistance, and help in gaining public assistance to a much greater extent than did those without problems. For these individuals, mental health and substance abuse problems were compounded by many other problems and many other needs. Although others in the arraignment process may have similar problems and needs that require intervention, at the point of arraignment, such problems are less severe and less numerous and general functioning may be higher.

Only eight percent of the sample endorsed a need for mental health treatment and eleven percent endorsed the need for substance abuse treatment lower than rates of acute psychiatric symptoms, disorders, or drug and alcohol abuse or dependence. The disinterest in treatment may reflect past experiences with treatment systems, lower priority given other essential basic needs, motivation, a lack of knowledge that a serious disorder was present and could potentially benefit from intervention, or other reasons. This data, however, implies that programs focused on the pre-arraignment population may not want to rely on self-identification alone, rather, outreach, education, and engagement would be necessary if identification and increased service use were goals of a chosen intervention.

The results of this Study show that there are significant differences between those with and without symptoms that reach solidified psychiatric and substance abuse conditions. Those in the arraignment process with mental health and/or substance abuse problems form a distinct group in which each individual's unique problems are woven into an intricate web. The data also indicate a progressively worse "step-up" effect in terms of needs, number, and extent of problem areas (for example, symptom severity, type and amount of drug and alcohol use, homelessness, unemployment, lack of insurance, victimization, criminal justice involvement, etc.) from those with no diagnosis, to those with mental health only diagnoses, to substance abusers, and finally to those with both mental health and substance abuse problems, with the first two and last two groups sharing the most similarities. Future analyses will focus on the relationship of substance abuse to dysfunction, along with other factors.

In terms of criminal justice data, those who were detained following arraignment, as opposed to those released, were more likely to be charged with a felony, be male, and have more extensive histories of homelessness, mental health, and substance abuse treatment, as well as current along with lifetime psychiatric diagnosis.

When looking at those with mental illness, substance abuse, and a combination of disorders, rather than comparing those detained versus those released, the four groups (MI, MICA, SA, and None) did not significantly differ in type, severity, or violent nature of current charges. In studying the mentally ill homeless, others have made a similar point, noting that offense severity is not related to mental illness.[149]

How mental health, substance use, or a combination of disorders impact criminal justice outcomes may depend on whether recidivism, length of stay in jail, or conviction is the primary focus. Although there were no differences between groups regarding current charges, there were differences both in retrospective criminal justice history and prospective criminal justice outcomes. Retrospectively, substance use may be an important contributor to recidivism, as substance users and co-occurring individuals were significantly more likely to have an increased number of arrests, prior drug arrests, and prior misdemeanor convictions. Prospectively, in terms of the index offense, those with co-occurring mental health and substance abuse problems, and those with only substance use problems were more likely to spend time confined on their original charge. Those with co-occurring problems and those with mental health only problems were more likely to be convicted as a result of their arrest.

In terms of prospective criminal justice recidivism, those with substance use problems were most at risk for re-arrest. Further analyses are needed to tease-out the primary influencing factors and determine if mental health status, type of substance abuse, or a combination of disorders rather than charge severity, history, treatment, or other variables serve as the main explanatory factors.

VI. CONCLUSION

A. Criminal Justice Interventions

While the descriptive nature of this Study does not allow for causal explanation, it does examine the pre-arraignment population in sufficient detail to support the need for both community service and criminal justice interventions. Nearly one-quarter of the pre-arraignment population is detained in jail following arraignment, and forty percent are re-arrested and detained during the twelve-months following arraignment. Because those with mental illness and substance abuse are among the detained, the

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149. *See, e.g.*, Zapf et al., *supra* note 79, at 438-39.

availability of jail treatment and services, along with mechanisms to access community services subsequent to detention, such as diversion and reentry, are important program and policy goals. The need for jail and prison treatment has been described for both the substance abusing and the mentally ill populations,[150] and some studies have shown that recidivism is reduced through in-jail or in-prison treatment when combined with community follow-up.[151]

The high cost of imprisonment and the failure of traditional mental health and substance abuse service systems to adequately address mental illness has led to the examination of alternatives to incarceration.[152] The criminal justice system has become the de facto system responsible for the treatment of a substantial part of this population (within jails and prisons), for creating access to treatment (for example, diversion, reentry, and community supervision), and for creating and enforcing treatment retention strategies (for example, mandated treatment). In an attempt to reduce rates of mental illness and substance abuse in incarcerated populations and to stop the cycle of arrest, release, and rearrest among the mentally ill and substance abusers, policymakers, advocates, and program planners have developed two primary strategies: (1) providing increased access and linkage to mental health services through diversion, discharge planning, and jail and prison reentry;[153] and (2) engaging and maintaining people in treatment or

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150. Carl G. Leukefeld & Frank R. Tims, *Drug Abuse Treatment in Prisons and Jails*, 10 J. SUBSTANCE ABUSE TREATMENT 77, 78 (1993); Metzner et al., *supra* note 11, at 255-56.

151. *See, e.g.*, Kevin Knight et al., *Three-Year Reincarceration Outcomes for In-Prison Therapeutic Community Treatment in Texas*, 79 PRISON J. 337, 347-49 (1999); James A. Swartz et al., *The Impact of IMPACT: An Assessment of the Effectiveness of a Jail-Based Treatment Program*, 42 CRIME & DELINQ. 553, 569 (1996); Harry K. Wexler et al., *Three-Year Reincarceration Outcomes for Amity In-Prison Therapeutic Community and Aftercare in California*, 79 PRISON J. 321, 332 (1999).

152. *See, e.g.*, HEATHER BARR, URBAN JUSTICE CTR. & CORR. ASS'N OF N.Y., PRISONS AND JAILS: HOSPITALS OF LAST RESORT 5-6 (1999).

153. *See* AM. ASS'N OF CMTY. PSYCHIATRISTS, POSITION STATEMENT ON POST-RELEASE PLANNING (2001), *available at* http://www.wpic.pitt.edu/aacp/finds/postrelease.html (last visited Jan. 15, 2003); FRED OSHER ET AL., NAT'L GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYS., A BEST PRACTICE APPROACH TO COMMUNITY RE-ENTRY FROM JAILS FOR INMATES WITH CO-OCCURRING DISORDERS: THE APIC MODEL 4-5 (2002); JEREMY TRAVIS ET AL., URBAN INST., FROM PRISON TO HOME: THE DIMENSIONS AND CONSEQUENCES OF PRISONER REENTRY 25-30 (2001), *available at* http://www.urban.org/pdfs/from_prison_to_home.pdf (last visited Jan. 15, 2003); Gerald Gaes et al., *Adult Correctional Treatment*, 26 CRIME & JUST. 361, 374 (1999); Patricia A. Griffin, *The Back Door of the Jail: Linking Mentally Ill Offenders to Community Mental Health Services*, *in* EFFECTIVELY ADDRESSING THE MENTAL HEALTH NEEDS OF JAIL DETAINEES 91, 94-99 (Henry J. Steadman et al., eds. 1990); Lamon et al., *supra* note 16, at 146-51.

other service programs through mandated court or community supervision, or through mandated treatment.[154]

One way to ensure access may be through diversion programs.[155] Because best practices protocols for post-booking diversion have been slow to develop even though core principles have been described,[156] these programs have largely developed independently and in response to specific local circumstances. They are heterogeneous with varying degrees of coercion, oversight, and systems integration.[157] Pilot programs to address mental illness and substance abuse have used various types of diversion models[158] including alternatives to incarceration programs,[159] drug courts,[160] and mental health courts.[161] While initial findings are modest and

154. *See* Arthur J. Lurigio & John A. Swartz, *Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness, in* 3 CRIMINAL JUSTICE 2000: POLICIES, PROCESSES, AND DECISIONS OF THE CRIMINAL JUSTICE SYSTEM, at 45, 88-93 (U.S. Dep't of Justice ed., 2000); Roger H. Peters & Holly A. Hills, *Community Treatment and Supervision Strategies for Offenders with Co-Occurring Disorders: What Works?, in* STRATEGIC SOLUTIONS: THE INTERNATIONAL COMMUNITY CORRECTIONS ASSOCIATION EXAMINES SUBSTANCE ABUSE 81, 116-19 (Edward J. Latessa ed., 1999); Marvin S. Swartz & John Monahan, *Special Section on Involuntary Outpatient Commitment: Introduction,* 52 PSYCHIATRIC SERV. 323, 324 (2001).

155. *See* Henry J. Steadman et al., *A National Survey of Jail Diversion Programs for Mentally Ill Detainees,* 45 HOSP. & CMTY. PSYCHIATRY 1109, 1109-13 (1994).

156. Steadman et al., *supra* note 12, at 1634-35.

157. Nahama Broner et al., *Criminal Justice Diversion of Individuals with Co-Occurring Mental Illness and Substance Use Disorders: An Overview, in* SERVING MENTALLY ILL OFFENDERS, *supra* note 3, at 97-98; Patricia A. Griffin et al., *The Use of Criminal Charges and Sanctions in Mental Health Courts,* 53 PSYCHIATRIC SERV. 1285, 1287-89 (2002); Pamela K. Lattimore et al., *A Comparison of Prebooking Diversion Programs for Mentally Ill Substance-Using Individuals with Justice Involvement,* 19 J. CONTEMP. CRIM. JUST. 30, 58-59 (2003).

158. *See* SERVING MENTALLY ILL OFFENDERS, *supra* note 3, at 47-156.

159. Broner et al., *supra* note 157, at 87-88; Leukefeld & Tims, *supra* note 150, at 79-80.

160. STEVEN BELENKO, NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., RESEARCH ON DRUG COURTS: A CRITICAL REVIEW 5 (1998), *available at* http://www.casacolumbia.org/usr_doc/researchondrugs.pdf (last visited Jan. 15, 2003); Roger H. Peters & Mary R. Murrin, *Effectiveness of Treatment-Based Drug Courts in Reducing Criminal Recidivism,* 27 CRIM. JUST. & BEHAV. 72, 89-94 (2000). *See generally* NAT'L GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYS., DRUG COURTS AS A PARTNER IN MENTAL HEALTH AND CO-OCCURRING SUBSTANCE USE DISORDERS DIVERSION PROGRAMS (1999), *available at* http://www.gainsctr.com/pdfs/fact_sheets/drug_courts.pdf (last visited Jan. 15, 2003).

161. JOHN S. GOLDKAMP & CHERYL IRON-GUYNN, U.S. DEP'T OF JUSTICE, EMERGING JUDICIAL STRATEGIES FOR THE MENTALLY ILL IN THE CRIMINAL CASELOAD: MENTAL HEALTH COURTS IN FORT LAUDERDALE, SEATTLE, SAN BERNARDINO, AND ANCHORAGE vii (2000), *available at* http://www.ncjrs.org/pdffiles1/bja/182504.pdf (last visited Jan. 15, 2003); Henry J. Steadman et al., *Comparing Outcomes for Diverted and Nondiverted Jail Detainees with Mental Illness,* 23 L. & HUM. BEHAV.

vary by type of diversion, in general, diversion has been found to reduce time spent in jail, reduce recidivism for misdemeanor divertees, and serve as an access mechanism for treatment, which may in turn reduce jail and prison time along with recidivism.[162] While diversion may increase access to treatment, criminal justice programs that identify their participants by their mental illness create complex issues that require ongoing attention: stigma, vulnerability to other inmates, injustice with respect to length of incarceration, and, at times, screening out by the very public systems and community providers with whom linkage is attempted.

Whether it is diversion, jail treatment, discharge planning, or reentry, defining the target population and determining the method by which the population is targeted becomes essential.[163] One way that identification has occurred is through targeting the legal charge or the level of charge severity (misdemeanor versus felony). This is problematic, since definitions for misdemeanors and felonies, along with charging practices, differ from jurisdiction to jurisdiction, as does the categorization of a charge as violent by statute and practice. A cross-sectional intervention strategy that distinguishes between felons and misdemeanants is based on the erroneous assumption that those with mental illness are more likely to commit a misdemeanor offense, and therefore is not a useful method for finding those best suited to diversion or reentry. In fact, in this Study, neither offense severity nor type of offense distinguished among problems or between those with and without mental·health and substance abuse problems. Although using type of charge to identify potential substance abusers is more feasible, only forty-three percent of substance abusers were charged with drug offenses. To identify defendants in need of mental health intervention by drug charge (to capture those with co-occurring mental illness and substance use disorders) further narrows the pool, as just under half of the sample of substance abusers had co-

615, 624-26 (1999) [hereinafter *Comparing Outcomes*]; Henry J. Steadman et al., *Law and Psychiatry: Mental Health Courts: Their Promise and Unanswered Questions*, 52 PSYCHIATRIC SERV. 457, 457-58 (2001); Amy Watson et al., *Mental Health Courts and the Complex Issues of Mentally Ill Offenders*, 52 PSYCHIATRIC SERV. 477, 479-80 (2001).

162. NAHAMA BRONER ET AL., N.Y. UNIV. INST. AGAINST VIOLENCE, SAMHSA JAIL DIVERSION KDA PROGRAM INITIATIVE EVALUATION OF NEW YORK CITY'S LINK JAIL DIVERSION PROGRAMS: A FINAL REPORT 5-6 (2002); Rani A. Hoff et al., *The Effects of a Jail Diversion Program on Incarceration: A Retrospective Cohort Study*, 27 J. AM. ACAD. PSYCHIATRY & L. 377, 383 (1999); *Comparing Outcomes*, *supra* note 161, at 616-17.

163. Broner et al., *supra* note 3, at 4-5.

occurring mental illness, that is, only one-quarter of those with mental health diagnoses in this pre-arraignment population.

A second common strategy for identification has been to find those who are in criminal justice custody and have been previously treated by the local mental health system.[164] While, that may be an effective strategy for post-arraignment populations (assuming that those detained may be more likely to have had past mental health or substance abuse treatment according to the results presented), the data suggests that only a third to a half of those with potential mental health and substance abuse problems (a quarter of the sample overall) have received treatment of in the past.

A third strategy is to institute brief broad screening for mental illness identification upon entrance to jail. While this may be a good strategy to ensure in-jail treatment, where basic mental health emergency treatment is provided,[165] the identification of those who may be in need, but have not been identified or do not self-identify, is not required by law.[166] Thus, court-based pre-arraignment screening could provide an opportunity for linkage to community services for those immediately released and an assurance that for those detained that the potential provision of treatment or other services would be reviewed. In sum, screening for psychiatric history and current symptoms and secondarily for past service use, along with measures of functionality to determine treatment resource priority may be the effective approach for initial identification,[167] once the legal case and charge history review has been completed.

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164. NAT'L GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYS., USING MANAGEMENT INFORMATION SYSTEMS TO LOCATE PEOPLE WITH SERIOUS MENTAL ILLNESSES AND CO-OCCURRING SUBSTANCE USE DISORDERS IN THE CRIMINAL JUSTICE SYSTEM FOR DIVERSION 1 (1999).

165. *See* Inmates of Allegheny County Jail v. Pierce, 612 F.2d 754, 763 (3d Cir. 1979).

166. Metzner et al., *supra* note 11, at 252-53. In New York City, as a consequence of *Brad H. v. City of New York*, 729 N.Y.S.2d 348 (Sup. Ct. 2001), discharge planning for those identified by the jails as having mental health problems (excluding those in jail for less than twenty-four hours or for parole violations) is now required, but general screening to identify the need for mental health and substance abuse intervention during or following detainment is not. *Id.* at 351.

167. ROGER H. PETERS & HOLLY A. HILLS, NAT'L GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYS., INTERVENTION STRATEGIES FOR OFFENDERS WITH CO-OCCURRING DISORDERS: WHAT WORKS? 13 (1997); Lurigio & Swartz, *supra* note 154, at 73.

B. Community Services

While it is easy to think of the entire group as a detainee popula-
tion, over three-quarters of the pre-arraignment population return
to the community immediately following their arraignment. Ac-
cordingly, those with mental health and substance abuse problems
may benefit from community, rather than criminal justice, inter-
vention during the arraignment process. While this discussion fo-
cuses primarily on those who may have mental health or substance
abuse diagnoses, many of those without such disorders have signifi-
cant symptoms, are likely to use marijuana or alcohol, and have
substantial social service needs. This "at risk" group further signals
the need for coordinated public health prevention targeting those
who are coming into contact with the criminal justice system.

The description of the potential client that emerges from this
Study's data reemphasizes the need to provide holistic services to
this underserved community so not to perpetuate a public health
tragedy that comes at great social costs. Without intervention,
communicable diseases spread unchecked, crime, whether public
nuisance or more serious, remains substantial, homelessness per-
sists, emergency services remain the primary and costly avenue for
treatment, and cycles of familial violence are left intact, producing
victims and perpetrators, and requiring costly systems interven-
tions (for example, child welfare involvement, family and criminal
court proceedings, shelter systems, and emergency medical care).
Just as wrap-around service models developed to address multiple
need populations have long been described, the evidence that there
is the knowledge to treat this population successfully is overwhelm-
ing, though not generally implemented. For instance, there are ef-
fective clinical engagement and treatment technologies for various
clinical populations and there are guidelines for implementing evi-
denced-based treatment practices in public health settings.[168] And
it is well established that treatment and services intervention can
reduce a number of negative consequences, but such reduction is
dependant on receiving a certain quality, and quantity, of services
that are comprehensive and integrated. If the range or intensity of
services needed is appropriately provided, there may be no addi-
tional potential added effect for treatment retention through man-

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168. Robert E. Drake & Kim T. Mueser, *Psychosocial Approaches to Dual Diagno-
sis*, 26 SCHIZOPHRENIA BULL. 105, 110-12 (2000); Robert E. Drake et al., *Implement-
ing Evidence-Based Practices in Routine Mental Health Service Settings*, 52
PSYCHIATRIC SERV. 179, 180-81 (2001).

dating such services.[169] In fact, the focus on mandating treatment represents a continuum of social control strategies,[170] and such coercion may not be more effective than other, perhaps less innocuous, forms of social control. Individual level help-seeking beliefs, health services policies, and community provider and criminal justice biases toward the tri-occurring mentally ill, substance abusing, criminal justice involved population have been well described, in terms of deterring access to services, and perhaps contributing to recidivism.[171]

Given this Study's description of the population, there is clearly the opportunity to make a substantial contribution to solving this problem if treatment providers or the public mental/health and substance abuse systems were to target those awaiting arraignment. Collaboration with the criminal justice system to provide "inreach" into the courts through pre-arraignment screening and services engagement would allow continuity for those that return to the community immediately, as well as for those who continue in the criminal justice process. For those streaming out of the courts on their first appearance, community agencies (who have wraparound services or well-developed alliances with housing, employment, health, and other treatment and faith-based organizations) using mobile vans stationed outside of the courts could reach a substantial portion of the population. While obstacles such as confidentiality, security, and competing goals of partners (for example, whether to avoid new clients, to assure no treatment, to ensure forced treatment, or to ensure freedom) are substantial, they are simply implementation obstacles that can be overcome with will and collaboration among stakeholders.[172]

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169. *See* Robert E. Drake et al., *Implementing Dual Diagnosis Services for Clients with Severe Mental Illness*, 52 PSYCHIATRIC SERV 469, 473 (2001); Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 53 PSYCHIATRIC SERV. 330, 332 (2001).

170. *See* John Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, 52 PSYCHIATRIC SERV. 1198, 1199 (2001).

171. *See* David Mechanic, *Mental Health Policy at the Millenium: Challenges and Opportunities, in* MENTAL HEALTH, UNITED STATES, 2000, *supra* note 18, at 59; Solomon & Draine, *supra* note 9, at 168; Nancy Wolff, *Interactions Between Mental Health and Law Enforcement Systems: Problems and Prospects for Cooperation*, 23 J. HEALTH, POL., POL'Y & L. 133, 133-36 (1998).

172. Nahama Broner et al., *Knowledge Transfer, Policymaking and Community Empowerment: A Consensus Model Approach for Providing Public Mental Health and Substance Abuse Services*, 72 PSYCHIATRIC Q. 79, 96-97 (2001).

C. Policy

If one were to reduce the priorities for policy makers to a few, given competing demands for local economic resources in most communities, the following should be considered: 1) identification mechanisms; 2) implementation of evidence-based treatment and services; and 3) resources within correctional settings for basic medical, substance abuse and mental health treatment, and the infrastructure to incorporate transitional services (discharge planning/reentry, diversion, and the attendant linkage partners). Identification of those in need of intervention at the earliest stage of criminal justice contact has been promoted as described previously and should include, at the very least, brief screening[173] and information systems capability.[174] Arguments that this is "net-widening" are superfluous, given that almost half of the population is rearrested within a year. Though, it is not an irrelevant argument to be concerned about the impact that mental health and substance abuse information could have on the judicial determination. By developing a system in which information is not released prior to such determination, except in the case of formal arraignment diversion or reentry programs (as per informed consent), such concerns may be protected.

Establishing standards and funding treatment in correctional and community settings that are consistent with evidence-based practices for the target populations, are essential if the goals of intervening with this population are to be attained. Having fewer, but targeted services, that are known to be effective may be wiser fiscally, for public safety reasons, and from a public health perspective, than the presence of many services that are ineffective. Combining mental health and substance abuse city or state agencies, in those jurisdictions where this has not been done, would remove a number of obstacles for implementing treatment and other services practices that could address the multiple needs of this population. With regard to diversion, and other criminal justice interventions, innovative and fiscally conservative strategies have been developed to pool resources among systems.[175] Further, new court

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173. *See* Lurigio & Swartz, *supra* note 154, at 73.

174. *See* NAT'L GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYS., *supra* note 164, at 1; Faye S. Taxman & Stephan Sherman, *What is the Status of My Client? Automation in a Seamless Case Management System for Substance Abusing Offenders*, 31 J. OFFENDER MONITORING 25, 25 (1998).

175. NAT'L GAINS CTR. FOR PEOPLE WITH CO-OCCURRING DISORDERS IN THE JUSTICE SYS., BLENDING FUNDS TO PAY FOR CRIMINAL JUSTICE DIVERSION FOR PEOPLE WITH CO-OCCURRING DISORDERS 1 (1999).

structures can be effective with few new resources, if a system is in place to attain court or jail screening information and if the community is held to its responsibility of providing appropriate treatment. Finally, policy initiatives that ensure continuity of benefits (the mechanism by which providers can offer services) and provide assurances that government agencies responsible for benefits and housing accept all that are in need, are crucial in supporting access to treatment and services.

D. Future Research Directions

A larger study of the pre-arraignment population is needed to replicate and expand upon this Study. Multi-variant model analyses are planned for this Study's data and should provide a better understanding of factors related to this population that would be helpful to programs creating interventions.

ACKNOWLEDGMENTS