An Evaluation of the Outcomes of a Court Outreach Program for People with Severe and Persistent Mental Illness Who Are Legally Involved

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ABSTRACT

The current study evaluated the outcomes of an outreach program that provides individualized services to people with severe mental illness who are legally involved. Client outcomes included increased community ability and reduced homelessness for a group of 45 clients still receiving services from the program, and increased community ability and diminished severity of mental health symptoms for 50 clients who had been discharged from the program. Only 2 of the 50 discharged clients (4%) were found to be incarcerated at termination; 1 other client (2%) was detained at termination through the Ontario Review Board.

Court support programs provide intensive and individualized support on a time-limited basis to persons with severe and persistent mental illness who are legally involved. The receipt of these services by an individual

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may lead to "court diversion" in some cases, where the charges are dropped pre-trial in exchange for participation in treatment (Hartford, Carey, & Mendonca, 2007). This paper presents findings of an evaluation of the outcomes of the Court Outreach Program located at the Ottawa Branch of the Canadian Mental Health Association (CMHA Ottawa). This paper complements another paper that evaluates the implementation of the Court Outreach Program (Sylvestre, Aubry, Smith, & Bridger, this volume).

In a recent review of the literature on court diversion programs, Hartford et al. (2007) explain that the number of court diversion programs in Canada has increased because of the "criminalization" of people with severe mental illness, in which these individuals are criminally prosecuted for what are considered relatively minor offences. Hartford and her colleagues cite three factors that contribute to the criminalization of people with mental illness, namely, the growing number of people with severe mental illness living in the community, the increased transactions occurring between the police and this population, and the difficulty encountered by people with severe mental illness in accessing community-based treatment and support. In relation to the latter factor, court diversion programs often serve as a portal for people with severe mental illness to access community mental health services.

Similar to other jurisdictions across North America, in Ontario the number of court support programs has increased significantly in recent years (Dewa et al., 2008). Notably, recent investments by the Ontario Ministry of Health and Long-Term Care, through the Service Enhancement Initiative beginning in 2005, were allocated for a number of services including court support programs (Dewa et al., 2008). The initiative was the result of an interministerial partnership intended to keep people with mental illness out of the criminal justice and correctional systems. CMHA Ottawa's Court Outreach Program, on which the research presented in this paper was conducted, received funding through the initiative to expand and enrich its services.

Review of the Relevant Research Literature on Court Support Programs

Court support services share many similarities to those offered through intensive mental health case management. In particular, they entail individualized services that focus on client identification, outreach, direct services, service planning, linkage to other community services, and client advocacy (McGurrin & Worley, 1993). Reviews of effectiveness research on intensive case management have concluded that these services produce a number of positive client outcomes including improved social functioning, increased medication adherence, improved housing stability, increased use of community services, reduced use of emergency services, diminished hospitalizations, and shorter hospital stays (Aubry, Dostaler, & Baronet, 2004; Baronet & Gerber, 1998; Mueser, Bond, Drake, & Resnick, 1998; Nelson, Aubry, & LaFrance, 2007).

None of the research to date on intensive case management has focused on the provision of intensive case management as court support services that clients access at the point of entry into the criminal justice system. There is an emerging research base that has examined court diversion programs for people with mental illness; however, Hartford and her colleagues (2007) concluded in a recent review of the empirical literature that this research is at a very early stage of development with only a few studies having evaluated outcomes. Moreover, they noted that most of the published literature examining the outcomes of court diversion programs was limited to focusing on participation in mental health services and recidivism.

In fact, Hartford et al. (2007) found only five studies that met their criteria for inclusion (i.e., focused on people with mental illness who did not have a concurrent disorder, and presented results that were relevant to court diversion programs in other communities). In describing the studies, the researchers identified a number of limitations including research designs that did not have a control group, a reliance on cross-sectional data, and a lack of objective data to enable comparison studies. Based on the review, Hartford and her colleagues concluded that (a) the use of formal case-finding procedures is helpful in identifying clients who can benefit from the service, (b) stable housing appears to be an important precursor for clients' remaining in treatment, and (c) active case management provided by a court diversion program reduces the likelihood of recidivism.

Other studies on court diversion programs reported positive effects on diverted clients, including decreasing the length of their incarceration and increasing their access to mental health and substance abuse treatment, with no greater risk for recidivism when compared to non-diverted clients (Broner, Lattimore, Cowell, & Schlenger, 2004; Broner, Swern, & Goldfinger, 2003; Hoff, Baranosky, Buchanan, Zonana, & Rosenheck, 1999; Lamb, Weinberger, & Reston-Parham, 1996; Steadman & Naples, 2005).

In the only published Canadian research on a court diversion program to date (Swaminath, Mendonca, Vidal, & Chapman, 2002), a retrospective study was conducted in which the outcomes of a small number of diverted clients were examined in two court diversion programs in southern Ontario, one urban (n = 58) and the other rural (n = 17). In both programs, psychiatric nurses coordinated treatment programs for diverted clients and referred them to community services. The recidivism rate in the urban and rural diverted groups after 1 year of supervised care was only 2% to 3%.

The development of mental health courts is playing a crucial role in the development and sustainability of diversion programs. Mental health courts are a form of court diversion wherein diversion typically occurs post-plea (Steadman, Morris, & Dennis, 1995). Despite their increasing number and popularity, research on mental health courts is sparse with only a few single-site studies evaluating their outcomes (Erickson, Campbell, & Lamberti, 2006; Redlich, Steadman, Monahan, Robbins, & Petrila, 2006).

Cosden, Ellens, Schnell, Yamini-Diouf, and Wolfe (2003) used an experimental design and found that a mental health court that diverted individuals from the criminal justice system into Assertive Community Treatment resulted in improvements in functioning as well as reductions in substance abuse and new criminal activity when compared with non-diverted individuals receiving standard care. Other studies found that clients of mental health courts experienced reduced rearrest rates for new offences and reduced probation violations relative to pre-enrolment in mental health courts (Henrinckx, Swart, Ama, Dolezal, & King, 2005) and relative to comparable criminal court defendants (Moore & Hiday, 2006).

Overall, findings from the small number of studies on court diversion programs and mental health courts suggest that these types of services are promising at least from the standpoint of reducing incarceration and facilitating access to mental health services for people with severe mental illness who have been charged with minor criminal offences. The recidivism rate for participants diverted in these programs appears to be comparable to or better than that of non-diverted individuals.

Description of CMHA Ottawa's Court Outreach Program

The Court Outreach Program at CMHA Ottawa is a community support program to which individuals with severe and persistent mental illness who have been charged with a criminal offence are referred for outreach services. Clients are referred to the program by Crown attorneys, defence attorneys, duty council, court psychiatrists, court peace officers, probation officers, family members, and through self-referrals. The primary objectives of the program are (a) to support individuals during their interactions with the court, (b) to ensure clients can access and maintain the community housing of their choice, and (c) to address the psychosocial community rehabilitation needs of clients.

The bulk of court outreach services are delivered by a primary worker in the context of a one-to-one relationship with the client. The worker delivers a variety of individualized services based on client needs, including assertive outreach, client and systems advocacy, symptom management, life-skills teaching, supportive counselling, family support, and crisis intervention. The most common services provided to clients focus on mental health, legal charges and processes, housing, financial issues, physical health, and substance use. Treatment is variable depending upon both the need and level of engagement of clients. More details on the characteristics of services delivered to clients are described in an article evaluating the implementation of the program (Sylvestre et al., this volume).

In addition to the individualized support provided by outreach workers, the Court Outreach Program is incorporated within the integrated service approach of CMHA that includes access to registered nurses and a nurse practitioner, psychiatric consultation and treatment, group treatment for concurrent disorders, brokerage services for individuals with a dual diagnosis, extended hours support and bridging service, vocational services, recreational and volunteer support services, and rent-geared-to-income housing units. Court outreach workers carry caseloads of approximately 15 clients at a time, and services are usually short term (i.e., 7–12 months).

Contribution of Study and Research Questions

The research on community support programs for people with severe mental illness who are legally involved is still at an early stage of development. Multiple models exist, making it impossible to generalize from this research. As well, most of the research to date has been conducted in the United States, which has a different judicial system and different mental health services than Canada. Notably, in contrast to the universal coverage provided in Canada, health services in the U.S. are characterized by reliance on a patchwork of public and private services with a segment of the population lacking insurance to access needed services (Lasser, Himmelstein, & Woolhandler, 2006).

The current study evaluated the outcomes of the Court Outreach Program located in Ottawa. This program is considered innovative because of its goal of finding and linking individuals with severe and persistent mental illness to mental health services after they have been charged with a criminal offence. These types of services are considered critical to the enhancement of the community mental health system in Ontario. In addition to being only the second study that formally investigates the effectiveness of a court support program in Canada, this research makes an original contribution to the area by using a longitudinal pre-post research design. The study also improves on previous research by evaluating a wide range of outcomes

beyond recidivism and use of mental health services, and by collecting data using both client self-report measures and clinician rating scales.

The following questions guided the outcome evaluation:

1. Are there changes in functioning for clients over the course of participation in the Court Outreach Program?
2. Are there changes in the number of hospitalizations or number of days in hospital for clients in the Court Outreach Program?
3. What are the legal outcomes of clients during their participation in the Court Outreach Program?
4. What types of services delivered by the Court Outreach Program are predictive of reduced rates of recidivism?

METHOD

Study Sample

All clients who were admitted into the court outreach program between August 31, 2005, and February 28, 2007, and who received at least 3 months of service were included in the study. Because of the 2-year timeline of the study, two groups of clients were available for evaluating outcomes: (a) an active group (AG) composed of clients who had been in the program for at least 3 months and who were still receiving services in the program at the point of follow-up, and (b) a terminated group (TG) made up of clients who were followed subsequent to their discharge from the program. In total, there were 95 participants in the study of whom 45 were in the AG and 50 were in the TG. There were 24 clients admitted to the program during the study period who were not included because they participated in the program for less than 3 months before being discharged. Since the AG clients were still presumably in need and receiving services from the program, it was decided to evaluate the outcomes of the two groups separately.

Among clients of the TG ($N = 50$), the average amount of time in the program was 285.08 days ($SD = 140.00$) with a range of 90 to 704 days. Two thirds of the terminated clients (66%) were in the program for approximately 9 months (296 days) or less. Of the 50 clients in the TG, 8 clients withdrew prematurely from services, 4 clients terminated because of a relocation, and 2 clients died.

The average length of time among active clients ($N = 45$) was 365.89 days ($SD = 140.25$) with a range of 139 to 659 days. All active clients had received services for at least 4 months, and only 4 clients had been in the program for less than 6 months. The average length of time in the program was significantly higher for active clients compared with the terminated group of clients, $t(93) = 2.81$, $p < .01$. Less than half of the active clients (36%) had been in the program for 9 months (275 days) or less.

Measures

To evaluate outcomes, the study used measures that were part of the internal data collection system put in place by CMHA Ottawa, the community agency hosting the program. These measures were intended to operationalize the most common outcomes targeted by the program.

Client and service characteristics. Client data on demographic, clinical, and legal characteristics as well as the amount of time and number of contacts associated with different services delivered to them by CMHA staff were accessed for analysis from the Client Record Management System (CRMS), a computerized administrative database used by CMHA Ottawa. CRMS stores data collected by CMHA staff on the variables from the Canadian version of the "PSR Toolkit" (Ontario Federation of Community Mental Health and Addiction Programs, 1999) including housing status and information about hospitalizations (i.e., episodes, type, length of stay) in the 2 years prior to entering the program and during participation in the program, as well as data on types and duration of services delivered to clients. Court outreach workers also record in the program's computerized client database any legal charges against their clients and associated legal outcomes of these charges at program entry and over the course of their participation in the program.

Severity of symptoms. An 8-item self-report measure that is part of the Functional Assessment Inventory created by Mueser, Noordsy, Drake, and Fox (2003) was used to assess the severity of symptoms. The items asked clients to rate the distress they were experiencing related to different types of symptoms (e.g., depression, anxiety, hallucinations, delusions). Response alternatives ranged from *not at all* (1) to *extremely* (5). The summed score of the 8 items can range from 8 to 40. Cronbach's alpha for the severity of symptom measure was found to be 0.69 at program entry and 0.83 at follow-up or termination.

Multnomah Community Ability Scale (MCAS). The 17-item MCAS was used to measure the degree of impairment experienced by Court Outreach Program clients (Barker, Barron, McFarland, & Bigelow, 1994). The MCAS measures degree of disability experienced by individuals with severe mental illness living in the community related to interference with functioning, adjustment to living, social competence, and behavioural problems. Ratings are completed on each item by clinicians knowledgeable of clients. Rating alternatives can range from *no impairment* (1) to *extreme impairment* (5). Total scores on the MCAS can range from 17 to 85. Barker et al. (1994) showed the MCAS to be reliable and valid. Cronbach's alpha for the MCAS was 0.81 at program entry and 0.88 at follow-up or termination.

Alcohol Use Scale–Revised (AUS-R). The AUS-R was used as a clinician rating measure for assessing for the presence of alcohol use problems. The measure consists of a 1-item, 5-point scale ranging from *abstinence* to *dependence with institutionalization*. The scale was completed by clients' court outreach workers. The AUS has been shown to result in high interrater reliability and to be highly correlated with other measures of current use (Drake et al., 1990).

Drug Use Scale–Revised (DUS-R). The DUS-R was used as a clinician rating measure for assessing for the presence of drug use problems. It also consists of a 1-item, 5-point scale and was completed by clients' case workers. Again, responses can range from *abstinence* to *dependence with institutionalization*. While no known studies have examined the DUS-R, the scale is thought to have many of the psychometric characteristics reported for the AUS.

Alcohol Use Disorders Identification Test (AUDIT). The 10-item AUDIT was used as a self-report measure to identify individuals at risk of or with alcohol use problems (Maisto, Carey, Carey, Gordon, & Gleason, 2000). Four items ask about current alcohol consumption habits. The other 6 items query for the presence of consequences in the past year related to overconsumption of alcohol. Individual items are scored 0 to 4, and AUDIT total scores can range from 0 to 40. Scores of 8 or above are considered indicative of

individuals at risk of or having an alcohol use problem (Conigrave, Hall, & Saunders, 1995). The AUDIT has been shown to have good internal reliability and validity as well as good specificity and sensitivity when used with persons with severe and persistent mental illness (Maisto et al., 2000). Internal reliability analysis of the AUDIT in the current study found a Cronbach's alpha for the measure of 0.94 at program entry and 0.86 at follow-up or termination.

Drug Abuse Screening Test-10 (DAST-10). The DAST-10 (Maisto et al., 2000) was used to assess for the presence of drug use problems. The DAST-10 asks a series of 10 questions about substance use, such as "Have you used drugs other than those required for medical reasons?" and "Have you been involved in a treatment program specifically related to drug use?" Potential responses to each question are either *yes* (1) or *no* (0). Total DAST-10 scores range from 0 to 10, with higher scores reflecting a higher level of drug use. A score of 2 or higher on the DAST-10 has been shown to have good specificity and sensitivity in identifying people with severe and persistent mental illness who have a drug use problem (Maisto et al., 2000). Internal reliability analysis of the DAST in the current study found a Cronbach's alpha of 0.81 at program entry and 0.80 at follow-up or termination.

Procedures

The methodology of the study was approved by the Research Ethics Board at the University of Ottawa. Anonymized data from the program's information system were provided to researchers. Data collection comprised the completion of the PSR toolkit, MCAS, AUS-R, and DUS-R by outreach workers and interviews of clients on self-report measures by their court outreach workers. Data collection was initiated as soon as possible after entry into the Court Outreach Program for all clients and at least within the first 3 months after admission.

The interval between the two phases of data collection represented the amount of time in which TG and AG clients were in the study. In the case of clients in the TG, rating scales were completed and interviews were conducted around the time of their discharge from the program. For all other clients who were still receiving services from the program at the conclusion of the study, follow-up data collection that involved completion of rating scales by outreach workers and interviews of clients were undertaken over a period of several weeks in August and September 2007.

RESULTS

The analyses conducted for evaluating outcomes involved examining changes in outcome measures for each of the two groups over the course of their receipt of services. A series of repeated measures ANOVAs were conducted comparing baseline and follow-up scores on outcomes of variables operationalized using continuous measures. McNemar chi-squares were calculated to compare scores on outcomes at baseline versus follow-up for variables operationalized using categorical measures.

Because a significant amount of self-report data on participants was missing at baseline and at follow-up in both groups, comparisons between participants with complete self-report data and participants missing self-report data were conducted on baseline clinician rating scales that measured similar outcomes (e.g.,

severity of symptoms and community ability; problematic alcohol use; problematic drug use). No differences were found between the participants in either the AG or TG on clinician-rated data.

Characteristics of the Two Groups

Demographic characteristics. Both groups had a disproportionate number of men (AG = 71%; TG = 78%). The average age of participants was 33 years old in the AG and 36 years old in the TG. All or virtually all of the participants in both groups were single, separated, divorced, or widowed (AG = 100%; TG = 95%). There was also little difference between the groups in terms of the percentage of participants who were homeless at program entry (AG = 29%; TG = 38%).

Clinical characteristics. A comparison of the two groups found differences in the proportion of clients with different primary diagnoses as provided by referral source. Specifically, significantly more TG clients (46%) had a primary diagnosis of schizophrenia when compared to AG clients (22%), $\chi^2(2, N = 95) = 5.91$, $p < .02$. As well, significantly more AG clients (51%) had a primary diagnosis of a mood disorder in comparison to TG clients (22%), $\chi^2(2, N = 95) = 8.73$, $p < .01$.

Legal characteristics. No differences were found on legal characteristics between the AG and the TG. A majority of clients in both the AG (67%) and the TG (57%) had multiple charges against them upon admission into the program (AG: $M = 3.53$, $SD = 2.67$; TG: $M = 3.02$, $SD = 3.11$). The most common preadmission charge was assault for both AG clients (18%) and TG clients (18%). The next most common preadmission charge was failure to comply with court orders (AG = 18%; TG = 15%), followed by uttering threats (AG = 14%; TG = 10%), breach of condition (AG = 10%; TG = 7%), and theft (AG = 7%; TG = 7%; see endnote for other types of charges).[1]

Changes in Functioning

Client outcomes associated with functioning examined in the study were severity of mental health symptoms, level of ability to live in the community, presence of alcohol and drug use problems, and housing status. Table 1 presents the means and standard deviations for continuous functioning variables or percentages for dichotomous functioning variables for each of the two groups at baseline and follow-up.

Severity of mental health symptoms. Clients in the AG showed no changes in the level of severity of mental health symptoms from program entry to follow-up. In contrast, clients in the TG group exhibited a significant reduction in the level of severity of mental health symptoms from baseline to termination, $F(1,21) = 15.98$, $p < .01$.

Community ability. Clients in the AG were assessed by their workers as showing significant improvements in their ability to live in the community from baseline to termination, $F(1,40) = 13.36$, $p < .01$. Similarly, clients in the TG were judged by their workers as demonstrating significant improvements, $F(1,46) = 4.40$, $p < .05$. Despite these improvements, it is important to note that the mean score on the MCAS remained in the moderate range of functioning for both groups.

Presence of alcohol use problems. Alcohol use was measured by both the AUDIT, a self-report measure, and the AUS, a clinician rating scale. Data on these measures were recoded into a dichotomous variable

indicating either the presence or absence of an alcohol use problem. A score of 8 or more on the AUDIT was considered reflective of an alcohol use problem. A rating of "abuse," "dependence," or "dependence with institutionalization" on the AUS-R was considered indicative of an alcohol use problem. The proportion of clients shown to have an alcohol use problem did not change significantly from baseline to follow-up on either the self-report measure (AUDIT) or the clinician rating scale (AUS-R) in either of the groups.

Table 1

Changes in Functioning, Symptomatology, and Housing Status for Active Clients at Baseline and Follow-up and for Terminated Clients at Baseline and Termination

	Active Group		Terminated Group	
	Baseline *n* *M* (*SD*) or %	Follow-up *n* *M* (*SD*) or %	Baseline *n* *M* (*SD*) or %	Termination *n* *M* (*SD*) or %
Severity of mental health symptoms	(*n* = 28) 1.50 (5.16)	(*n* = 28) 21.32 (7.57)	(*n* = 22) 22.41[a] (5.75)	(*n* = 22) 17.91[a] (5.69)
Community ability (MCAS)	(*n* = 41) 53.59[b] (8.56)	(*n* = 41) 57.54[b] (8.45)	(*n* = 47) 52.04[c] (9.79)	(*n* = 47) 55.72[c] (13.69)
Presence of alcohol use problem (AUDIT)	(*n* = 23) 44%	(*n* = 23) 48%	(*n* = 15) 40%	(*n* = 15) 20%
Presence of alcohol use problem (AUS-R)	(*n* = 41) 32%	(*n* = 41) 29%	(*n* = 40) 25%	(*n* = 40) 23%
Presence of drug use problem (DAST-10)	(*n* = 34) 65%	(*n* = 34) 68%	(*n* = 25) 80%	(*n* = 25) 80%
Presence of drug use problem (DUS-R)	(*n* = 40) 60%	(*n* = 40) 55%	(*n* = 39) 51%	(*n* = 39) 46%
Housing status (% homeless)	(*n* = 45) 29%[d]	(*n* = 45) 9%[d]	(*n* = 50) 38%	(*n* = 50) 26%
# of hospitalizations per year[e]	(*n* = 39) 0.40 (0.67)	(*n* = 39) 0.41 (0.68)	(*n* = 33) 0.41 (0.42)	(*n* = 33) 0.67 (1.39)
Length of hosp. per year[e]	(*n* = 39) 11.96 (29.45)	(*n* = 39) 16.73 (66.50)	(*n* = 33) 18.55[f] (27.11)	(*n* = 33) 53.45[f] (114.79)

Note. [a]$F(1,21) = 15.98$, $p < .01$. [b]$F(1,40) = 13.36$, $p = .001$. [c]$F(1,46) = 4.40$, $p < .05$. [d]$p < .005$. [e]Based on the 2-year period prior to program entry for the baseline and for the period of time in the program at follow-up or at termination. [f]$F(1, 32) = 3.50$, $p = .07$.

Presence of drug use problems. Drug use was measured by both the DAST-10, a self-report measure, and DUS-R, a clinician rating scale. Like the alcohol use scores, both drug use measures were recoded into a dichotomous variable indicating either the presence or absence of a drug use problem. A score of 2 or more on the DAST was considered indicative of a drug use problem. A rating of "abuse," "dependence," or "dependence with institutionalization" on the DUS-R was interpreted as reflecting a drug use problem. Similar to alcohol use, no significant changes in drug use were evident, whether based on the self-report measure (DAST-10) or on the clinician rating measure (DUS-R).

Housing status. Housing status was examined to determine if there was a change in the proportion of clients who were homeless from program entry to follow-up in the AG and from program entry to termination in the TG. Both groups showed a reduction in the proportion of clients who were homeless over the course of their participation in the program. Results showed a 20% decrease in the number of AG clients who were homeless from program entry (29%) to follow-up (9%), $p < .005$. In the TG, although there was a 12% decrease in the number of homeless clients from program entry (38%) to termination (26%), this change was found to be non-significant.

Number of hospitalizations and length of stay. Table 1 presents the number of hospitalizations per year and number of days in hospital per year for each group before program entry (baseline) and during participation in the program (follow-up). Clients in the AG showed no significant change in the number of episodes of hospitalization per year while participating in the Court Outreach Program ($M = 0.41$, $SD = 0.68$) compared with the number of episodes per year over the 2-year period prior to program entry ($M = 0.40$, $SD = 0.67$). A comparison of the number of days of hospitalization per year for AG clients before program entry ($M = 11.96$, $SD = 29.45$) and during participation in the program ($M = 16.73$, $SD = 66.50$) also showed no significant change.

Similar to AG clients, TG clients showed no change in the number of episodes of hospitalization per year when comparing the 2-year period prior to program entry ($M = 0.41$, $SD = 0.42$) to the period of time in the program ($M = 0.67$, $SD = 1.39$). A comparison of the number of days of hospitalization per year for TG clients before program entry and after participation in the program found a trend toward an increase in the number of hospital days during participation in the program, $F(1, 32) = 3.50$, $p = .07$. Specifically, TG clients averaged approximately 18.55 days of hospitalization per year in the 2-year period prior to entering the program ($SD = 27.11$) and 53.45 days per year over the course of participating in the program ($SD = 114.79$). It should be noted that over three quarters (76%) of TG clients on whom we had data ($n = 33$) were not hospitalized while they participated in the program; however, 6 of 8 clients who were hospitalized averaged over 200 days of hospitalization per year during their participation in the program, and this contributed to the higher number of days of hospitalization for the TG while participating in the program.

Legal Outcomes

Among AG clients, 63% did not have charges brought against them while they were participating in the Court Outreach Program. Among those charged ($n = 16$), an average of 2.86 charges were brought against them, with 75% of these clients having two or more charges. As shown in Table 2, the most common charges laid were theft (21%) followed by assault (16%) and breach of condition (14%).

Table 2

Types of Charges Brought Against Active and Terminated Clients During Their Participation in the Court Outreach Program

Type of charge	# of charges active group ($N = 44$)	# of charges terminated group ($N = 47$)
Theft	9 (21%)	10 (21%)
Assault	7 (16%)	2 (4%)
Breach of condition	6 (14%)	11 (23%)
Failure to comply	5 (11%)	5 (11%)
Failure to appear	4 (9%)	4 (9%)
Mischief	3 (7%)	2 (4%)
Uttering threats	2 (5%)	2 (4%)
Other	8 (18%)	11 (23%)

Similar to the AG group of clients, 65% of TG clients did not have any further charges brought against them while they were participating in the Court Outreach Program. Among those clients charged ($n = 17$), an average of 2.82 charges were brought against them, with 65% of these clients having two or more charges. As shown in Table 2, the most common charges laid against TG clients while they were in the program were breach of condition (23%) followed by theft (21%).

At termination, 30% of clients in the TG ($N = 50$) were awaiting trial while another 28% were on probation. Twenty percent of clients had received an absolute or conditional discharge, suspended sentence, stay of proceedings, or had completed their sentence. Only two clients (4%) were incarcerated and another client (2%) was detained through the Ontario Review Board.

A sequential logistic regression was conducted to determine what types of services predicted recidivism for clients in the Court Outreach Program after controlling for time in the program and level of disability. For this analysis, clients from both the AG and the TG were examined together. To control for time in the program and level of disability, number of days in the program and scores on the Multnomah Community Ability Scale at baseline were entered in a first step. The total number of minutes of service delivery for the most common types of services was entered in a second step. Eight different types of services were examined as predictors, namely, services focusing on searching for clients, finances, housing, social support, legal processes, mental health, physical health, and substance abuse.

The combination of days in the program and level of disability in the first step of the regression approached significance, χ^2 (1) = 5.34, $p < .07$. Level of disability was a significant predictor of recidivism, with clients who presented with a higher level of disability being more likely to be charged while in the Court Outreach Program (Wald 1 = 4.12, $p < .05$). The second step proved to be significant, χ^2 (8) = 16.45, $p < .05$, with services focusing on searching for clients and physical health emerging as significant predictors of recidivism. A greater amount of time spent on services related to searching for clients (Wald 1 = 6.32, $p < .02$) and a smaller amount of time spent on services focusing on physical health (Wald 1 = 4.99, $p < .03$)

predicted recidivism among AG and TG clients. Overall, the regression model was significant, correctly predicting 72% of the cases, χ^2 (9) = 21.79, $p < .02$.

DISCUSSION

Overall, our findings demonstrated that a number of positive outcomes occurred for clients over the course of their participation in the Court Outreach Program. In particular, clients who had terminated the program experienced an improved ability to live in the community and diminished mental health symptoms. Clients who were still receiving services from the program also showed improved adaptation to living in the community and reduced homelessness. These outcomes were achieved with a minority of clients having new legal charges laid against them while they were participants in the program.

The services delivered by the Court Outreach Program have been conceptualized by the host agency as short-term case management services. The finding of improved community abilities is in line with research findings on client outcomes achieved by some intensive case management programs (Johnston et al., 1998; Macias, Kinney, Farley, Jackson, & Vos, 1994; Modcrin, Rapp, & Poertner,1988; Patterson & Lee, 1998). The significant improvement in the community ability of clients as judged by their court outreach workers on the MCAS is also an outcome consistent with previous research on other community support programs at the host agency and in other regions of Ontario (Aubry & Riesin, 2005; Ontario Ministry of Health and Long-Term Care, 2004).

It is noteworthy that clients in the TG reported decreased severity of mental health symptoms while clients in the AG did not. Given that AG clients have been in the program significantly longer than TG clients, it appears that there are differences between the two groups at least in terms of how they respond to support services. Research on intensive case management has shown mixed results in terms of its effectiveness in decreasing the severity of mental health symptoms (Aubry et al., 2004).

Our results show no changes in substance use problems, whether these involved difficulties associated with alcohol use or drug use. This finding is consistent with previous research that has examined the effectiveness of intensive case management in relation to this problem area (Lehman, Herron, Schwartz, & Myers, 1993; Toro et al., 1997). There is currently no evidence that the kind of generic community support provided through intensive case management will reduce substance use problems. Moreover, the court support services provided by this program focused firstly and mostly on basic and pressing needs related to housing, income, and health as well as assisting clients with the legal process (Sylvestre et al., this volume).

A large number of clients admitted into the Court Outreach Program present with a history of housing problems including homelessness, and the services delivered by outreach workers focus on these difficulties (Sylvestre et al., this volume). The decrease in the proportion of clients who are homeless over the course of their participation in the program suggests that this focus is making a difference. There is evidence in previous research that intensive case management is effective in reducing homelessness, particularly when it is combined with housing interventions such as rent supplements or placement in supportive housing (Nelson et al., 2007). The targeting of this area for legally involved clients seems to be important, and having housing has been shown to be an important condition for clients to continue participation in court support programs (Hartford et al., 2007).

Our findings showed no significant changes in the number of hospitalizations or number of days of hospitalization for either group. However, clients in the TG did show a trend toward having an increased number of days of hospitalization while receiving services in the program relative to the 2-year period prior to entering the program. The latter finding is at least partially the result of a small number of clients (n = 6) being hospitalized for significant periods of time (i.e., > 200 days). Research on intensive case management has shown mixed findings in terms of reductions of the number of hospitalizations and days in hospital (Aubry et al., 2004). Moreover, an important goal of court support services such as those offered by this program is to connect underserved clients to appropriate mental health services (Sylvestre et al., this volume).

A large study examining outcomes for participants receiving court diversion services from eight different programs found that participants received greater levels of mental health services including hospitalizations than individuals detained in jail (Broner et al., 2004). Dewa and colleagues (2008) reported decreases in hospitalizations for clients in court support programs in seven urban and rural regions of Ontario over a 2-year period; however, over 40% of clients reported a hospitalization in the past 12 months at the last follow-up conducted in their study.

Over one third of clients in both the active group and the terminated group had new charges brought against them after entering the program. These outcomes highlight that a significant proportion of clients remain at risk of engaging in criminal behaviour even after they begin receiving support services. It appears that these clients have not fully engaged in the services, as a greater time spent searching for clients emerged as a predictor of recidivism. The finding that the delivery of services focusing on physical health for a longer period of time was predictive of less recidivism suggests that clients with physical health problems are less likely to reoffend.

The rate of recidivism of clients in our study is much higher than that reported in the only published Canadian study on a court diversion program, in which only 2% to 3% of clients were rearrested after entering the program (Swaminath et al., 2002). Swaminath et al. (2002) noted that the programs adopted a very stringent process in selecting clients for the program. In contrast, the Court Outreach Program examined in the current study is not a court diversion program (although diversion is sometimes an outcome), and clients are selected based on high levels of need and isolation (Sylvestre et al., this volume).

The primary goal of a court support program, such as the one we studied, is to begin the process of engaging and connecting clients to mental health services while minimizing risk and further criminal behaviour. As described to us by staff of the program, the courthouse becomes a door through which clients can access much-needed mental health services enabling them to live in the community. The legal status of terminated clients—only two clients were incarcerated, and one was detained under a supervision order—can be interpreted as providing evidence that the program is meeting its goal.

This evaluation research on the Court Outreach Program in Ottawa has a number of limitations that need to be taken into account in the interpretation of its findings. Firstly, the design of the outcome evaluation did not include a comparison group of clients who were not receiving services from the Court Outreach Program. Therefore, it is not possible to conclude definitively that the outcomes achieved can be attributed to services received from the program. Secondly, the length of time in which clients were followed in the study was limited for both the active group and the terminated group. It remains unknown if improvements experienced by Court Outreach Program clients will be sustained after termination from the program.

Thirdly, the quantitative data collected for the evaluation relied on administrative data collected internally by the program. The reliability of the data collected is unknown. Moreover, there was a significant amount of missing information, particularly from data collected using self-report measures. Fourthly, the size of the samples in both groups (TG: $N = 50$; AG: $N = 45$) on which outcomes of the program were evaluated is relatively small, requiring moderate to large effects for changes to be significant. As well, the sample size limited our ability to identify client and service characteristics that are predictive of outcomes. However, this does suggest that the significant changes that were found are clinically meaningful.

Given the state of the research on court support programs and the limitations of our study, the following future directions for conducting research on court support programs are recommended. It is important that future research examine a wide range of outcomes that include functioning, service utilization, and legal outcomes. Future research should adopt more rigorous designs including conducting randomized controlled trials so that researchers can more conclusively attribute outcomes to the program.

As well, future research needs to follow clients for a period of time that extends beyond termination from the program in order to examine the sustainability of achieved outcomes as well as the extent that other positive outcomes occur for clients as a result of receiving an extended period of support. We also recommend that future studies on court support programs be conducted on larger samples of clients that will allow for the detection of at least medium size effects. The use of multisite research designs is worth considering to address this issue. Larger samples will also allow for an examination of client and service characteristics that predict positive outcomes.

NOTE

1. Percentages are based on total number of pre-admission charges against Active Group and Terminated Group clients. Other preadmission charges for the two groups were mischief (AG = 4%; TG = 5%), caused a disturbance (AG = 0%; TG = 4%), break and enter (AG = 3%; TG = 3%), harassment (AG = 3%; TG = 1%), unlawfully dwelling in house (AG = 3%; TG = < 1%), obstruction of justice (AG = 2%; TG = 4%), breach of probation (AG = 2%; TG = 5%), possession of prohibited weapon (AG = 2%; TG = < 1%), carrying a concealed weapon (AG = 1%; TG = 0%), possession of stolen property (AG = 1%; TG = 1%), arson (AG = 1%; TG = 0%), traffic fine (AG = 1%; TG = < 1%), fraud (AG = 1%; TG = < 1%), resisting arrest (AG = 1%; TG = 1%), extortion (AG = < 1%; TG = 0%), forcible entry (AG = < 1%; TG = < 1%), forging of documents (AG = < 1%; TG = 0%), impersonating a peace officer (AG = 0%; TG = < 1%), disguise with intent (AG = 0%; TG = < 1%), escape lawful custody (AG = 0%; TG = < 1%), robbery (AG = 0%; TG = < 1%), trespassing (AG = 0%; TG = < 1%), substance trafficking (AG = 0%; TG = < 1%), breach of recognizance (AG = 0%; TG = < 1%), resist peace officer (AG = 0%; TG = < 1%), and intimidation (AG = 0%; TG = < 1%).

RÉSUMÉ

La présente étude a évalué les résultats d'un programme de suivi communautaire qui offre des services individualisés aux personnes atteintes de maladie mentale grave qui ont des difficultés légales. Les résultats de l'étude démontrent des habilités améliorés de vivre dans la communauté et une diminution de l'itinérance pour un groupe de 45 clients et clientes qui recevaient toujours des services du programme et des habilités améliorés de vivre dans la communauté et une sévérité diminuée des symptômes de santé mentale pour un groupe de 50 clients et clientes qui avaient complété le programme. Seulement 2 des 50 clients et clientes (4%) qui avaient complété le programme étaient incarcérés à la cessation; 1 autre client (2%) était détenu par la Commission ontarienne d'examen.

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