Diversion to Treatment when Treatment is Scarce: Bioethical Implications of the U.S. Resource Gap for Criminal Diversion Programs

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Précis: Despite significant scholarship, research, and funding dedicated to implementing criminal diversion programs over the past two decades, persons with serious mental illness and substance use disorders remain substantially overrepresented in United States jails and prisons. Why are so many U.S. adults with behavioral health problems incarcerated instead of receiving treatment and other support to recover in the community? In this paper, we explore this persistent problem within the context of "relentless unmet need" in U.S. behavioral health (Alegría et al., 2021).

Despite significant scholarship, research, and funding dedicated to implementing criminal diversion programs, persons with serious behavioral health conditions, including substance use disorders (SUD) and serious mental illnesses (SMI), remain substantially overrepresented in United States jails and prisons. An estimated 58% of adults in state prisons and 63% of those sentenced to jail have an SUD, compared to about 5% of the general adult population.[1] About 14% of adults in prison and 26% of those in jail meet criteria for "serious psychological distress," compared to about 5% in the general population.[2] An estimated 75% of those in state prison and jail who had any recent mental health problem also have SUD.[3] Why are so many U.S. adults with behavioral health problems incarcerated instead of receiving treatment and other support to recover in the community? In this paper, we explore this persistent problem within the broader context of "relentless unmet need" in U.S. behavioral health.[4] We use a common bioethics framework[5] to examine concerns that this unmet need raises for diversion-to-treatment programs, which are designed to help justice-involved adults with behavioral health conditions access appropriate resources in the community as an alternative to incarceration. We consider whether diversion programs that are implemented in resource-constrained service environments can fulfill their ambitious promise to reduce justice involvement, improve clinical outcomes, promote self-determination, and enhance overall quality of life for their target populations. What are the implications for diversion programs if persistent resource gaps make it unlikely that they will achieve these worthy goals for a significant proportion of participants?

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The Problem: Unavailable, Inappropriate, and Inaccessible Resources

In 2022, merely 13.1 million out of an estimated 54.6 million people in the U.S. aged 12 or older who needed substance use disorder (SUD) treatment received it, and about half of the estimated 15.4 million U.S. adults with serious mental illness (SMI) perceived an unmet need for mental health services.[6] Marginalized communities disproportionately bear the burden of this unmet need: among adults with any substance use or mental health disorder, those who are poor, uninsured, or persons of color are consistently less likely to receive behavioral health services.[7]

A deep resource gap in treatment and human services is the backdrop for this unmet need. In many communities, treatment and related service options are practically nonexistent. For example, some prescribers decline to offer buprenorphine, making this key SUD treatment resource unavailable. In other cases, available treatment is inappropriate and may cause more harm than good. Many treatment options are not evidence-based, patient-centered, or culturally sensitive. Individuals who need social support, housing, or help identifying their drug use triggers may instead be forced into abstinence-based treatment programs because of a limited resource landscape or the constraints of court-sanctioned programs. Finally, available and desired treatment options may remain inaccessible for community members who lack the time or resources to travel to a clinic, pay for treatment, or follow intensive and long-term requirements. Without steady income, housing, childcare, transportation, or other key resources, engagement in treatment may be nearly impossible. We will refer to these three barriers — unavailable, inappropriate, and inaccessible resources — collectively as the "resource problem." The "resource problem" thus encompasses any gap in the supply of accessible, evidence-based treatment, as well as other resource gaps that prevent people from effectively participating in a treatment program. The underlying causes of the resource problem and their ethical implications are not within the scope of this analysis, but we note that specific public policies (e.g., drug control policies that shape access to methadone) and contextual factors (e.g., lack of training for clinical professionals working within the criminal legal system, healthcare workforce shortages (particularly in rural areas), and limited political will to fund behavioral services) likely contribute to these gaps.

The resource gap may help explain the apparent lack of willingness among people with SUD to pursue treatment. In 2022, a national survey estimated that 96 percent of individuals with SUD who did not receive treatment at any specialty facility perceived no need for such treatment.[8] In many cases, lack of perceived need may reflect a person's rational decision not to engage with treatment that is stigmatizing, unregulated, unproven (e.g., abstinence-based approaches for opioid use disorder (OUD)), or overly burdensome (e.g., mandatory daily in-person appearances at methadone clinics). Inadequate knowledge of treatment options and low public awareness and recognition of problematic substance use[9] likely also play a role. Moreover, some people with SUD may not be ready to enter treatment because their other needs, such as housing, are not met.[10]

For these reasons, addressing the resource gap requires responsiveness to individuals' complex web of needs. Programs that "meet people where they are" (rather than, for instance, requiring abstinence) and address their basic needs for shelter, food, and medical and mental health care can help those who are not yet ready or able to attend treatment.[11] Building a more diverse behavioral healthcare workforce can help provide culturally-sensitive services, address stigmatizing attitudes towards mental illness and addiction, and ensure that treatment resources appropriately address patients' needs.[12] Together, such interventions could encourage participation and help alleviate the racial and socioeconomic disparities in addiction treatment completion.[13]

In the context of criminal diversion, the resource problem implicates not only the health but also the liberty and safety of individuals. Criminal diversion programs offer defendants alternatives to traditional criminal prosecution, often with the goal of avoiding a criminal record and its many collateral consequences. Many diversion programs target individuals with SUD or SMI by incorporating treatment and other resources to prevent unnecessary justice involvement.[14] Examples include pre-arrest diversion such as Law Enforcement Assisted Diversion (LEAD), in which a police officer links individuals to case management instead of arresting them;[15] drug treatment court, in which a judge mandates participation in supervised treatment instead of conviction or incarceration; and post-conviction behavioral health probation, in which a person who has pleaded guilty to an offense receives a probation sentence that may have specific conditions, such as court-ordered drug testing or therapy.[16]

One important distinction is between programs that involve supervision by the criminal legal system, such as drug court and mental health probation, and those that do not, such as LEAD. Most programs in the former category, which we call supervised diver-

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sion, require the defendant to plead guilty, although some, like drug courts in certain jurisdictions, allow participants to avoid a criminal record if they successfully complete program requirements. Programs in the latter category, which we call community-based diversion, connect individuals to appropriate treatment, social, or human services without imposing requirements or sanctions through the criminal legal system. As we will discuss, the presence of criminal supervision often raises distinct ethical issues for diversion programs.

Diversion programs focused on behavioral health, which are the topic of this paper, aim to reduce criminal justice contact by intervening at various points or "intercepts" along the continuum of justice involvement, as depicted in the Sequential Intercept Model (SIM).[17] The original model identifies five intercepts, each one of which presents an opportunity for diversion to treatment: law enforcement and emergency services; initial hearings and initial detention; jails and courts; reentry from jails, prisons, and forensic hospitals; community corrections and community support services.

A key principle of the SIM is that diversion should occur as early as possible, and ideally prevent justice involvement altogether. An "accessible, comprehensive, effective" behavioral health treatment system would serve as the "ultimate intercept" by preventing the criminalization of behavioral health disorders in the first place.[18] In theory, this would mean that people with these disorders would never become involved with the justice system as an indirect consequence of untreated SUD or SMI (these individuals might nonetheless become involved with the justice system as a result of individual or social risk factors, just like the broader population; the ultimate intercept does not promise to prevent all justice involvement). Recently, scholars have incorporated this "ultimate intercept" into the SIM as "Intercept 0." Intercept 0 includes the full range of emergency services that respond to behavioral health crises, such as mobile crisis outreach teams, crisis respite services, and first responders,[19] as well as the entire integrated community behavioral health system.[20] Under this conception, substance use, mental health, primary medical, criminogenic, and social needs of individuals would be "addressed in a coordinated and timely manner to achieve the desired goals of improved health, prevention of institutionalization (hospitalization and incarceration), and overall recovery."[21] An integrated community behavioral health system is essential to the ethical planning and operation of diversion programs. Thus, we include Intercept 0 in our analysis.

The resource problem has already been recognized as a roadblock to diversion. Researchers evaluating a variety of diversion programs have identified the resource problem as a factor limiting programs' effectiveness,[22] and advocates have posed the question, "diversion to what?"[23] Here, we examine the bioethical implications of this longstanding problem for diversion programs and those who participate in them.

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Analytical Framework: The Four Principles of Biomedical Ethics

We explore the resource problem through a bioethics framework for three reasons: First, the principles of non-maleficence, beneficence, autonomy, and justice reflect a shared set of values among clinicians and are directly related to the treatment of behavioral health patients. Diversion efforts are healthcare efforts, not only because they help direct people to treatment, but also because the avoidance of justice involvement is a health-promoting measure.[24]

Second, the principles of bioethics were formulated to protect patients and research participants from abuse due to the mismatch of power and information between them and researchers and clinicians.[25] Individuals considering whether to enter diversion programs are in a particularly vulnerable position not only because of the sanctions and other liberty restrictions

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that may consequently be imposed on them, but also because justice-involved individuals are disproportionately from socially marginalized communities.[26]

Third, and finally, bioethics must be responsive to the social and political context in which it operates. The field has been criticized for failing to address the effects of racism and other structural inequities on clinical and research outcomes. Scholars have argued that bioethics can and should contribute to addressing racism[27] and have conceptualized a "bioethics of the oppressed."[28] Here, we apply this conceptual framework to behavioral health diversion programs, which operate against significant racial and economic disparities that shape the U.S. criminal legal system.[29] While we focus on a systemic resource problem, our analysis largely addresses how that problem impacts individual patients' experiences in diversion. Other ethical frameworks, while beyond the scope of this commentary, could provide valuable insight to this issue as well.

In the next four sections, we outline how each bioethical principle relates to criminal diversion, and the series of complications created by the lack of an accessible, comprehensive network of evidence-based and person-centered treatment, support programs, and human services. We focus on decision-making for individuals who do not pose an imminent threat of danger to themselves or others, as safety considerations may be overriding in other cases. Crucially, while we address only the ethical challenges raised by the resource gap, we acknowledge that other, serious ethical issues implicate certain supervised diversion programs like drug courts (for instance, public hearings can compromise private medical information, program-wide bans on effective and needed forms of medication can compromise participant wellbeing, and the therapeutic jurisprudence philosophy underlying drug courts is inherently coercive and perhaps irreconcilable with the principle of autonomy).[30] While we touch on how these issues relate to the resource problem, they are not our focus and would require internal reforms to those diversion programs rather than external reforms aimed at the resource gap. In sum, responding to the issues we outline in this commentary will be necessary yet not sufficient for many diversion programs to align their practices with the principles of bioethics.

1. Autonomy

The principle of autonomy requires respecting the rights of patients to make their own treatment decisions, including by providing sufficient information to enable reasoned and informed choices.[31] Autonomy is particularly implicated in the context of diversion from incarceration, a near-complete loss of autonomy. However, diversion programs often involve limitations on autonomy as well. For example, participants in prosecutor-led diversion, treatment court, and mental health-related probation are supervised by a prosecutor, judge, or probation officer. Moreover, participants can face sanctions including fees, a criminal record, or incarceration if they do not comply with program requirements. As we describe in the introduction, we refer to this family of programs as "supervised diversion," which we differentiate from "community-based diversion." The latter allows health providers and patients to chart out a treatment plan without criminal sanctions, threats, or supervision.

Ideally, diversion programs should avoid all unnecessary restrictions of autonomy (i.e., those that are not warranted by public or individual safety concerns) in both the criminal and clinical setting. The resource problem can be a barrier to this ideal if treatment is more easily accessible to people enrolled in a diversion program. We discuss the implications of this issue in the context of coercion and patient-centered care.

Autonomy requires that individuals participate in treatment voluntarily, typically by providing informed consent. A reasoned and informed choice to participate entails "more than a simple declaration by the defendant."[32] It requires briefing people on the potential positive and negative consequences of and alternatives to participation in the program. It also requires providing special care for individuals who have difficulty understanding the premises of diversion, including the voluntariness of the offer or the inherent lack of guarantee of success of the treatment.

Before entering a diversion program, participants are typically presented with a choice between diversion and continuing along the standard criminal prosecution pathway. These choices may be treatment court rather than jail time or conviction; community services under probation supervision rather than jail time; referral to community services rather than arrest. Transfer to a diversion program in some instances may be the only opportunity for immediate release from jail to the community. In each of these instances, individuals are "free" to refuse diversion and to choose, for instance, to spend six months in jail rather than 18 months in a court-supervised treatment program or on probation. However, these choices come under the pressure of criminal sanctions and are notably different from the choices patients typically make when giving informed consent.

Presenting criminal sanctions as the alternative to treatment unavoidably adds a degree of coercion to

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individuals' decision to participate in diversion, making the decision less and less "free" as the criminal alternative becomes more and more restrictive. Treatment programs that do not threaten criminal consequences or supervision as the consequence of nonparticipation, such as those operating at Intercept 0 prior to arrest or conviction, can avoid the coercive aspect inherent in supervised diversion programs. Such community-based programs are thus preferable for promoting patient autonomy, unless a clear public safety concern warrants greater supervision or confinement.

However, coercion may become unavoidable under conditions of resource scarcity, where diversion offers the only chance for treatment. For people who live in resource-constrained areas or are uninsured, treatment may only be available through a supervised diversion program. Well-meaning justice professionals may coerce people into diversion programs to secure treatment, just as well-meaning health providers may involuntarily commit a psychiatric patient because that is the only way to secure an inpatient bed (which is arguably an unconstitutional abridgement of rights[33]). In some instances, such as arrests for trespassing, overnight camping, panhandling, and other laws that essentially criminalize homelessness, supervised diversion may impose greater restrictions on autonomy than the criminal charges would warrant.

Such coercive interventions to enroll participants in diversion, no matter how well-intentioned, require a "strong justification."[34] In the context of involuntary commitment, some have argued that "there may be no ethical case" for commitment if "the problem is merely one of addressing removable barriers to treatment—that is, providing access to services that the person would be willing and able to accept voluntarily, if available." Similarly, if supervised diversion functions solely as a means of addressing removable barriers to treatment or other human services for individuals who are not a threat to themselves or others, there will be no ethical case for its use over community-based alternatives.

In addition to avoiding unjustified instances of coercion, diversion programs can promote autonomy through patient-centered care that responds to the complex needs, goals, and preferences of patients related to co-occurring disorders; trauma history; gender, race, and sexual identity; social support; basic needs; and more. Ideally, this would mean allowing individuals with SUD to choose the services that they need to recover, including by pursuing social and mental health supports that help them identify and avoid triggers, rather than being forced into a dichotomy between abstinence-based treatment and criminal sanctions. The experience of autonomy in patient-centered care is not only ethically desirable but also likely to improve treatment outcomes by allowing patients to feel empowered and invested in their recovery.

Unfortunately, choice of care specifically and patient-centered care generally are difficult to achieve in the context of mandated treatment, a common component of supervised diversion programs. People who have been diverted are often seen as "beggars, not choosers;" this attitude prevents clear-eyed consideration of whether treatment requirements actually meet participants' needs. For example, for many individuals with SUD, recovery may require only social support and counseling to help identify triggers of drug use, rather than a stay at an inpatient residential facility. For those with OUD, medications are often a crucial component of recovery. However, some forms of medication-assisted treatment (MAT) are barred by supervised diversion programs that require abstinence and equate MAT with illegal drugs, often due to misinformation on the part of diversion program administrators.[35] Some drug courts allow one form of MAT—naltrexone—because it is an opioid antagonist and therefore more in line with an abstinence philosophy. However, patients and their doctors might prefer an alternative type of MAT, such as buprenorphine, because it is less expensive, easier to start because it does not require detoxification,[36] and less likely to lead to overdose.[37] It is not only ethical but also feasible and more effective for supervised diversion programs to implement a person-centered approach that includes any form of MAT that is medically indicated. Indeed, practitioners have outlined specific strategies to help programs make the transition.[38]

Patient-centered care and autonomy might be compromised by other program components too, especially in supervised diversion. For example, some judges require women to participate in anger management classes as a condition of program completion. In such programs, women with trauma histories of male-perpetrated violent victimization, which make up the majority of justice-involved women,[39] can be mandated to attend a group with men.[40] Given a free choice, a woman in this situation might reasonably reject participating in group therapy with men, and a trauma-informed clinician would likely not recommend it.

The above examples illustrate how the resource problem, in addition to being an external barrier to ethical program implementation, can itself be exacerbated by internal program policies. Diversion participants may not have access to MAT if affordable and appropriate options are not available in their rural setting.[41] Others might be denied access to available

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treatment because program administrators disallow it. In the former scenario, diversion programs suffer the consequences of longstanding and vast resource problems in the American behavioral health infrastructure. In the latter, diversion participants suffer the consequences of program policies that insufficiently accommodate participants' autonomy. For women who are mandated to participate in mixed-gender anger management, finite resources and program requirements combine to constrain treatment options. While the necessary policy solutions will vary widely in each case, patient-centered care becomes elusive in all as individuals get forced to meet requirements that fail to meet their needs and even make things worse.

Under conditions of resource abundance and scarcity alike, community-based diversion programs that are not supervised by criminal legal system actors are best positioned to promote participant autonomy, both by ensuring that the decision to participate is not coerced by the threat of criminal sanctions and by allowing participants to access the resources that best align with their needs and goals. Supervised programs are appropriate only for individuals who pose a significant threat to public safety. Realistically, when community-based programs are unavailable or inaccessible, supervision is likely to expand to include individuals who do not pose such a threat, leading to restrictions of autonomy that are difficult to justify.

2. Non-Maleficence

The principle of non-maleficence states that health professionals should avoid causing harm in treatment.[42] In criminal diversion, unlike in typical clinical settings, this duty is two-fold: Diversion programs, operating at the intersection of the criminal legal and health systems, must avoid causing harms through either system.

Although diversion programs are intended to prevent the many harms related to contact with the criminal legal system,[43] they may inadvertently increase criminal involvement in the context of the resource gap. This can happen in at least two ways.

First, diversion programs may contribute to net-widening, which refers to the expansion of the "criminal net" via the surveillance, control, and punishment of a broader group of people.[44] Law enforcement officers and prosecutors have significant discretion, and some may choose to arrest or prosecute individuals for whom they believe diversion offers the best or only access to treatment and social resources. When resources are scarce, criminal involvement can become the first point of access to care, particularly for uninsured, unhoused, and otherwise marginalized individuals who have no meaningful alternative.

Second, diversion programs might increase criminal contact among their participants. Many supervised diversion programs involve requirements of successful completion and/or sanctions for noncompliance. Some of these requirements and sanctions cause the very harms that diversion seeks to avoid, such as burdensome court fines, frequent interactions with criminal legal officials, and even jail time. Nonadherent drug court participants may receive longer periods of incarceration than they would have through traditional sentencing.[45] Mental health probation participants without sufficient time or money to meet program requirements may receive technical violations and return to jail or prison.[46]

Non-maleficence requires that diversion programs avoid causing harm, in particular the kinds of adverse health effects that often result from standard criminal prosecution and incarceration. Restrictive conditions might become necessary if an individual poses a significant public safety risk. In all other cases, programs must avoid conditions and sanctions that mimic the

Inappropriate treatment poses a greater risk of harm in programs that mandate treatment. When programs require compliance with treatment that turns out to be unavailable, inappropriate, or inaccessible, participants can be left to suffer not only the consequences of untreated SUD and SMI but also the financial, physical, and mental burdens of attempting to meet program requirements and the adverse consequences of failing to do so. Participants may consequently suffer long-lasting health effects if, due to feelings of alienation and discouragement, they become less likely to pursue treatment in the future.

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very harms diversion is meant to prevent (e.g., jail days as a program response to relapse[47]).

The second set of potential harms that criminal diversion must seek to avoid relates to contact (or lack thereof) with the healthcare system. Diversion might harm participants' health by diverting them to treatment that is unavailable, inaccessible, or inappropriate, without enabling access to supports required to meaningfully participate, and imposing consequences if the person does not succeed. Individuals may be unable to complete a diversion program because there are no affordable or appropriate resources in their community, or because they are unable to follow treatment due to other problems like being unhoused. Alternatively, resources that do not appropriately address individuals' needs might delay recovery or even cause harm, such as the aforementioned examples of abstinence requirements for individuals with OUD [48] and mandatory mixed-gender anger management classes for women with sexual trauma histories.[49] As mentioned, diversion programs sometimes mandate inappropriate treatments even when better alternatives are available due to the biases or lack of clinical expertise among judges or diversion program staff.

Inappropriate treatment poses a greater risk of harm in programs that mandate treatment. When programs require compliance with treatment that turns out to be unavailable, inappropriate, or inaccessible, participants can be left to suffer not only the consequences of untreated SUD and SMI but also the financial, physical, and mental burdens of attempting to meet program requirements and the adverse consequences of failing to do so. Participants may consequently suffer long-lasting health effects if, due to feelings of alienation and discouragement, they become less likely to pursue treatment in the future.

3. Beneficence

The principle of beneficence states that treatment must aim to maximize possible benefits and minimize possible harms.[50] Diversion programs can do this by minimizing contact with the criminal legal system and by maximizing positive treatment outcomes — in other words, by using the least intrusive intervention that has a chance of success.

The goal of providing a benefit while removing or minimizing potential harms, as required by the principle of beneficence, is subtly different than the goal of simply "doing no harm," as required by non-maleficence. To promote beneficence, diversion programs ideally must facilitate participants' access to treatment and human services that improve their wellbeing — in ways that are meaningful to them — in part by avoiding the harms of criminal prosecution, but also by minimizing any adverse consequences of the treatment program itself. In this way, beneficence demands a more ambitious and imaginative understanding of what diversion can and ought to be.

Following the guidepost of the "least intrusive intervention that has a chance of success," justice officials can employ their considerable discretionary powers to help people avoid criminal sanctions as much as possible. Prosecutors can drop the charges against individuals arrested for low-level crimes and refer them to voluntary treatment, rather than proceeding with prosecution or imposing court-supervised programs.[51] Similarly, judges can decide to dismiss cases, and police officers can choose not to arrest individuals in the first place. If supervision is necessary for public safety reasons, prosecutors and judges can select the least demanding requirements possible, working, for instance, to prioritize connections to treatment and human services over frequent check-ins with court personnel. Doing so would help maximize benefits for individuals by sparing them the harms of criminal supervision and potentially increasing their engagement with treatment in the absence of looming criminal or civil sanctions; participants might feel more comfortable with honest disclosure of their symptoms and struggles in a therapeutic context where "failure" in treatment will not be met with sanctions as severe as jail time or loss of child custody. Discretion used in this way can minimize the potential harms of diversion. Of course, for such discretion to be effective, services meeting the needs of individuals need to be available in the community, outside of supervised diversion settings.

Similarly, the principle of maximizing potential benefits requires not only that programs offer a better alternative to traditional criminal prosecution, but also that they maximize treatment outcomes to the extent possible. To do so, programs would ideally offer a range of evidence-based, person-centered, culturally sensitive treatments that address participants' various needs and help them achieve long-term recovery. These might include trauma-informed counseling, appropriate medications, assertive community treatment (if intensive team-based case management services are warranted), treatment for co-occurring disorders, individual psychotherapy, harm reduction, and program features to meet social and economic needs like housing and transportation.

Including knowledgeable and enlightened clinicians in the design of diversion programs could help to align treatment philosophy and policies with the most effective and evidence-based treatment approaches,

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modalities, and interventions to promote patient-centered recovery. Thoroughgoing involvement of behavioral healthcare professionals in diversion at the programmatic level could foster productive collaboration with system actors in the criminal legal realm — sheriffs, judges, prosecutors — who might otherwise structure and implement diversion programs with constraints to prioritize their concerns with risk management and crime control, deemphasizing the beneficence principle with respect to participants' own life chances and wellbeing.[52] Allowing behavioral health experts to make behavioral health-related decisions in diversion would promote health outcomes and may be welcomed by criminal justice professionals who lament having been "placed in the position of taking on the responsibility of justice-involved people with serious mental illness."[53] Yet, the resource problem poses a challenge to implementing this change. An acute national shortage of behavioral health providers is "compounded by the lack of racial, ethnic, and language diversity in the behavioral health workforce."[54] Efforts to improve diversion must thus include recruitment, training, and employment of behavioral health providers at higher rates, particularly those who are traditionally underrepresented in the workforce. They must also include internal reforms to diversion programs which so often exclude healthcare professionals from their staff and program design.

To promote beneficence, diversion must aim to maximize, rather than merely improve, benefits, and minimize, rather than merely reduce, harms. Programs that avoid criminal supervision whenever possible and that include, following the expertise of healthcare professionals, an integrated system of evidence-based behavioral health services alongside social and human services can be expected to maximize beneficence.

4. Justice

The principle of justice states that the benefits and risks of an intervention should be equitably distributed among the population.[55] Each of the three principles we have addressed — autonomy, non-maleficence, and beneficence — implicate justice in the context of the resource problem. This is because the resource problem is a justice problem that disproportionately affects racially and economically marginalized individuals. Unsurprisingly, the resource problem is also a barrier to the equitable distribution of resources within diversion programs.

Ideally, diversion programs following the justice principle would help alleviate existing disparities in the criminal legal system. They would do so by reducing the overrepresentation of individuals with behavioral health conditions as well as those from racially and economically marginalized communities across all stages of criminal prosecution. Diversion programs would provide all participants equal access to treatment, regardless of insurance status or ability to pay, and address people's unmet needs for housing, transportation, employment, etc., that prevent their access to treatment.

Unfortunately, justice remains elusive in many diversion programs. Black and Hispanic people are increasingly overrepresented at each level of criminal supervision, i.e. among arrestee, probation, and incarcerated populations.[56] Yet, Black and Hispanic people are consistently underrepresented in diversion program participation and completion rates.[57] This reversal from over- to underrepresentation may be explained by factors like resource disparities between White participants and participants of color, shortage of culturally-sensitive programs, limited racial diversity in the behavioral health workforce, and racist perceptions of people of color as more dangerous and less appropriate candidates for diversion.[58] The full extent of racial disparities in diversion and the factors driving them are difficult to gauge since many programs do not measure and report outcomes by race. This lack of data is another, significant barrier to racial justice in diversion.

Ironically, the severity of individuals' behavioral health conditions can lead to disparities as well, especially when resources are limited. This is because individuals with milder symptoms may require fewer resources and thus be considered "easier" to divert. According to one recent study, individuals with SMI experience not only longer stays in jail but also lower rates of treatment engagement and enrollment in specialty courts as well as poorer diversion outcomes compared to individuals without SMI.[59] Since diversion programs often measure their success by successful completion rates, program operators may be incentivized to enroll individuals who have less severe symptoms or more resources to help them complete program requirements, including individuals who may not have SMI or SUD. Under resource scarcity, diversion programs may leave out the very people they were designed for.[60]

Diversion programs can exacerbate economic disparities as well, shutting out participants who cannot afford participation fees, which can be as high as $5,000 for a single offense.[61] Program and treatment fees create a "pay to play" system wherein diversion offers a way out of the criminal continuum solely for individuals with the ability to pay. Primary caregiv-

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ers to children who cannot afford childcare, full-time employees who cannot afford to stop working, and individuals who are uninsured or otherwise unable to meet program requirements due to financial limitations are similarly denied the opportunity to exit the criminal continuum and receive the treatment and services that they need.

Individuals who face criminal conviction are often uninsured, underinsured, or indigent. When diversion programs disproportionately allow the advantaged to avoid or end contact with the criminal system while disproportionately leaving in the individuals who have been the most marginalized by it, the principle of justice remains woefully unmet.

Conclusion

To assess diversion programs, we must address the question, diversion to what? For many U.S. communities, the answer continues to be "not enough." We have analyzed diversion programs using a bioethical framework in the context of a persistent resource problem in behavioral health and other human services. We find that programs operating under such circumstances are faced with difficult ethical dilemmas and may at times cause more harm than good, especially when they involve criminal legal supervision.

It is possible to design and implement diversion programs that effectively promote health and reduce harms while preserving the dignity and autonomy of justice-involved individuals with behavioral health needs. However, doing so requires addressing the background resource problem that permeates the behavioral health and human services infrastructure. Without public investments to increase treatment capacity, choice of treatment options, and the representativeness of the health and human services workforce, diversion programs cannot provide ethical care to participants, especially to those from marginalized communities. Crucially, doing so also requires significant internal reforms to many programs' staffing, eligibility criteria, conditions of participation, and success metrics, so that diversion itself does not become an additional barrier to accessing an already scarce supply of resources. If diversion programs are to live up to their goals of reducing justice involvement and improving clinical outcomes, including in communities that have been most deeply underserved by the justice and healthcare systems, we must all become more responsive to the resource problem. The bioethics framework offers a helpful tool to begin that work.

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