MODEL JAIL DIVERSION AND REENTRY SERVICE PROGRAMS: REVIEW OF THE LITERATURE

Kathy Crane, MA / Danna Mauch, PhD / Genevieve Mulligan, BA / Catia Sharp, MPP

MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH / TRUEBLOOD COURT MONITOR

MODEL JAIL DIVERSION AND REENTRY SERVICES PROGRAMS

UPDATED LITERATURE AND RESOURCE REVIEW—NOVEMBER 2019

I. Introduction

The purpose of this paper is: 1) to summarize the recent literature related to model jail diversion and reentry services and programs, and, 2) to offer guidance to state and local jurisdictions on the development of a full continuum of effective and evidence based jail diversion services to reduce the number of persons with mental health and/or substance use conditions in the criminal justice system. A number of proven and/or promising practices are highlighted. The literature suggests that there is no one "model" jail diversion program, rather there are model practices within each component of the Sequential Intercept Model (SIM). The Sequential Intercept Model (SIM) was created as a tool to conceptualize solutions to address the overrepresentation of people with mental health and substance use conditions in the justice system (Munetz & Griffin, 2006). This model consists of five points of interception within the criminal justice system at which one might intervene to prevent vulnerable individuals from getting deeper into the justice system. Additionally, a sixth intercept point is outside the criminal justice system: community-based services (Abreu et al, 2017) can intercept an individual's involvement with the criminal justice system before initial interaction with police or upon reentry to the community after detention or incarceration, highlighting the cyclical nature of the criminal justice system and suggesting that the SIM is really a circle.

The characteristics of individuals who use jail diversion and reentry services programs are reported in several studies, and include:

- Age: mean ages between young adult and middle age years, depending on population targeting in a particular program
- Gender: varies by targeting of the program but diversion clients are more often female and reentry clients are more often male
- Ethnicity: In the US, this varies by state and geography, with African Americans disproportionately represented in the South and Whites in the majority in programs in the North and Northwest
- Diagnoses and Previous Treatment: While the large majority of those diverted have mental health and/or substance use conditions, the rates of prior treatment are lower (at about half), with most men having a diagnosis of psychosis and/or substance use and poor rates of compliance with treatment; women have highest rates of mood and substance use conditions with frequent histories of sexual abuse and being victims of interpersonal violence (IPV); those with substance use have very low rates of prior treatment
- More women than men enter these programs from being housed, with nearly half the men being homeless at admission to diversion programs and more facing homelessness at reentry. (Cuddeback et al, 2019; Puntis et al, 2018)

Programs described here have the primary goal of reducing criminal justice system involvement. A secondary goal of some programs is to treat mental illness and/or substance use conditions, or to connect individuals to services intended to support their emotional wellbeing and community stability. It is often assumed that the latter goal

supports the former, but these two goals can come into conflict in the application of specific programs. In this white paper, we highlight the intended goal(s) of a program, the evidence that the program is effective at achieving that goal or goals, and any conflict that may arise in implementation between various goals.

Within each intercept, the peer-reviewed literature can be categorized into three basic types: 1) research on management and organizational practices which generally have two objectives: referring individuals to behavioral health and other social services, and reducing the injury caused to individuals with behavioral health conditions within the criminal justice system; (2) research on the evidence of service models; and (3) research on methods for increasing the take-up rate of treatment services. Each reviewed component of an effective diversion strategy below is categorized into one of these types in order to help clarify how to implement each most effectively, with fidelity to the evidence supporting its effectiveness. For example, a management or organizational practice would be implemented through organizational procedures and policies, whereas a service model might be implemented as a singular functional area within an organization's portfolio of activities. A method of increasing the take-up rate for services might be applied to the implementation of a specific program or suite of programs.

This white paper will distinguish between programs with more rigorous, peer-reviewed evidence of success in Part II and programs with less rigorous cost-benefit or self-assessed evidence that offer innovative and/or promising approaches for further trial in Part III.

II. Summary of the Peer Reviewed Literature

This section will review peer-reviewed evidence of effectiveness of programs across the SIM and discuss implementation considerations raised by the literature.

An overarching area of research on methods for increasing the take-up rate of service models is applicable to services across the SIM. Individuals in the criminal justice system have high rates not only of behavioral health conditions, but also trauma histories. Additionally, public institutions and service systems themselves, including the criminal justice system, can be trauma-inducing (SAMHSA, 2014). Research on trauma shows that coercive methods for increasing the take-up rate for services are not as effective at treating the symptoms of mental health and substance use conditions for individuals who have experienced trauma as methods that are non-coercive (SAMHSA, 2014). Coercive methods can re-traumatize individuals, which is often counterproductive to the goal of reducing symptomatology. This finding may seem to contradict research that suggests that coercive methods of increasing uptake of services are effective at reducing criminal activity and/or future criminal justice involvement, for example research on the effectiveness of the risk-needs responsivity model of corrections and probation (Andrews et al, 1990), but in fact helps to highlight the problem of conflicting goals and objectives described above.

Improving connection to behavioral health services in attempts to divert individuals from the criminal justice system requires more systematic identification of those individuals at criminal justice intercept points. Numerous studies, white papers, and policy guidelines

cite the critical importance of identifying the behavioral health needs and potential safety risks of individuals. Among these are the *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*,"(Blanford and Osher, 2013), the *Five-Level Risk and Needs System: Maximizing Assessment Results in Corrections through the Development of a Common Language* (Hanson, et al., 2017), and the *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery (Osher et al., 2012).* A summary report of all risk assessment instruments utilized across the United States offers a full menu of potential instruments (Desmarais and Singh, 2013). At each Intercept below, we highlight opportunities for the use of evidence-based screening and assessment tools to identify individuals with behavioral health conditions who might be appropriately diverted from criminal justice involvement.

Below is a brief summary regarding those six intercept points and examples of evidence informed programs that exist at each intercept. Please also refer to Appendix C for a full list of references for the cited literature. Please note that the evidence summarized below applies only to the specific model studied and described here. In some cases, there is a tendency for agencies replicating evidence-based models toward changing components of those models to meet local needs. In such cases, the evidence base described here may have a weaker relationship to potential outcomes in replicating jurisdictions not using the so-called "fidelity model." In such cases, implementing jurisdictions should seek to evaluate the effectiveness of the amended service model they are implementing given the differences in service model and the potential difference in demographic and other environmental factors (i.e., implications related to the internal and external validity of existing studies).

Intercept Zero: Preventing Involvement in the Justice System

Investments in prevention and early intervention services are deemed essential to a model jail diversion program. The earlier the behavioral health needs of an individual are addressed, the more likely it is that they will never enter the justice system. Opportunities for evidence-based screening and assessment of behavioral health needs at Intercept 0 include:

- Primary care settings: early detection of behavioral health conditions in primary care settings and referral to appropriate treatment may prevent later criminal justice involvement, as well as further deterioration of mental health.
- Behavioral health urgent care and crisis prevention: if urgent care exists in the behavioral health setting, it can be an alternative to initiating law enforcement interactions in the first place.
- Crisis intervention and restoration centers and crisis centers can effectively screen and asses individuals with behavioral health needs, if available. These models are described in more detail in Section 3.

In a recent report prepared by the TriWest Group for the State of Illinois (Zahniser, 2017), the authors recommend that systems develop capacity to deliver evidence based

early interventions such as **First Episode Psychosis Care**, a service model intended to intervene early with individuals experiencing psychosis:

> From a long-term perspective, mental health systems need to detect mental illness and provide effective intervention early in a person's illness trajectory. Historically, systems have been poor in this area. Researchers estimate that, on average, people with mental illnesses wait five years before receiving appropriate treatment. We also know from recent research on First Episode Psychosis (FEP) Care that intervening early in the course of illness leads to better life outcomes. For example, Kane and colleagues found that when people entered FEP Care programs within the first 17 months of the onset of their psychosis, quality of life in such areas as school and work improved at a statistically significant higher rate (Kane, J.M., et al., 2015). FEP Care programs are similar to ACT and FACT in that they represent a multidisciplinary team-based approach to meeting the needs of youth and young adults experiencing their first episode of mental illness.

FEP has been found to reduce symptomatology and also reduces substance abuse, although these effects do not appear to be durable through the transition to standard treatment (Nordentoft et al, 2014).

Intercept 1: Law Enforcement/Emergency Services

The second point of intercept is pre-arrest which includes interactions with law enforcement personnel, who sometimes serve as first responders during mental health emergencies and can be key partners to behavioral health and emergency services personnel. Interventions at this intercept are largely focused on the education and training of police officers in their capacity as first responders, as well as introducing mental health professionals into this setting. Opportunities for evidence-based screening and assessment of behavioral health needs at this intercept include:

- Crisis Intervention Teams, discussed below, which include officers specially trained to identify and divert individuals with behavioral health conditions.
- 911 dispatch: upon receipt of emergency calls, call takers and dispatchers could more effectively triage calls related to behavioral health emergencies and dispatch more appropriate services, if such services were available (services are described below).
- Emergency medical services (EMS): upon arrival at an emergency, EMS may find that the emergency is behavioral health in nature and make an appropriate referral, if adequately trained to do so.
- Mobile crisis teams: described below, such teams may help law enforcement agencies better screen and assess individuals with behavioral health needs.

Law enforcement diversion models have proliferated, and naming conventions for various models have not been developed to help jurisdictions considering replication of programs easily decipher program elements that are part of the "fidelity" evidence-based model. In their *Pre-Arrest Diversion/Deflection Frameworks: A Decision Making Tool for*

Police Leaders, Treatment Alternatives for Safe Communities (TASC) attempts to start this work by laying out a taxonomy for pre-arrest diversion/deflection program frameworks which can unify groups of programs with similar characteristics. We adopt the TASC taxonomy here.

- *Naloxone Plus* is a framework in which engagement with treatment occurs following an overdose response and crisis-level treatment is readily available. No peer-reviewed, evidence-based examples of such programs were reviewed for this white paper.
- *Active outreach* is a framework in which participants are identified by law enforcement, but are engaged primarily by a treatment expert who actively contacts them and motivates them to engage in treatment.
    - **Crisis Intervention Teams (CIT)** designed using the Memphis model are evidence-based management or organizational practices. Research indicates that CIT programs result in fewer officer injuries, greater access to crisis and other supportive services, fewer subsequent contacts with the justice system, lower justice costs, and higher treatment costs (Compton et al., 2008) (Reuland et al., 2009). CIT is often misunderstood as a police training regime. However, the core elements of the Memphis model for CIT are more expansive than officer training, and include 1) ongoing elements including partnerships between law enforcement, advocacy, and mental health providers, community ownership and involvement, and changes to policing policies and procedures; 2) operational elements including coordination between dispatch, officers, mental health, and advocacy, a 40-hour officer training based on the Memphis model, dispatch training, and specialized mental health emergency care; and 3) sustaining elements including evaluation and research, in-service training, recognition and honors (Dupont, Cochran, and Pillsbury, 2007). All core elements, not simply the training element, are critical to the evidence-based model.
    - **Co-responder** programs in which behavioral health clinicians accompany law enforcement officers on calls for service to help triage behavioral health emergencies might fall into this category. A systematic review of co-responder models found that street triage might reduce police detentions and psychiatric hospitalization, but that there remains a lack of evidence to evaluate the behavioral health outcomes of recipients of service. It also found wide variation in the implementation of the co-response model, which makes conclusions about the effectiveness of specific models difficult to ascertain (Puntis et al, 2018). More research should be done to identify specific co-responder models that are effective, and to determine whether co-responder models are effective at improving behavioral health outcomes.
    - The **San Diego Psychiatric Emergency Response Team (PERT)** intervention (delivered by CIT trained officers paired with mental health professionals) averted hospitalization or incarceration for 51 percent of

over 6200 cases (San Diego County Grand Jury, 2016).

- **Mobile Crisis Teams and Crisis Centers with 24/7 drop off availability** are complementary programs. Mobile crisis teams consist of mental health professionals who help respond to crises by providing consultation by telephone or in person when a psychiatric emergency involving law enforcement arises. Mobile Crisis Programs are documented as leading to fewer involuntary psychiatric hospitalizations, lower arrest rates, lower costs per case, higher police and consumer satisfaction, and increased referral to community based care (Scott, 2000). CIT and Mobile Crisis Teams can depend on a site-based resource - Crisis and Triage Centers – as an alternative to court and jail. Crisis Centers are discussed in more detail in Section 3.

- *Self-referral* is a framework in which drug-involved individuals initiate engagement with law enforcement without fear of arrest, and an immediate treatment referral is made. No peer-reviewed, evidence-based examples of such programs were reviewed for this white paper.
- *Officer prevention referral* is a framework in which law enforcement initiates the treatment engagement, and no charges are filed. Peer-reviewed, evidence-based examples of such program include the following:
  - The **Law Enforcement Assisted Diversion (LEAD)** program developed in King County, WA, offers diversion of low level drug and prostitution offenders into intensive, community based social services. LEAD participants are more likely to have housing, employment, and legitimate income, all outcomes associated with lower recidivism (Clifasefi et al., 2016). A quasi-experimental study design found direct evidence of reductions in criminal justice and legal system utilization and associated costs (Collins, Lonczak, and Clifasefi, 2019). This model has been replicated in other sites nationally.
- Officer intervention referral is a framework in which law enforcement initiates the treatment engagement, and charges are held in abeyance or citations issued. No peer-reviewed, evidence-based examples of such programs were reviewed for this white paper.

Intercept 2: Initial Detention and Court Hearings

The third point of intercept is post-arrest at initial hearing and initial detention. This is a period when criminal charges are laid out, and decisions are made about release, bail, or detention during the trial. A research summary commissioned on behalf of the Bureau of Justice Assistance, US Department of Justice in 2010 analyzed the overall effectiveness of pretrial diversion programs (Camilletti, 2010). The Joplin Study (Joplin, 2016) summarized Camilletti's findings:

Overall, participants in pretrial diversion programs spend less time in prison, are

less likely to be in jail or a treatment center a year after their crime, and, because they have avoided a criminal conviction, are more successful at finding employment and housing. Pretrial programs also have been shown to (1) reduce criminal justice costs in most jurisdictions, (2) save time, by diverting people and reducing court dockets, and (3) reduce overcrowding in jails and prisons.

The opportunities for evidence-based screening and assessment of behavioral health needs at this intercept include:

- Police lock-up: some jurisdictions hold individuals until arraignment in a police holding cell. Screenings and/or assessments could be made at this initial lock-up point to determine service needs, especially in situations where an individual might be locked up for long enough to require continuation of medications, for example if police lock-up will extend over a long weekend until the courts open.
- Courts: some courts have introduced court clinics, in which clinicians can screen and assess individuals for behavioral health needs.
- Jail: jails should regularly screen and assess individuals upon entry for behavioral health needs.

The Misdemeanor Arraignment Diversion Project in New York City (Policy Research Associates, 2013) is an effective **Behavioral Health Specialty Court** program at this intercept, specifically focusing on identifying individuals at or prior to arraignment/initial hearings. The Project is an early intervention model that seeks to decrease the frequency of arrest and shorten jail sentences for individuals with mental illnesses. This program operates in general criminal courts, rather than specialized treatment courts. The defendant works with an interdisciplinary team that includes a licensed clinical social worker that is responsible for identification and assessment, treatment planning, court advocacy, and connecting to community providers. Additional Behavioral Health Specialty Court models that fall into Intercept 3 are identified below.

Intercept 3: Jails/Courts

This intercept point is post-arrest, when individuals are before the courts and/or detained in jails. This intercept spans the trial itself, including sentencing. The programs at this intercept include specialized treatment courts (drug courts and mental health courts) as well as screening and treatment in jails.

Opportunities for evidence-based screening and assessment at this intercept include behavioral health specialty courts.

Behavioral Health Specialty Court programs are special jurisdiction courts that limit punishment and instead focus on problem-solving strategies and linkage to community treatment. Behavioral Health Specialty Courts at this intercept represent an alternative to trial and sentencing, while keeping the option for sentencing available. The research on mental health courts is limited and varying. Most studies point to at least a small reduction in recidivism. Many, however, also point to only small or no changes in symptoms. This indicates that while people who are involved in mental health courts are

avoiding re-arrest, they still may not be getting the community mental health care that they need to address the symptoms of their illness. Behavioral Health Specialty Courts are typically voluntary, which helps to reduce (but not eliminate) the coercive nature of their connection to services. As discussed above, coercive methods of linking individuals to care can be re-traumatized.

- The **Seattle Municipal Mental Health Court** is a voluntary program that consists of a presiding judge, mental health professional, probation staff with mental health expertise, a prosecutor, and a public defender. All participants of this court have reportedly increased their use of mental health services, reduced contact with crisis services, decreased contact with police, and had an increase in their quality of life. (Dubois & Martin, 2013)
- **San Francisco Mental Health Court** study showed a re-arrest rate of 42% for people in mental health court compared to 57% in criminal court (McNeil & Binder, 2007).
- A meta-analysis showed that mental health courts reduced recidivism by an overall effect size of -0.54 and that they led to better clinical outcomes and reduced psychiatric emergency room costs (Sarteschi, Vaughn, & Kim, 2011).

Medication-Assisted Treatment (MAT) is an evidence-based program model for treating opioid addiction. Some jails are starting to adopt the use of MAT for detainees, either continuing treatment that had been ongoing in the community prior to arrest or inducing treatment within the facility. MAT is a proven model for addressing opioid addiction, and detention can disrupt treatment.

Intercept 4: Reentry

Programs at this level promote continuity of care between the criminal justice system and community-based systems upon which individuals rely when they leave jails or prisons.

Opportunities for evidence-based screening and assessment at this intercept are ongoing throughout the duration of detention and/or incarceration.

Peer-reviewed evidence available in this intercept includes:

- **Transitional Care Management (TCM)** is a service model that provides screening, community case management, and coordinates support for individuals with mental health conditions who have committed multiple misdemeanors, with preliminary research showing that this program reduced arrest rates by at least 32 percent.
- **SSI/SSDI Outreach, Access, and Recovery (SOAR)** program is a method of increasing take-up of services that provides technical assistance to help states and communities increase access to Supplemental Security Income/Social Security Disability Insurance for adults with disabilities who are homeless. Examples reported include: extending this program to jails in Miami-Dade County has helped to relieve overcrowding in the county jail and has provided immediate access to safe housing with the necessary treatment and wraparound services)

with early results showing recidivism decreasing from 70 to 22% (Dennis & Abreu, 2010); and the Massachusetts Forensic Transition Team Program that follows clients for three months after their release from correctional facilities and coordinates services to assist in community reintegration (Harwell & Orr, 1999).

- **Critical Time Intervention (CTI)** is a management/organizational model that provides time-limited evidence based practice that mobilizes support during periods of transition. It facilitates community integration and continuity of care. CTI has been applied to veterans, people with mental illness, people who have been homeless or in prison. Studies have shown CTI to be effective in helping adults with SMI make the transition out of homelessness, inpatient settings, and criminal justice system settings to community living. The Coalition for Evidence Based Policy (now a part of the Laura and John Arnold Foundation) developed a summary of the evidence for CTI based on a systematic search of the literature, and correspondence with leading researchers, to identify all well-conducted randomized controlled trials of CTI for individuals with mental illness being discharged from a shelter, hospital, or other institution. They rated CTI as a "top tier" intervention, noting more than a 60 percent reduction in likelihood of homelessness 18 months after participation began. Given the link between homelessness among persons with behavioral health conditions and criminal justice involvement, this outcome is of interest in efforts to lower incarceration and recidivism rates. http://toptierevidence.org/wp- content/uploads/2013/08/CTI-write-up-for-Top-Tier-site-September-2013.pdf
- **Peer Support Specialists** are trained individuals with personal lived experience of mental illness, substance abuse disorders, and/or involvement in the justice system. They work in a variety of programs and settings to improve take-up of services by improving the level of comfort in treatment settings. Peer support specialists are increasingly being introduced into forensic settings, and can make an impact at all the intercept points.
    - According to Chapman et al., 2015, there are a growing number of randomized controlled trials on the efficacy of mental health peer support programs in aiding recovery. Much of the literature suggests positive patient outcomes resulting from the inclusion of peer support, hence its inclusion as an "evidence-based practice" eligible for Medicaid reimbursement. However, a number of reviews of the literature conclude that the research on effectiveness has limitations, with methodological weaknesses including lack of randomization, minimal categorization of different roles of peer providers, poor comparability of comparison and control groups, and lack of consistency across studied sites. Problems with variability in intervention – in terms of type of program, target population, intensity (dose), and duration – continue to challenge the research, as does overall specification of goals and objectives. There is relatively little research published on the effectiveness of SUD peer support. There is also little, if any, research on the effectiveness of forensic peer providers and peer respite services.

However, there are examples of programs that demonstrate the positive impacts of peers who function as "bridgers" between hospital settings and the community, an analogous role played by "forensic" peer specialists who serve individuals leaving jails.

- As noted in Westat, 2015: The New York Association of Psychiatric Rehabilitation Services (**NYAPRS) Peer Bridger program** reduces the rate of re-hospitalization. The Optum Health's behavioral health sciences group reports that after including NYAPRS Peer Bridgers into their managed care program, there was a 47.9 percent decrease in the use of inpatient services; the average number of inpatient days decreased by 62.5 percent, from 11.2 days to 4.2 days; and outpatient visits increased by 28 percent. The overall behavioral health cost decreased by 47.1 percent.
- The **King County Peer Bridger Program** analysis showed that participants significantly reduced hospital episodes and days, reducing hospital days an average of 23.4 days per participant and hospital length-of-stay by an average of 18 days per participant. Reductions were greater for participants in the Peer Bridger program than a comparison group. Participants increased their enrollment in outpatient mental health services from 29% to 70%, and their enrollment in Medicaid from 42% to 81%. (Srebnik, 2016, *King County Peer Bridger Final Report* for the Washington State Attorney General's Office, Division of Consumer Protection, unpublished).

- As described above, MAT is a proven program model for addressing opioid addiction. Similar to jail settings, continuance of or induction to MAT in prison can limit disruptions in successful treatment due to criminal justice involvement.

Intercept 5: Post Incarceration/Community Corrections/Community Support

This intercept point includes community corrections and community support services, including a wide range of evidence based treatment models. Opportunities for evidence-based screening and assessment at this intercept include probation and parole intake, to the extent that screening has not happened during incarceration.

Peer-reviewed evidence available at this intercept includes:

- **Specialty Probation Caseloads** are an organizational model in which probation (itself a method of increasing take-up of services) agencies work with people with mental health conditions to address service needs and avoid re-arrest with more psychiatric services and more probation services. The effectiveness of the risk-needs responsivity framework for general probation is supported by a large body of evidence that the framework reduces recidivism (Andrews, 1989). Specialty probation caseloads for mental health combine risk-need responsivity to address criminal behavior with mental health treatment (Manchak, Loth, Skeem, 2019). One study of a New Jersey program found evidence of effectiveness at reducing recidivism rates, but did not make any findings on effectiveness of mental health

treatment (Wolff, Epperson, Shi, Hueng, 2014). In another study, participants were 1.94 times less likely to be rearrested (Skeem et al., 2009).

Specialty probation caseloads are an example of a program that suffers from conflicting goals. On the one hand, they are found to reduce recidivism. On the other hand, probation models can be coercive, which can be challenging to individuals who have experienced trauma. Coercive methods of increasing the uptake of mental health services are not trauma-informed.

- **Forensic Assertive Community Treatment (FACT)** is a service model that is an extension of the ACT model that combines treatment, rehabilitation, and support services in conjunction with probation services to prevent future arrests and incarceration. According to a recent fact sheet, "Current research on FACT consists of a handful of single-site studies with mixed results. The studies have relatively small sample sizes, variable team characteristics, and lack uniform outcome measures. Although there are some moderately strong findings supporting the effectiveness of FACT, more high quality, multi-site, randomized controlled studies are needed to consolidate findings and to demonstrate their reproducibility across diverse communities and geographical areas" (Morrissey, 2013). That said, ACT has a substantial evidence base (Phillips et al, 2001) supporting its effectiveness at reducing psychiatric hospitalization, improving housing stability, and reducing substance use while proving a better consumer experience than and similar clinical outcomes to traditional treatments or case management. Fidelity to the evidence-based ACT model is important, and there are self-assessment tools for organizations implementing ACT to assess their model's fidelity.
- **Community Based Competency Restoration** is an organizational or management model offering restoration services in settings other than state hospitals. An excerpt from the Joplin Study offered two examples of effective programs:
    - **Miami Dade Forensic Alternative Center** opened in 2009 with a goal of providing safe, effective, and cost-efficient alternative placement options for defendants ruled incompetent to stand trial and who are charged with non-violent second- and third-degree felonies. Individuals at the center are less likely than those returned to jail to decompensate and be declared incompetent to proceed. Competency is restored more quickly in the program than at state hospital facilities (103 days versus 146 days) and the program costs less per bed day ($229, versus $333 at state hospital facilities) (The Florida Senate Interim Report 2012- 108).
    - **Multnomah County Mental Health and Addiction Services Division Forensic Diversion Program** participants are evaluated on a case-by-case basis to assess criminogenic risk and behavioral health needs. Participants must be currently involved or at risk of being involved in the criminal justice system; have an acute, chronic mental health illness; reside in Multnomah County; and voluntarily agree to participate. Program services include behavioral health screening and assessment,

development of individualized restoration/diversion plans, services to address basic needs (e.g., housing, food, and clothing), treatment to address behavioral health needs and barriers to recovery, legal skills education, referral and linkage to community-based care, systems navigation and forensic case coordination to ensure that participants attend treatment appointments and court hearings, follow through on court orders, etc. In fiscal year 2016 the program served 405 unduplicated clients, saved 5,513 state hospital days for a cost savings of $4,961,700, and saved 6,577 jail bed days for a savings of $1,313,756 (Multnomah County program presentation, August 4, 2016).

- **Supported Housing** is a service model that combines permanent affordable housing with individualized supportive services. The Joplin Study cites strong evidence that supportive housing reduces use of jails, emergency services and shelters. A recent white paper prepared for SAMHSA (Steadman, H.J., et al. 2016) noted that:

  > The potential benefits of housing for justice-involved people with mental and substance use disorders, such as reentry housing models, were first documented in a 2002 study of supportive housing in New York. That study showed a decrease of 22 percent in criminal convictions and 73 percent in days of incarceration for people placed into supportive housing compared with an increase for a comparison group (Culhane, Metraux, & Hadley, 2002).
  >
  > In New York City, the **Frequent Users Systems Engagement (FUSE)** was one of the nation's first demonstration initiatives that targeted people caught in a cycle of jail and homelessness through a data match to identify people with multiple stays in each system. A 2014 evaluation of the FUSE initiative showed that the program was successful in maintaining housing stability for 86 percent of tenants and reducing shelter costs by 94 percent and jail use by 59 percent (Aidala, McAllister, Yomogida, & Shubert, 2014). Furthermore, the FUSE initiative generated an annual crisis care service cost offset of $15,680, exceeding the $14,624 in public investment in services, resulting in a savings of over $1,000 per person (Aidala et al., 2014).

- **Supported Employment** is an evidence based service model for securing employment for people who have a mental illness. A recent fact sheet prepared for the GAINS Center (Bond, 2013) cited the positive evidence for the Individual Placement and Support (IPS) model of supported employment, and by extension, the use of IPS to support justice involved people. It was recommended that the core IPS model be utilized and adapted for this group; that specialty ISP teams be dedicated solely to this group; that integrated dual disorders treatment be offered; and that individuals be assisted with when and how to disclose their legal history to potential employers.

- **Wellness Plans** are organizational/management tools that promote recovery and community tenure, helping individuals stay out of hospitals, jails, and other more

restrictive settings.

  - **Copeland's Wellness Recovery Action Plans (WRAP)** a peer-led, self-determined and self-managed tool, which offers individuals a framework for defining and maintaining whole health. It is included as an evidence based approach in the National Registry of Evidence based Practices (NREPP) https://nrepp- learning.samhsa.gov/. WRAP participants experience greater reduction in symptom severity, greater improvement in hopefulness, and enhanced improvement in quality of life (Cook et al., 2012).
  - **Illness Management and Recovery (IMR)** is an evidence based practice that was developed at Dartmouth Psychiatric Research Center. IMR helps people set meaningful goals for themselves, acquire information and skills to develop more mastery over their psychiatric illness and make progress towards their own personal recovery. A recent fact sheet (Mueser, 2013) reviewed the literature on IMR and proposed potential adaptations for the justice involved population.

- **Behavioral Health Evidence Based Practices (e.g., Motivational Interviewing, Moral Reconation Therapy, Dialectical Behavioral Therapy, Cognitive Behavioral Therapies, Integrated Dual Disorder Treatment, Medication Assisted Treatment, etc.)** In any jail diversion services continuum the availability of evidence based treatments is essential. For each there is a full body of research that supports their efficacy (it is beyond the scope of this paper to summarize the research literature). These practices are widely but not universally available in the Washington public behavioral health system. However, EBPs are costly to deliver and are dependent upon trained staff, expert supervision, and ongoing fidelity monitoring, making them challenging to sustain.

III. Promising Models and Areas for Future Research

This section describes additional management and organizational practices, service models, and methods for achieving service take-up that lack a rigorous evidence base of peer-reviewed scientific literature. These models and programs are nevertheless innovative and are supported by less rigorous evidence like cost-benefit analysis or self-assessment. These models and programs therefore merit further study of their effectiveness. In some cases, we describe core elements and differences between specific models of emerging services and practices to illustrate where additional research can help to advance our understanding of what works in diversion.

Intercept 0: Preventing Involvement in the Criminal Justice System

Promising models at this intercept include:

- **Crisis Stabilization Centers** are a program that provides urgent psychiatric care for short periods of time (typically less than 24 hours). They are often available

for walk-in clients or those dropped off by law enforcement.

- **Mental Health Integrative Support Team (MHIST)** is an enhanced CIT program designed to prevent crises via early identification and services engagement. The program targets two groups of individuals at risk: persons in the civil commitment population with high emergency services use rates, and persons with low level "nuisance" offenses pending. The program is designed to prevent escalation of conditions to a crisis that then demands emergency room use, hospitalization and/or arrest and incarceration. (Balfour et al, 2017)
- **Restoration Centers** are similar, but more expansive. They include crisis stabilization services, and may add assorted wrap-around services like respite (longer-term transitional stays in crisis care), sobering units, behavioral health outpatient care, and connections to other social services like housing.

  The Bexar County Jail Diversion Program, which includes a restoration center, was developed in 2002 and ultimately created a full spectrum of jail diversion services. The reader is referred to the *Blueprint for Success: The Bexar County Model* by Leon Evans of The Center for Health Care Services (Appendix B). The Blueprint describes in great detail the development and implementation of this model program. http://www.naco.org/sites/default/files/documents/Jail%20Diversion%20Toolkit.pdf

  The most widely reported program, the Restoration Center is open 24 hours and has behavioral health professionals on staff. Research indicates that individuals brought to the Center are treated within an hour of arrival, and preliminary results have shown that Bexar County has saved $2.4 million in jail costs tied to public intoxication, $1.5 million in jail costs for mental health, and $1 million in emergency room costs (Evans, 2007). A similar program in Minneapolis saved $2.16 for every dollar spent on its triage center and one in Salt Lake City led to a 90% decrease in emergency room use by patients with psychiatric conditions. Program outcomes noted in a National Association of Counties 2015 monograph "Case Study: Bexar County, Texas":

  - More than 95 percent of Bexar County and San Antonio law enforcement officers have been trained in crisis intervention training – over 5,000 officers.
  - The Crisis Care Center and the Restoration Center see about 2,200 people per month or 26,000 people per year who used to go to jails or emergency rooms or return to the streets.
  - Prior to the Crisis Care Center and the Restoration Center, law enforcement officers spent an average of 12 to 14 hours in emergency rooms waiting on psychiatric evaluations. Officers now wait about 15 minutes.
  - The county saves more than $10 million per year on averted jail costs and emergency room costs. It costs $2,295 per jail booking. It costs $350 per

diversion.

- **The Living Room** is a service model that provides a low-threshold setting for individuals in mental health or substance use crisis to de-escalate and connect with services. An Illinois study found that 93% of cases using the Living Room were diverted from emergency department utilization and had lower self-reported levels of distress (Heyland, Emery, Shattell).

Intercept 1: Law Enforcement/Emergency Services

Promising models at this intercept include:

- **Naloxone Plus.** Opiate response teams, composed of clinicians and law enforcement, are programs that follow up with individuals after an overdose event to engage them in substance use treatment. No evaluations of such a program were reviewed for this white paper.

  In 2018, Massachusetts began requiring hospital emergency departments to induce patients who agree to MAT after an overdose, and to connect those patients with ongoing MAT in the community. No evaluations of such a program were reviewed for this white paper.
- **Active Outreach.** The Arlington Model program from Arlington, Massachusetts Police Department involves a public health clinician conducting direct outreach to known addicts and their families to offer support and connection to service. No evaluations of such a program were reviewed for this white paper.
- **Self-Referral.** The Gloucester Angels program from the Gloucester, Massachusetts Police Department allows individuals with substance use conditions to obtain connection and transportation to a treatment provider from the police department with a guarantee that the individual will not be arrested. If the individual is in possession of illicit substances or paraphernalia, law enforcement disposes of such items without arrest. While no outcomes evaluations of such a program were reviewed for this white paper, a qualitative study of the implementation of the model and participant experiences with the model was conducted, finding that participants had positive experiences with the program; that 75% of participants found a referral placement; and that 37% of participants reported substance abstinence six months after referral (though there was no difference in this rate between those who entered referral placement and those who did not). The study concluded that the program was feasible to implement and acceptable to participants, and while it was effective in finding initial access to treatment through short-term detoxification services, it was not able to overcome a fragmented treatment system focused on acute episodic care which remains a barrier to long-term recovery. (Schiff et al, 2017)
- **Officer Prevention Referral.** No promising interventions were reviewed in this framework.
- **Officer Intervention Referral The Stop, Triage, Engage, Educate and**

Rehabilitate (STEER) program in Montgomery County, Maryland uses evidence-informed officer decision making to triage calls for service. Officers use both a criminogenic risk proxy tool and treatment need profile to identify individuals at high need of substance use treatment and low criminogenic risk to make a warm handoff to a community-based case manager. Diversion may be a "prevention" contact (when no criminal charges are present) or an "intervention" contact (where charges are held in abeyance pending voluntary treatment referral). An evaluation of the STEER program is currently underway.

Several counties in Florida have experimented with a civil citation, and recently expanded these statewide. Civil citations can be categorized as a method for increasing the take-up rate of treatment services. Individuals who commit minor offenses like drug possession may be cited rather than arrested at the discretion of the officer. Participants will then be screened for behavioral health treatment needs and referred to services, and may be required to pay a fine or submit to drug testing. No evaluations of the program were reviewed for this white paper. Note that these types of programs may suffer from the problem described above of coercive methods for increasing the take-up rate of behavioral health treatment services, and therefore may re-traumatize clients.

In jurisdictions with Restoration Centers, officers or other first responders may utilize a center (described above) as an alternative to arrest or psychiatric hospitalization.

- **Mental Health First Aid** is a training program on risk factors and warning signs for mental health and addiction, as well as strategies to help individuals in crisis and non-crisis situations. Such trainings are often directed at general members of the public, but may also be used for law enforcement officers. No evaluations of the use of this tool with law enforcement officers were reviewed, but a meta-analysis of its use with members of the general public found that it changed attitudes and knowledge, improved helping behaviors, and benefited the mental health of the participants. However, no studies have evaluated effects on those who are recipients of the first aid (Hadlaczky, 2014).
- The **Police Mental Health Collaboration**, a program of the US Bureau of Justice Assistance, makes recommendations for the training of 911 call takers and dispatchers on behavioral health signs, symptoms, and treatment. This could allow dispatch itself to make more informed dispatch decisions, effectively intervening and referring individuals to appropriate levels of care No evaluations of such a program were reviewed for this white paper.

Intercept 2: Initial Detention and Court Hearings

In Washington State, the parties in the *Trueblood* matter (which addresses the needs of individuals charged with misdemeanors and felonies for whom there is a question of competence to stand trial) have made investments during the last two years at Intercept 2. The US District Court funded several Pretrial Diversion programs in large counties across the state that screen all jail detainees for behavioral health conditions and history

with the competency services system. When individuals are identified post arrest and either pre or post arraignment, a designated behavioral health services provider offers the court, prosecutor and defense attorney a plan to provide diversion services in the form of treatment, housing and recovery supports. Similarly, the State Department of Social and Health Services (DSHS) contracts in several counties for Prosecutorial Diversion Services, identifying individuals post arrest and arraignment, with behavioral health conditions and competency issues, offering a plan of community services engagement as an alternative to incarceration. Outcomes data from these interventions are pending; interim findings include that most individuals enrolled have stayed out of jail and out of homelessness during the period of program enrollment and have been reenrolled in treatment and pubic benefits.

Intercept 3: Jails/Courts

Promising models at this Intercept include:

- In 2018, **California** passed *AB 1810* legislation allowing criminal offenders to be released to the community during trial for the purposes of mental health treatment, rather than being held in jail. The **Office of Diversion and Reentry** manages the release and service protocols. No evaluations of such a program were reviewed for this white paper.
- **Massachusetts** introduced **Pre-trial Probation** in 2018 to allow defendants to be supervised by the probation department while living in the community during their trial, rather than being supervised in jail. While no evidence specific to outcomes of Pre-Trial Probation were reviewed for this white paper, the risk-needs responsivity model for traditional probation services is generally regarded as an evidence-based practice for addressing the criminogenic needs of individuals in the criminal justice system. It is currently unclear what impact Pre-Trial Probation might have on reductions in criminal justice involvement or on improvements in behavioral health.

Intercept 4: Reentry

Promising models at this Intercept include:

- Many individuals who are incarcerated will be eligible for Medicaid upon release from a correctional setting. Coordinated efforts of the jail and prison system to enroll then in this health insurance program upon release is a method of increasing the take-up rate of Medicaid, which can fund mental health and substance use treatment for enrollees. No evaluations of programs to do so were reviewed for this white paper.

Intercept 5: Post Incarceration/Community Corrections/Community Support

Promising models at this Intercept include:

- The **Worcester Initiative for Supported Reentry (WISR)** program provides care

navigation to individuals reentering the community from prison who have behavioral health needs, connecting individuals to services to address their behavioral health, criminogenic, and social service needs to reduce recidivism rates. In a 2017 outcomes report from Brandeis University following 152 men, outcomes include recidivism reduction and treatment access improvements. Only 9% of WISR participants were reincarcerated one year after release, whereas 20% or the comparison group were reincarcerated. At three years post-release, only 21% of WISR participants were reincarcerated, as compared to 40% of the control group. The comparative cost of WISR at $6,327 per person to incarceration at $53,041 per person per year is favorable. In the months ahead, the results of a small randomized control trial of the program that is currently underway will be available for review.

- **Treatment Alternatives for Safe Communities (TASC)** opened a Supportive Release Center outside of the Cook County Jail in Chicago, which provides a safe environment for releases from the jail to seek food, shelter, sleep, shower, and social service needs evaluations when released at after hours. The program is being replicated in Bernalillo County, New Mexico (called the Resource Reentry Center). No evaluations of the program were reviewed for this white paper.

IV. Overarching Policy Guidelines

There are a number of comprehensive guidelines that can assist Washington State with developing model jail diversion and reentry programs across all intercept points. A brief synopsis of the documents most often referenced in the literature is offered:

- A *National Survey of Criminal Justice Diversion Programs and Initiatives was conducted by The Center for Health and Justice at TASC* (2013) The summary report noted that "with many diversion programs in existence across the country, there are no apparent overarching standards for collecting or publishing data for purpose of evaluating different types of programs against common sets of performance measures such as cost savings or reduced recidivism." "The report intends to provide state and local policymakers, justice practitioners, community service providers, advocates, and other stakeholders with an understanding of what many jurisdictions are doing in terms of diversion-based alternatives, what constitutes effective and efficient programming, and what policies, practices, and innovations may be applicable in their own contexts to promote positive public safety and health outcomes and generate cost savings." http://www2.centerforhealthandjustice.org/sites/www2.centerforhealthandjustice.org/files/publications/CHJ%20Diversion%20Report_web.pdf.

- *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements*. New York: Council of State Governments Justice Center. Fader-Towe, H., and Osher, F.C., (2015) summarizes current pre-trial approaches and defines the essential elements needed for an effective pre-trial diversion service continuum. http://csgjusticecenter.org/jc/publications/

- Alex Blanford and Fred Osher authored "*Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*," on behalf of the GAINS Center and The Council of State Governments Justice Center (Blanford and Osher, 2013). The Guidelines offer specific steps to create a collaborative and effective program for addressing the needs of persons transitioning from incarceration, based on the nationally recognized APIC model. https://csgjusticecenter.org/wp-content/uploads/2013/12/Guidelines-for- Successful-Transition.pdf. Of note, these guidelines were referenced in the Washington State Medicaid Transformation Toolkit for Project 2C Transitional Care, Evidence-informed Approaches to Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration (2016). https://www.hca.wa.gov/sites/default/files/program/medicaid- transformation-toolkit.pdf

- The Council of State Governments Justice Center created the Criminogenic Risk and Behavioral Health Needs Framework. "The framework weaves together the science on risk and needs to provide an approach to achieve better outcomes for adults in contact with the criminal justice system with substance use disorders, mental illness, or both."(Osher, et al., *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery (2012)).* The Framework is designed to help systems prioritize and allocate resources based on the Risk-Needs-Responsivity (RNR) principles used by criminal justice professionals to identify and target interventions to reduce recidivism. http://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12_Behavioral- Health-Framework-final.pdf
- For cross system use, *A Five-Level Risk and Needs System: Maximizing Assessment Results in Corrections through the Development of a Common Language* (New York: Council of State Governments Justice Center and National Reentry Resource Center, 2017) provides a more comprehensive guide "for researchers, practitioners, and policymakers who share the goal of reducing recidivism by improving the application of risk and needs assessments. This white paper presents a model for supporting the implementation of RNR principles through a standardized five-level risk and needs assessment system. The five levels are designed to inform case planning, guide how justice professionals classify risk and needs, and help identify people who can benefit most from intervention." https://csgjusticecenter.org/wp-content/uploads/2017/01/A-Five-Level-Risk-and-Needs- System_Report.pdf

- The Council of State Governments Justice Center, in concert with the American Psychiatric Association Foundation and the Judges' and Psychiatrists' Leadership Initiative developed "*A Primer for Psychiatrists, Supporting People with Serious Mental Illnesses and Reducing Their Risk of Contact with the Criminal Justice System*." (Council of State Governments Justice Center, 2017). It offers psychiatrists an overview of the RNR principles for this population. https://csgjusticecenter.org/courts/publications/supporting-people-with-serious- mental-illnesses-and-reducing-their-risk-of-contact-with-the-criminal-justice-system/

- *Practical Considerations Related to Release and Sentencing for Defendants Who Have Behavioral Health Needs: A Judicial Guide* (Council of State Governments Justice Center and American Psychiatric Association Foundation, 2017) provides judges with practical information and strategies to help them recognize signs that a person may have a mental illness and/or substance use disorder; understand the process for screening and assessing people for these conditions; become familiar with the different types of treatment that best address particular behavioral health needs; collaborate with behavioral health care providers to identify the treatment resources that are available in their communities; and make release and sentencing decisions and referrals to treatment that can improve public health and safety outcomes." https://csgjusticecenter.org/wp-content/uploads/2017/11/11.15.17_Practical-Considerations-Related-to-Release-and-Sentencing-for-Defendants-Who-Have-Behavioral-Health-Needs.pdf