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 Massachusetts’ state and local jurisdictions in the continued development of a full continuum of effective and evidence based jail diversion services for persons with mental illness and/or substance use conditions. A number of proven and/or promising practices are highlighted, some of which are already utilized in the Commonwealth of Massachusetts. 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). One community’s comprehensive, multifaceted jail diversion program will be highlighted in Section III (Bexar County, Texas).

This summary incorporates the literature review contained in the prior published MAMH White Paper and in Trueblood Diversion Services documents and incorporates findings from reports of the Council of State Governments (CSG) Justice Center and the Substance Abuse and Mental Health Administration (SAMHSA) GAINS Center. The summary relies heavily on the November 2016 Joplin Consulting study conducted for the State of Washington’s Office of Financial Management (OFM), “Jail Diversion for People with Mental Illness in Washington State” (See Appendix A.). The Joplin study included a literature review of nationally recognized jail diversion programs for persons with mental illness and formulated a number of well-considered recommendations for system improvements. This current paper also provides additional information from the literature.

II. Summary of the Peer Reviewed Literature

The Sequential Intercept Model (SIM) was created as a tool to conceptualize solutions to address the overrepresentation of people with mental illness in the justice system (Munetz & Griffin, 2006). This model consists of six points of interception at which one might intervene to prevent vulnerable individuals from getting deeper into the justice system. 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.
Intercept Zero: Community Services

Intercept Zero was only recently added to the SIM, as investments in prevention and early intervention services are proving to be 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. In addition to services intersecting with law enforcement (discussed below in Intercept One), Intercept Zero includes community interventions for people with mental health conditions and co-occurring conditions at risk for system involvement.

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:

> From a long-term perspective, behavioral health systems need to detect mental health and substance use conditions 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.

The Access to Psychiatry through Intermediate Care (APIC) Program at the University of Buffalo Jacob’s School of Medicine and Biomedical Sciences is providing mobile psychiatric care and case management to individuals with developmental or intellectual disabilities who are at risk for arrest, hospitalization, or other unnecessary system penetration. This program addresses an important population of individuals with co-occurring conditions. [https://apicout.org/](https://apicout.org/)

Other programs at Intercept Zero include individualized crisis plans and safety plans. The Massachusetts Behavioral Health Partnership has developed a model safety plan to use when a crisis situation arises to prevent people from getting hurt. They can be distributed to providers and local law enforcement in advance to communicate potential crisis support or intervention. [https://www.masspartnership.com/provider/CrisisPlanning.aspx](https://www.masspartnership.com/provider/CrisisPlanning.aspx)

Intercept 1: Law Enforcement/Emergency Services

The first 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.

- **Crisis Intervention Teams (CIT)** are evidence-based programs. 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).
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).

- The Lead Enforcement Assisted Diversion (LEAD) program 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). This program has been replicated in other sites nationally, and is referenced as a model program in the Washington State Medicaid Transformation Toolkit for Project 2D Diversion Interventions, Evidence-supported Strategies (2016). https://www.hca.wa.gov/sites/default/files/program/medicaid-transformation-toolkit.pdf

- Mobile Crisis Teams and Crisis Centers with 24/7 drop off availability are complementary interventions that consist of some combination of police officers and 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. In Bexar County, TX, the most widely reported program, the Crisis Care 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.

Intercept 2: Initial Detention and Court Hearings

The second point of intercept is post-arrest at initial hearing and initial detention. 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.

Pre-trial diversion programs

- Mental Health Courts: There are a few examples of effective programs, including the Seattle Municipal Mental Health Court (Dubois & Martin, 2013) and the Misdemeanor Arraignment Diversion Project in New York City (Policy Research Associates, 2013). 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. The Misdemeanor Arraignment Diversion 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.

- **Evidence based screening, risk assessments, and behavioral health assessments:** 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). According to the Joplin Study there is considerable opportunity for improvement in use of this evidence based assessment approach in Washington State:

Of the jails we surveyed, fewer than 10 percent use a formal screening tool to identify incoming inmates for mental illness, and only 20 percent use a formal pretrial risk assessment tool to assess inmates’ risk of (1) failing to appear for court hearings or (2) committing a new crime if they are released before trial. Reliable, evidence-based mental health screening and pretrial risk assessment tools are available and relatively inexpensive to implement. Together, they provide ways to accurately identify people with mental illness who can safely and appropriately be diverted to community-based treatment or other services as they await trial. Without the use of such tools, jails almost certainly are missing opportunities to divert and/or treat people with mental illness, either because the individuals have not been identified as having a mental illness or because their charge keeps them from being released, regardless of their actual risk to the community (which typically is low).

**Intercept 3: Jails/Courts**

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

- **Mental Health Courts** are special jurisdiction courts that limit punishment and instead focus on problem-solving strategies and linkage to community treatment. 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.

- 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).
- Meta-analysis showed that MHCs reduced recidivism by an overall effect size of -0.54 and that MHCs led to better clinical outcomes and reduced psychiatric emergency room costs (Sarteschi, Vaughn, & Kim, 2011).

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. Examples of several program models are noted in the literature, including:

- **Transitional Care Management (TCM)** that provides screening, community case management, and coordinates support for individuals with mental disorders 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 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 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](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, increasingly in 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).

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. Model programs at this level include:

- Specialty Probation Caseloads in which probation agencies work with people with mental disorders to address service needs and avoid re-arrest, with more psychiatric services and more probation services, they were 1.94 times less likely to be rearrested (Skeem et al., 2009).
• **Forensic Assertive Community Treatment (FACT)** 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).

• **Community Based Competency Restoration** programs offer restoration services in settings other than state hospitals. An excerpt from the Joplin Study offered two examples of effective programs:

  o **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).

  o **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** 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 practice 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 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/](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. Bexar County, Texas: A Model Jail Diversion Program
The Joplin Study recommended that “a statewide and regional intercept mapping process with healthcare, behavioral health, law enforcement, and criminal justice stakeholders be conducted to clearly identify needs and system gaps at each intercept point and to develop a comprehensive plan to address those gaps at the state and regional levels.” The Trueblood Parties Joint Submission to develop a settlement agreement calls for a similar process. Going forward it may be useful to call upon the learnings of Bexar County, Texas.

The Bexar County Jail Diversion Program 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

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.

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.


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


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.”