Bureau of Justice Assistance (BJA)
Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP)

Jail Diversion Models: Part II
Implementation Challenges and Best Practices

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Introduction

The first article in this two-part series provided an overview of programs that divert adults with serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders (CODs) from the criminal justice system and into appropriate community services. We grouped these programs by the point at which diversion is initiated—namely, pre-arrest, pre-charges, and pre-sentencing—and highlighted examples and resources for each. In this companion article, we focus on core aspects underlying implementation of most jail diversion programs, regardless of exit point, and accordingly illustrate common challenges and best practices that can guide Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) grantees in the specific tailoring of their own jail diversion programs.

Many different jail diversion models are being implemented across the United States. No two programs look the same, as specific elements of implementation (e.g., eligibility criteria, available community treatment, and supports) differ in and across jurisdictions.[1–3] This variability in program models can be a barrier to early adoption and implementation as there is no one playbook available to provide unified guidance. However, there are key tenets of jail diversion programs that can inform your own implementation regardless of category (e.g., pre-arrest) or model (e.g., co-responder). In what follows, we highlight three core aspects of jail diversion programs: collaboration, identification, and diversion.

Collaboration

Given that jail diversion programs exist at the intersection of the criminal justice and behavioral health systems, collaboration across agencies and partners is necessary for successful implementation. To that end, jail diversion programs involve multiple community-based partners spanning the justice system and recovery services. To illustrate, the Center for Health and Justice at Treatment Alternatives for Safe Communities (TASC) and the National Opinion Research Center (NORC) conducted a survey with 300 first responder agencies.[4] Of all participating programs, 95 percent reported having at least two partners, such as an SUD facility or case management

services. Almost half reported three or more partners, and more than a quarter reported four to six.

Whether a program is classified as pre-arrest, pre-charges, or pre-sentencing, cooperation among principal agencies is a key and active ingredient in the jail diversion process. However, though interagency collaboration can drive a successful program, it can also create challenges in communication and coordinated training. Fewer than half of all first responder agencies surveyed by TASC and NORC reported formal agreements with clear expectations of shared and distinct responsibilities, and only one-third have a full training curriculum. Even fewer offer training in skills specific to deflection implementation, such as motivational interviewing, implicit bias, trauma-informed care, and the neuroscience of addiction. Moreover, law enforcement agencies and behavioral health organizations often have differing incentives, resources, and attitudes related to jail diversion, resulting in gaps that need to be bridged through shared goals and—if needed—compromise.[2]

A profile of effective jail diversion programs identified key factors thought to be critical to programmatic success, including strategies to strengthen cooperation among agencies.[1] Of note, effective programs identified **regular meetings among agency representatives** as very important, as meetings kept communication channels open about funding, staffing, and individual treatment plans. In addition, integration of services can be facilitated by having a **dedicated boundary spanner**, or a liaison, who directly manages interactions among agencies. A recent case study underscored these methods and additionally highlighted the importance of identifying common ground across agencies: for example, law enforcement agencies might stress the **community policing philosophy**, which underscores the practice of working closely with communities for the betterment of public safety.[2] Furthermore, **collaboration on training offered to law enforcement agencies and behavioral health providers** is a way to establish common understanding, lend credibility to the training, and spark connection among both facilitators and attendees.[5]

Identification

Diversion models are intended to serve a specific group of people, namely adults who present with or are suspected of having SUD, SMI, or COD. Early identification is crucial to maximizing the potential for intervention. However, it can sometimes be difficult to ascertain whether an individual might benefit from a treatment program—and if so, which one. **Screening tools** are helpful in identifying individuals with SUDs and SMIs. For example, mental health issues may be masked by drug or alcohol intoxication. A screener that inquires about both SUDs and SMIs should indicate what type of program is most suitable for that individual. Screening should take place in the first 24 to 48 hours of detention, if not before.

Screeners can also help **assess eligibility** for a specific program. Many programs have additional requirements that identify and limit the type of individuals who can participate. For example, many programs limit participation to adults who have no pending criminal charges or have no history of violent crime. Many programs also prioritize abstinence or full commitment to recovery and thus require individuals to hand over all illicit substances and paraphernalia and to maintain sobriety throughout their treatment.[6] Other programs also have **legal eligibility requirements**, such as release forms that protect participating agencies from liability or preclude the participating individuals from litigation or agreements that make the individual responsible for any costs associated with hospitalization and treatment. Unfortunately, restrictions like these limit access to diversion programs for many individuals who may benefit.

In contrast, some models have fewer requirements both for eligibility and sustained participation. For example, the Policy Alternatives & Diversion Initiative in Atlanta, Georgia, began as a program using the Law Enforcement Assisted Diversion model but has since expanded to provide emergency services, community listening sessions, and case management. There are no requirements for participation. These programs tend to emphasize meeting individuals where they are rather than achieving full recovery. It is therefore important to **consider your approach to SUDs and SMIs and your intended target population** when deciding which model to adopt.

Diversion

Diversion or deflection is the defining element common to all diversion models, regardless of type. Diversion is the bridge to appropriate community-based services rather than subsequent involvement in the criminal justice system. A recent study shows that all but two people in 1.5 years who were assessed for participation in a diversion program in Chicago, Illinois, were eligible.[7] However, a common challenge in developing or expanding diversion programs in other areas, especially rural jurisdictions, is lack of treatment programs to which responders can refer eligible individuals or a lack of capacity for existing programs. One way to address this challenge is to dedicate resources toward an environmental scan of service providers in your area. The survey conducted by TASC and NORC found that fewer than one-third of first responder programs partner with social services to connect adults to employment, education, or food support.[4] **Community resource mapping** is an excellent way of identifying assets in the community to serve different needs. Sometimes an organization has already created a map that can be used or adapted for the purposes of SUD and SMI treatment. If no map is available, the process of resource mapping is a good way to begin building relationships with organizations that could join the diversion program as partners.

It can also be difficult to identify which program would be the best fit for individuals' needs. The benefits of **screeners and needs assessments** were discussed in the previous section, but it is also necessary that staff members be able to conduct assessments. Moreover, assessment tools are not the only option. Some programs use a more personal approach, opting instead to use **guided conversations** to understand underlying issues and needs.[8]

Even when identification and diversion elements are in place, individuals may refuse treatment. This can be discouraging to responders and can contribute to stigma, especially in the early days of a program. Many jurisdictions have found creative ways to respond when an eligible person chooses not to participate in a diversion program. **Some teams prepare packages with information about treatment programs, contact information, and harm reduction tools**. Other jurisdictions have **dedicated teams to follow up** with individuals who have been identified as eligible for a program.

Conclusion

Regardless of the diversion model chosen for your jurisdiction, it is important to consider how law enforcement can collaborate with other agencies and organizations, how to identify individuals who may be eligible for and benefit from a treatment program, and how to connect people with the program that best fits their needs. Addressing these elements at the outset is ideal; however, many pieces may need to be improved or come together after the program is underway. Dedicated staff, appropriate training, and continued monitoring of implementation are keys to a program's success.

For more information and example documentation, visit COSSAP's First Responder Deflection Resource Library. To request technical assistance with your program, visit the Training and Technical Assistance Request page to be connected with learning opportunities and support.

Endnotes

1. *Steadman, H. J., Morris, S. M., & Dennis, D. L., 1995, "The Diversion of Mentally Ill Persons From Jails to Community-Based Services: A Profile of Programs," American Journal of Public Health 85(12): 1630–1635, retrieved from https://doi.org/10.2105/ajph.85.12.1630.*

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4. *Center for Health & Justice (CHJ) at Treatment Alternatives for Safe Communities (TASC), n.d., Report of the National Survey to Assess First Responder Deflection Programs in Response to the Opioid Crisis, CHJ at TASC, retrieved December 6, 2021 from https://www.cossapresources.org/Content/Documents/BriefingSheets/CHJ-TASC_First_Responder_Deflection_Infographic.pdf.*

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6. *Lake County Health Department, n.d., A Way Out Program Memorandum of Understanding, Lake County Health Department, retrieved December 6, 2021 from https://www.cossapresources.org/Content/Documents/Diversion_Library/A_Way_Out_MOU_Redacted_508.pdf.*

7. *Arora, Ashna, & Panka Bencsik, 2021, Policing Substance Use: Chicago's Treatment Program for Narcotics Arrests, University of Chicago, retrieved from https://www.sjsu.edu/economics/docs/events-ppe/Bencsik_PolicingSubstanceUse10152021.pdf.*

8. *Engelhardt, Will, Storm Ervin, Daniel S. Lawrence, & Rudy Perez, 2021, A Process Evaluation of the Misdemeanor Diversion Program in Durham County, North Carolina, Safety and Justice Challenge, retrieved December 6, 2021 from https://safetyandjusticechallenge.org/resources/a-process-evaluation-of-the-misdemeanor-diversion-program-in-durham-county-north-carolina/.*

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