FREQUENTLY ASKED QUESTIONS:

A Look into **Jail-Based** Behavioral Health Diversion Interventions

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Recognizing that people with behavioral health needs are overrepresented in the criminal justice system,[1] many communities have developed alternatives to incarceration that connect eligible people to community-based treatment and supports. While efforts around preventing people from entering the criminal justice system and developing law enforcement diversion interventions are critical to connecting people to treatment community wide, this brief focuses on diversion **efforts led by those working in jails**, which are generally designed to reduce the length of time in custody. For information on other diversion opportunities, see Behavioral Health Diversion Interventions: Moving from Individual Programs to a Systems-Wide Strategy, and other associated resources.

Why set up jail-based behavioral health diversion interventions?

Jail-based diversion presents an important opportunity to shorten average length of stay (ALOS) for people with behavioral health needs without increasing public safety risk.[2] By shortening ALOS, these interventions can help reduce jail costs. They also can eliminate or reduce the significant damage that time in a jail setting can do to people with behavioral health needs, including exposure to risk of violence and disruption of community-based care and supports to keep them stabilized. Jail-based diversion can also help to reduce the impact of collateral consequences associated with long periods of incarceration, such as barriers to finding employment, housing, or connections to community-based treatment and recovery support services.[3] Additionally, these interventions can increase connections to supports, such as housing, that ideally position people to improve their health and reduce their risk of returning to jail.

People with behavioral health needs often stay longer in **pretrial detention** than people without who are facing similar charges, making diversion at this stage a critical opportunity.[4]

"I've been working with a broad set of stakeholders across Massachusetts to bolster approaches that focus on connecting people to treatment. This means providing excellent treatment within our jail and working with our partners to identify diversion opportunities. By using data to identify those who can benefit most from diversion and co-locating behavioral health services in the jail, we can get people the help they need, improve public safety, and make our communities safer and stronger."

– Sheriff Peter Koutoujian,
Middlesex County, Massachusetts Sheriff's Office

Who can implement them?

Jail administrators and staff are critical to the implementation of jail-based behavioral health diversion interventions, whether during pretrial or after someone has been sentenced. But they cannot do it alone. Some common collaborators can include:

- County sheriffs to oversee behavioral health diversion programming
- Dedicated jail diversion staff or liaisons (from the jail facility itself or from community-based case management or behavioral health treatment providers), who can screen and assess for substance use disorders and mental illnesses and refer people to community-based services
- Medical and/or behavioral health staff (from correctional health care providers, county behavioral health, or contracted community-based providers), who can help identify people with behavioral health needs and also appropriately share information with jail staff, case management agencies, and community-based behavioral health treatment providers
- Discharge planners (also sometimes known as jail liaisons or navigators), whether from the jail, a community-based organization, or county behavioral health organization, who can help identify people who might be eligible for behavioral health diversion, assist with benefits, and make referrals to community-based care and supports
- Probation, pretrial, or court staff who can provide case management and supervision

1. Henry J. Steadman et al., "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60, no. 6 (2009): 761–765.
2. Henry J. Steadman and M. Naples, "Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders," *Behavioral Sciences and the Law,* 23 (2005):163-170.
3. For further information, see the "National Inventory of Collateral Consequences of Conviction," The National Reentry Resource Center, https://niccc.csgjusticecenter.org/—an online searchable database that identifies and categorizes the statutes and regulations that impose collateral consequences in all 50 states, the federal system, and the District of Columbia, U.S. Virgin Islands, and Puerto Rico.
4. The Council of State Governments (CSG) Justice Center, *Dauphin County, Pennsylvania: A County Justice and Mental Health Systems Improvement Project* (New York: the CSG Justice Center, 2019), https://csgjusticecenter.org/publications/dauphin-county-pennsylvania-a-county-justice-and-mental-health-systems-improvement-project/.

What are some common best practices?

Every community is different, but agencies and staff can look to other jurisdictions that have demonstrated success for guidance when designing and refining their diversion interventions. Some best practices include:

- Implementing **universal and standardized mental health and substance use screening** at or close to **intake processing**, typically within 24 to 48 hours of the person entering the facility, so that behavioral health needs can be identified, and the person is connected to behavioral health diversion interventions in the timeliest manner possible.[5] Screening—whether for behavioral health treatment needs, risk of suicide, or to assist with withdrawal management—is the first step to ensuring that all people needing treatment are identified and connected to treatment in the facility and upon release. It also helps staff identify people who may require crisis stabilization[6] and would likely be eligible for behavioral health diversion programs after they are stabilized.
- Offering **specialized pretrial services[7] based in jails**; these services can include interviewing, case management, or behavioral health treatment in coordination with the sheriff, a jail liaison, and/or or community-based treatment providers to treat mental illnesses and substance use disorders and to facilitate service linkages in the community.[8] They are often managed by a community supervision agency or the courts, but may also be led by the local jail[9] or take place within a jail or other holding facility.
- Developing community-based collaborative comprehensive case plans and negotiating with judges, prosecutors, or defense attorneys to **give select participants the opportunity to be diverted to community-based treatment;** this practice may be part of the role of a discharge planner and can lead to a reduction in jail time and charges after successful completion of treatment and other program requirements.
- Working with **peer support specialists** who can offer a variety of support activities, such as: peer support in the jail, recovery education groups, re-entry planning, aid in resources, home-planning, employment preparation, general socialization, and community resources.
- Providing **jail in-reach** for people preparing to enter community-based diversion programs where community providers engage people while they are in jail and help ensure treatment and services are continued upon release; these programs increase continuity of care for people with behavioral health needs who are incarcerated and provide connections to additional services, such as housing, if needed.[10]

Where and what can people be diverted to?[11]

The exact treatment services provided once someone has been diverted will vary based on individually assessed needs and each community's resources. However, once eligible people are identified through screening and assessment, they should be connected to a clinically appropriate level of care, needed supports (such as education and housing), and case management.[12] Some examples include:

- Community-based behavioral health treatment centers that offer case management, group therapy, and/or individualized services
- Holistic interventions to address whole health, which involve multi-disciplinary teams in health care settings such as Federally Qualified Health Centers, connections to health homes, Assertive Community Treatment (ACT) teams and Forensic ACT teams
- Supportive housing that offers affordable housing with wraparound services
- In-patient or residential treatment or partial hospitalization in community-based settings
- Community corrections centers operated by probation and/or parole agencies—an emerging model meant to couple community supervision with services and programs that help ensure people are sufficiently supported during their transition to the community
- Jail-based behavioral health treatment that can offer psychotropic medications and/or medication-assisted treatment,[13] a minimum-security criminal justice center, or a designated space within the facility used for programming; this can be a set aside space within a correctional facility, such as a mental health unit or Residential Substance Abuse Treatment (RSAT) program

Note: Community-based supervision may also be appropriate after someone has been diverted from jail. Care should also be taken to match people with gender and culturally appropriate services, as well as minimize any barriers to accessing these services (e.g., costs, transportation, and child care).

5. The CSG Justice Center, *In Focus: Implementing Mental Health Screening and Assessment* (New York: the CSG Justice Center, 2018), https://stepuptogether.org/wp-content/uploads/In-Focus-MH-Screening-Assessment-7.31.18-FINAL.pdf.
6. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines crisis stabilization as: "a direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder." See, SAMHSA, *Crisis services: Effectiveness, cost-effectiveness, and funding strategies* (Rockville, MD: SAMHSA, 2014), 9, https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848.
7. The National Association of Pretrial Services Agencies (NAPSA) developed performance standards for pretrial diversion and has a number of resources for communities seeking to implement them. See, "Pretrial Diversion," NAPSA, accessed March 17, 2018, https://napsa.org/eweb/DynamicPage.aspx?Site=NAPSA&WebCode=Diversion; and NAPSA, *Performance Standards and Goals for Pretrial Diversion/Intervention* (Washington, DC: NAPSA, 2008).
8. SAMHSA, *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide* (Rockville, MD: SAMSHA, 2017), https://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998. See also, Hallie Fader-Towe and Fred C. Osher, Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements (New York: the CSG Justice Center, 2015).
9. The Council of State Governments (CSG) Justice Center, Behavioral Health Diversion Interventions: Moving From Individual Programs to a Systems-Wide Strategy (New York: the CSG Justice Center, 2019), https://csgjusticecenter.org/publications/behavioral-health-diversion-interventions-moving-from-individual-programs-to-a-systems-wide-strategy/.
10. David S. Buck et al., "Best Practices: The Jail Inreach Project: Linking Homeless Inmates Who Have Mental Illness with Community Health Services," *Psychiatric Services* 62, no. 2 (2011): 120-122, https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.2.pss6202_0120.
11. For more information, see also, National Alliance on Mental Illness, *Divert to What? Community Services That Enhance Diversion* (Washington, DC: Bureau of Justice Assistance, 2020).
12. See, "Collaborative Comprehensive Case Plans," the CSG Justice Center, accessed April 1, 2020, https://csgjusticecenter.org/publications/collaborative-comprehensive-case-plans/.
13. Anna Pecoraro and George E. Woody, "Medication-assisted treatment for opioid dependence: making a difference in prisons," *F1000 medicine reports* 3, no.1 (2011), https://doi.org/10.3410/M3-1.

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