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Outcomes of National Jail Diversion Programs For Individuals With Mental Illnesses or
Substance Use Disorders: A Comparison to the Criminal Justice System As Is

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Abstract

Deinstitutionalization funneled individuals with mental illnesses out of so-called asylums and into the streets with no treatment plan, medication, or access to care. Although initially it was just an easy way to reallocate government funding, it sparked a systemic change in which individuals with mental illnesses are now primarily treated by the criminal justice system. The criminal justice system does not effectively treat or rehabilitate these individuals and often does more harm than good, creating criminal sanctions, homelessness, negative medical and mental health outcomes, and isolation. As a solution, jurisdictions have begun implementing diversion programs. Two programs are implemented on a national basis: Law Enforcement Assisted Diversion and Crisis Intervention Teams International. In comparison to the criminal justice system and arrest and prosecution as is, these programs appear to have much more positive outcomes. They both have completely different structures with one similar goal in mind: find an alternative solution for individuals for whom jail will be detrimental to their mental and overall well-being. These programs divert individuals who have committed low-level crimes, who are acting out because of a mental illness or substance use disorder, or who are in crisis. Together, they provide an alternative to the criminal justice system that may thoroughly rehabilitate and treat individuals and remove them from the revolving door of recidivism.

Outcomes of National Jail Diversion Programs For Individuals With Mental Illnesses or Substance Use Disorders: A Comparison to the Criminal Justice System As Is

According to the National Institute of Mental Health [NIMH], it is estimated that nearly 1 in 5 adults in the United States, that is, 46.6 million individuals in 2017, live with a mental illness (NIMH, 2017). Although these illnesses range in severity, this would mean about 20 percent of Americans should be receiving some sort of mental health treatment. But, only 35,000 individuals with mental illnesses are receiving treatment in state hospitals, a tiny fraction of the overall population of individuals with mental illnesses (Sawyer & Wagner, 2020). A much larger fraction of this overall group, approximately 450,000 individuals, are currently in jail (Cowell, 2016). That is about a quarter of the prison population and is still assumed to be a gross under-estimate as it only includes inmates with an official diagnosis or sentence. This rate of incarceration of individuals with mental health problems is significantly higher than the rate of mental disorders within the general population (Lamberti, 2004). This trend of using the criminal justice system to treat individuals with mental illnesses began in the 1960s, when Kennedy initialized a phase of deinstitutionalization. He wanted at least 50 percent of the population living in mental institutions and asylums to be returned to their communities (Harcourt, 2011). He believed that continuous federal funding was not solving the issue and that creating funding for community-based treatment would lead to better outcomes. Eventually, almost 85 percent of the people living in institutions were released (Harcourt, 2011).

But, many of them were not released into systems of care. They were released without any direction or treatment plan and many wound up homeless (Harcourt, 2011). This change in the mental health system created lasting repercussions that are still evident today. Much research

concludes that this policy change years ago is the root cause of many problems in the mental health system and the criminal justice system. Deinstitutionalization was a way of cutting government funding and directing patients to a, theoretically, less isolated place (Harcourt, 2011). The idea was that treating patients on an individual level would lead to better, more personal care, rather than simply a location to live out the days (Harcourt, 2011). Unfortunately, much of the funding for these community-based centers was never implemented and many centers never came into existence (Harcourt, 2011). Because this change was never corrected, individuals with mental illnesses were tossed from one system to another, never really receiving care anywhere. Many people with serious mental illnesses are not able to hold a job, get an education, or create a stable life. Thus, they fall into a pattern of harmful behaviors that lead to constant interactions with the criminal justice system. But, research shows that jail is not a beneficial place for these individuals and often leads to worse mental and medical outcomes. Individuals with mental illnesses rarely receive the treatment they need in jail and, if they do receive treatment, do not have the insurance or means to continue it once released. This restarts the cycle of not being able to get or maintain a job or find a place to live. So, these individuals are picked up, punished for their symptoms, and, turned back out onto the street, no better off.

So what can be done? The criminal justice system does not appear to be able to effectively carry out the treatment of individuals with mental illnesses. Thus, diversion programs have sprung up across the nation. There are countless different models of programs that serve slightly different populations. But, do these programs really lead to better outcomes than the criminal justice system as it currently is? The purpose of this paper is to look at various programs

to analyze whether or not these programs are a viable option for increasing public safety, reducing recidivism, and bettering individuals' well-being.

Literature Review

Through systemic changes, the criminal justice system has become the first option for individuals struggling with mental illnesses, (Cowell, 2016). A vast majority of individuals with mental illnesses are using drugs at the time of the arrest with approximately 40% considered dependent on the drug; a sub-category of mental health diagnoses that are not reflected in the 450,000 inmates with mental illnesses (Broner, 2005). Overall, Approximately 60% of those arrested test positive for drug use (National Institute of Justice, 2020) and over half of those incarcerated are believed to be drug dependent (National Institute of Justice, 2020).

Thus, the vast majority of indiscretions that lead to jail time either have to do with drugs or mental illness. This is consistent with statistics from the Federal Bureau of Prisons which show that, in April 2020, 45.7% of all offenses were drug offenses (BOP Statistics, 2020). Of the 157,000 drug offenses in jails, 88,000 offenses are solely for possession, meaning that half the individuals who are currently in jail are there because they were using drugs themselves, with no intention to sell or traffick drugs (BOP Statistics, 2020). And, of the 88,000 jail drug offense cases, 21,000 are only ever convicted (BOP Statistics, 2020). So, although a large percentage of individuals using drugs or with mental illnesses may find themselves in jail, they are often not the ones convicted. This is especially likely because of the overlap of individuals with mental illnesses and drug addictions as among those incarcerated and seriously mentally ill, at least 72% have co-occurring substance abuse or dependence disorders (Cowell, 2016). One study followed individuals diagnosed with serious mental illnesses and found that the individuals in their study

were charged 9,357 times over the course of ten years (Fisher et al., 2007). For 36 individuals, that could mean an arrest every two months per individual. This study shows that simply charging an individual with a drug offense does not change their future outcomes

Clearly, just between individuals with mental illnesses and individuals found with drugs, there are hundreds of thousands of people who might not belong in jail. They may benefit more from a drug or mental health treatment center, an option that most diversion programs include. So, maybe diversion programs lead to better outcomes than the system currently.

Methods

In order to conduct this research, the researcher first identified a target population: individuals with serious mental illnesses or substance use disorders. Then, the researcher primarily looked at diversion programs that served this population. To find various programs that specifically addressed this population, the researcher analyzed grants that fund these programs, eventually discovering a grant from the Substance Abuse and Mental Health Services Association [SAMHSA]. After reaching out to all of the grant recipients, the researcher was informed that SAMHSA does not allow receivers of this grant to provide researchers with private information.

So, the researcher changed tactics and decided to analyze two national diversion programs, assuming they would have the most amount of information available. The researcher investigated whether the two national diversion programs (Law Enforcement Assisted Diversion and CIT International) claimed to have positive outcomes compared to the criminal justice system. These two national programs were taken from a report on the approaches to early jail diversion published by the Office of the Assistant Secretary for Planning and Evaluation. These

two programs appeared to be good indicators of overall diversion program success because, even if programs are not technically tied to either of these national programs, they typically create their programs based on structures and components of these two programs.

The researcher searched public domains for outcome reports, financial reports, project proposals, grant proposals, and news articles in order to analyze various diversion programs, identify their structures, and find the outcome measures they claim. The researcher also interviewed a representative of the LEAD program and a representative of LEAD and CIT. Ultimately, the researcher wanted to determine whether such programs can lead to positive outcomes with the intention to bring more attention to these programs if it is shown that they can.

Results

Of the over 19,000 municipalities in the United States, 3,017 have already implemented a diversion program, 2,917 of which are Crisis Intervention Teams (Center for Health and Justice, 2013). The rest vary in structure and point of intervention on the Sequential Intercept Model which “outlines the points, or intercepts, along the criminal justice continuum where there are potential interventions to divert people away from the criminal justice system” (Pfefferle et al., 2019). Where diversion programs intervene is a big distinguishing factor between various programs (see Appendix). But, for individuals with mental illnesses and substance use disorders, intervention as far upstream as possible might be the most beneficial.

Generally speaking, there are two main types of criminal justice diversion: pre-booking programs and postbooking programs (Cowell, 2016). Pre-booking diversion occurs at the first point of contact between the police and the individual, before the police formally charge the individual (Cowell, 2016). Usually, this requires special police training and a 24-hour crisis

center, but it keeps the individual out of jail altogether (Cowell, 2016). Contrarily, post-booking programs identify individuals while they are in jail (Cowell, 2016). The main goal of this program is to implement a treatment plan once the individual is released (Cowell, 2016). These types of programs are the most prevalent, but not necessarily the most effective (Cowell, 2016).

Each jurisdiction can choose whether they want to have a diversion program, what model to follow, and which population they want to serve. Although typically diversion programs are different for each jurisdiction, there are two main overarching organizations that provide technical support to jurisdictions implementing programs similar to theirs: Law Enforcement Assisted Diversion [LEAD] and CIT International [CIT]. Although LEAD and CIT programs serve a specific population, low-level offenders and individuals in mental health crises respectively, jurisdictions have the freedom to adapt their programs to match their laws.

Law Enforcement Assisted Diversion (LEAD)

Purpose and Background

According to their main bureau's website, "LEAD is a community-based diversion approach with the goals of improving public safety and public order, and reducing unnecessary justice system involvement" (LEAD). LEAD is an approach to public safety that responds to "low level offenses such as drug possession, sales, and prostitution" (LEAD). As explained by a director of the bureau in an interview, the official LEAD program began in 2011 in Seattle, Washington. It was created to reduce the racial disparities of arrests in Seattle that were unintentionally caused by the War on Drugs. In order to help those constantly cycling through the criminal justice system, which were primarily individuals of a minority race, police, civil rights advocates, mental health and drug treatment providers, housing providers, and other

service agencies worked together. They wanted to change the status quo of the typical approach of arrest. Although the program began in Seattle, LEAD has now become a national umbrella organization that provides jurisdictions with guidance and technical support (LEAD). There are currently three official LEAD programs in Seattle, Santa Fe, and Albany, but over 60 programs either exploring, developing, launching, or operating LEAD programs (LEAD).

Structure

LEAD does not require programs to follow identical structures, as they recognize the unlikelihood that one program would work well everywhere. Rather, programs need to adhere to a set of core principles, as explained by a director of the bureau in an interview,

The first core principle is that this program is based on officer discretion. Across the country, most officers decide whether to make an arrest for low level crimes such as drug possession, property crime, and most crimes driven by substance use disorders, mental illnesses, and extreme poverty or homelessness. Because the officer is not obligated to make an arrest, they have the choice to divert the individual, which is where LEAD comes in. Diversion at the point of contact is another one of LEAD's core principles. Addressing situations as far upstream as possible typically leads to the best outcomes. It is one area where LEAD differs from many other diversion programs, as they typically occur after arrest or after court processing. According to a director for the LEAD National Support Bureau, these programs typically do not work for persistent offenders because they require abstinence or are only short-term.

LEAD does not require participants to prove they are drug-free before introducing them to services, another core principle and area of differentiation from other programs. When a case manager begins working with an individual, they first conduct a psycho-social assessment. Then,

they work with the individual to identify which goal that person specifically would like to work towards. If that includes drug treatment or rehabilitation, the case manager will work with the individual to make that happen. But, many individuals have been on the street for a while or have underlying mental health issues and are not ready to go through the process of drug treatment. So, the case manager will continue to work with them, until they might be ready for that change. Although the case manager does not require the individual to stop using drugs, they inform them that drugs are illegal and they may face consequences from police. By informing the individual, the choice to use or not remains theirs, and they are free to make it without being judged.

Another core principle is that LEAD uses the harm reduction approach. The harm reduction approach recognizes that not everyone is ready, willing, or able to make big changes in their lives. But there are ways that case managers can help to reduce the risks of people's behavior. LEAD has adopted this approach, using harm reduction as a public health response to behavioral health needs. LEAD recognizes that if they can reduce people's risk and meet them where they are at, figuratively and literally, then they can help them to improve their lives. Case managers start by addressing individuals' issues in small incremental needs. In terms of drug use, this could mean: providing clean needles, ensuring access to Narcan, and educating the individual about how to use safely.

The final core principle of LEAD is that their case management is street based. They meet their individuals exactly where they are. Once the police officer has decided not to make an arrest, they will call a case manager to the scene. The officer does a warm hand off to the case manager, who begins building a relationship with the individual. After this first interaction, the case manager meets the individual again, on a consistent basis. Rather than requiring the

individual to meet the case manager somewhere, the case manager goes to them, wherever they may be living at the time. The goal of the case manager is to reduce risk, help the individual achieve their goals, but not push them to do anything they are not ready for.

LEAD provides two ways of entering the program. The first, and most typical, option is a warm handoff. This avenue of getting into the program involves contact with a police officer, typically after a 911 call. Then the officer uses their discretionary authority to hand this individual off to the case manager. The individuals diverted at this point are almost always only low-level offenders. Another avenue is what LEAD calls a social contact referral. This is the avenue for an individual who has frequent interaction with the criminal justice system but who may not have recently committed a crime. In this case, if a police officer knows that this individual has a behavioral health need and believes they would benefit from the program, then the officer can refer this individual to LEAD. Because this individual is not being diverted because of a crime, it may be an individual who had previously committed and served time for a higher level crime. LEAD allows each jurisdiction to independently decide exactly who they would like to divert and how these two avenues intertwine. The pattern to date has been that jurisdictions that implement LEAD programs start off by diverting very few crimes. But, as the community witnesses positive outcomes and becomes comfortable, more offenses fall into the category of being able to be diverted.

Outcomes

The first program in Seattle used an evidence-based model to conduct a peer-reviewed Client Outcomes Evaluation. The following data comes from the most current evaluation on the LEAD bureau's website, which is from 2017. Although these outcomes are not generalizable for

every LEAD program, they provide an insight to potential positive outcomes. This evaluation wanted to compare LEAD and the system as usual. Seattle police officers were randomly divided into two shifts: one where officers diverted eligible offenders to LEAD and one where they continued to arrest individuals as usual. But, only LEAD participants were included in this evaluation, because measures could not be taken from non-participants. They tracked the participants from 1 month prior through 18 months after their referral (Clifasefi et al., 2017).

According to the outcomes, “LEAD participants were over twice as likely to have been sheltered in any given month during the follow-up versus baseline” (Clifasefi et al., 2017). The study also showed a similar trend in housing with participants being 89% more likely to have been housed during follow-up than at baseline and with a 5% higher likelihood of being housed associated with every additional case manager contact (Clifasefi et al., 2017). LEAD participants showed a significant increase in employment, with participants being 46% more likely to have been somewhere on the employment continuum during follow-up than at baseline. There was no significant interaction between status of employment and case manager contacts (Clifasefi et al., 2017). As for income and benefits, “participants were 33% more likely to have received legitimate income/benefits during the follow-up versus at baseline” (Clifasefi et al., 2017, p. 7).

These outcomes were determined by LEAD to be reasons why individuals commit crimes. So, if they could better these outcomes, they could reduce recidivism, and increase public safety. This is presented by participants being, “17% less likely to have been arrested during the 6-month follow up for each month housed” (Clifasefi et al., 2017, p. 11). And, for every month that participants were on the employment continuum, they were 33% less likely to have been arrested (Clifasefi et al., 2017). Overall, LEAD claims that, “ LEAD participants were 58% less

likely to be arrested after enrollment in the LEAD program in Seattle, compared to those who went through the ‘system as usual’ criminal processing” (LEAD)

Aside from these outcomes, the LEAD website claims to have brought reconciliation and healing to police-community relations. They claim that, “ LEAD has led to strong alliances among traditional opponents in policy debates surrounding policing, and built a strong positive relationship between police officers and people on the street who are often a focus of police attention” (LEAD).

Summary

The LEAD program appears to be an effective alternative to the current status quo. It diverts individuals who commit low-level crimes, especially if those crimes are committed due to an underlying substance use disorder or mental health issue. As evident by its outcome measures, it seems to have positively impacted people’s lives and changed the way the community interacts with the police. According to their website, “LEAD holds considerable promise as a way for law enforcement and prosecutors to help communities respond to public order issues stemming from unaddressed public health and human services needs -- addiction, untreated mental illness, homelessness, and extreme poverty -- through a public health framework that reduces reliance on the formal criminal justice system” (LEAD).

Crisis Intervention Teams (CIT)

Purpose and Background

Another overarching diversion program is CIT International. This nonprofit organization helps to implement and develop Crisis Intervention Teams (CIT) across the nation and the world. Their goal is to, “ promote and support collaborative efforts to create and sustain more effective

interactions among law enforcement, mental health care providers, individuals with mental illnesses, their families, and communities and to reduce the stigma of mental illness”(CIT International). To do so, CIT international holds an annual conference, raises awareness through education and outreach, provides technical assistance, and supports research that helps CIT programs demonstrate their value (CIT International). CIT international wants to “promote community collaboration using the CIT Program to assist people living with mental illness and/or addiction who are in crisis” (CIT International).

The model that CIT follows was originally developed in 1988. Years later, in 2007, the core elements were created by individuals who wanted to increase the spread of CIT programs. They met in Memphis, and therefore dubbed the plan the “Memphis Model”. The basic goals of CIT programs are to, “improve officer and consumer safety and to help persons with mental disorders and/or addictions access medical treatment rather than place them in the criminal justice system due to illness-related behaviors” (CIT International).

Structure

A CIT program is, “a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorder, their families, and other advocates” (CIT International). First-responder crisis intervention training is one of the main core components of CIT. The training is primarily police based and focuses on responding to calls in which it is suspected that the individual has a mental disorder and/or addiction. It allows the first-responder to provide the individual with access to medical treatment rather than arresting them for illness-related behaviors (Dupont et al., 2007). This training also emphasizes first-responder safety when approaching an individual in crisis. Officers learn how to

de-escalate the situation and when and where to transport individuals in need of treatment (Dupont et al., 2007). Enough CIT-trained officers should always be available to meet the demand of the community, which is typically 20-25% of each patrol division, but becoming a CIT-trained officer should be optional (Dupont et al., 2007). When 911 calls are made regarding an individual in crisis, the nearest CIT officer should be identified and dispatched.

The training for a patrol officer involves 40-hours of comprehensive training, typically completed in a week. The training, “emphasizes mental health-related topics, crisis resolution skills and de-escalation training, and access to community-based services” (Dupont et al., 2007, p. 14). It includes an array of lectures and hands-on exposure and visitation to mental health facilities and individuals with a mental illness, as well as scenario-based skill training (Dupont et al., 2007, p. 14). This type of training allows officers to retain behavioral and cognitive changes. Additionally, the success of the CIT program relies on the dispatcher’s ability to recognize CIT cases and relay them to the officers in proper ways. The dispatcher should be familiar with the program and what signs might point to a call being CIT applicable. So, dispatchers receive 8-16 hours of training (Dupont et al., 2007).

Partnerships between the community, law enforcement, and the mental health community are needed for any successful CIT program. The partnership must include professionals such as psychologists, psychiatrists, and social workers, and public, non-profit and private agencies such as hospitals, mental health centers, or emergency intake facilities (Margiotta, 2015). A large variety of inpatient and outpatient options should be available to CIT-trained officers and any barriers that prevent an individual from receiving mental healthcare should be eliminated (Margiotta, 2015). CIT programs also require that the community’s crisis system be responsive

and address the needs of the police as well as the community. Although it is important that the services provided are of high quality, partnerships need to be made with organizations that are responsive and accessible (Margiotta, 2015). To increase accessibility, hand-offs need to be efficient. Thus, police officers can return to their duties and individuals do not have to wait to receive treatment. Individuals brought in through CIT programs should have priority access to treatment and be treated regardless of current state or prior diagnosis (Margiotta, 2015). Finally, a successful CIT program includes education and advocacy. Consumers need to participate in the actual training curriculum, which leads to advocacy for the program and fosters understanding (Margiotta, 2015). Any participants for whom the CIT program was successful should help to educate the community and spread the word about the benefits of the program (Margiotta, 2015). This interaction could lead to the community being more involved and help police officers be better trained. Success stories can be helpful in advocating for CIT programs, encourage other jurisdictions to implement this program, and emphasize the importance of accessible healthcare.

In conclusion, CIT programs operate using a five-legged stool: police training, community collaboration, vibrant and accessible crisis system, behavioral health staff training, and family, consumers, and advocates collaborate and educate.

Outcomes

CIT programs encourage a form of evidence-based practices and therefore have measures that indicate the program's success. Researchers have found, "the CIT program has reduced arrest and increased safety and diversion to mental health services" (Watson & Fulambarker, 2012, p. 4). They found "an association between CIT and lower arrest rates of persons with mental illness" (Watson & Fulambarker, 2012, p. 4). Studies also found that individuals who are

diverted through CIT increase their use of mental health services for the next 12 months (Watson & Fulambarker, 2012). Additionally, studies have concluded that CIT may improve safety outcomes and that “CIT officers used force in only 15% of encounters rated as high violence risk” (Watson & Fulambarker, 2012, p. 5). Research also shows an association between CIT training and improved attitudes towards mental illness (Watson & Fulambarker, 2012)

One specific study of CIT programs was conducted in Chicago. Two demographically different districts piloted CIT following the proper training and steps. This study was focused on the police officers rather than CIT participants, but it can still provide some insight to the outcomes of CIT programs. Overall, 60% of the sampled police officers completed CIT training. In subsequent interviews, 15 of the 20 study participants attribute 44% of their successes to the use of CIT skills and knowledge. Overall, officers found CIT skills very helpful when responding to calls (Canada et al., 2010). Furthermore, “CIT trained officers reported that the training provided them with the ability to divert individuals with a mental illness from arrest and into mental health services” (Canada et al., 2010, p. 6). At the very least, CIT programs appear to reduce arrests and better the interactions between police officers and individuals with mental illnesses who are in crisis.

According to CIT International, CIT reduces the stigma around mental illness and the subsequent need for individuals with mental illnesses to have constant interaction with the criminal justice system. The foundation that CIT provides creates an effective solution to current problems between these individuals and the criminal justice system. It uses a problem solving technique to further the interaction between the criminal justice and mental health care system to create sustainable change (CIT International). CIT International claims that, “research shows that

communities that prescribe to the CIT Program model, have higher success rates in resolving serious crisis situations”. The website also claims that, “a sound CIT program based on the "Memphis Model" Core Elements will help strengthen your community in working together to help people who live with mental illness and/or addictions who are in crisis, it will also improve your community mental health system, save lives and bring hope and recovery to those in need. A strong CIT Program (and not just training) will sustain for years to come” (CIT International).

Summary

CIT International oversees the different jurisdictions that implement CIT programs. Although the specific structures of each CIT program in each jurisdiction vary, they all follow variations of the Memphis Model. Many of the illness-related crisis behaviors that typically prompt a bystander to call the police are not against the law but, when situations escalate, the officer may need to arrest the individual. In jurisdictions with CIT programs, officers are trained to handle situations and de-escalate them, so the potential for arrest is slim. Because individuals in crisis do not typically commit a crime, CIT programs are not true jail diversion programs. But, it still fosters positive outcomes and diverts individuals from facing worse situations or ending up in jail. They reduce the likelihood of more trauma for the individual in crisis and create the opportunity for individuals to receive proper treatment.

Current System of Arrest

Purpose and Background

According to the National Criminal Justice Reference Service [NCJRS], police, the courts, and corrections, are the three pillars of the criminal justice system. Police enforce the law and protect the public. Courts assure fair trials for suspects and determine whether they are

guilty. Corrections facilities are in place to “rehabilitate offenders or to alter their behavior so that they are law abiding. The goal of all three subsystems is the reduction of crime in the community” (NCJRS). Although nowhere in that purpose or set of goals does it state that it is the criminal justice system’s responsibility to treat individuals with mental illnesses, this is one criteria that exists in the system today, primarily because of a lack of other avenues of treatment for these individuals.

The transfer of care from mental health institutions to the criminal justice system began in the 1960s when deinstitutionalization began (Schaefer, 2003) At this point, over 85 percent of patients were released from state-operated hospitals (Schaefer, 2003). These individuals returned to the community without proper treatment plans or support, leading them to either be homeless or engage in criminal activity. Deinstitutionalization is said to be the root cause of the criminal justice system starting to treat these individuals. (Schaefer, 2003). This reorganization required major changes within the criminal justice system that were never carried out.

Structure

The criminal justice system has many different facets and avenues (see Appendix). The criminal justice system begins with either a community member or private sector company alerting the police of a potential crime. The Bureau of Justice Statistics claims that the criminal justice system will “apprehend, try, and punish offenders... at all levels of government” (Bureau of Justice Statistics). Next steps include arresting the suspect, holding them until they are charged, and releasing them if no charges are filed. Although technically innocent until proven guilty, suspects must either remain in jail or post bail until their case can be tried (Bureau of Justice Statistics). The suspect goes through an arraignment and possibly a trial and is either

found guilty or acquitted. If found guilty, they must serve their sentence, whether that be time in jail or prison, community service, a form of education, proof of sobriety, or other intermediate sanctions. Once the sentence has been served the individual is released from the system, typically with a form of probation (Bureau of Justice Statistics).

Outcomes

Thousands of individuals in jail are not yet convicted of a crime but this in-between time has negative ramifications on individuals with mental illnesses as mental health issues are often not addressed, despite receiving a medical and mental health evaluation upon intake (How Many Individuals, 2014). 83 percent of jail inmates with a mental illness do not have access to needed treatment and, because of this, end up getting worse and not better (How Many Individuals, 2014). Individuals with mental illnesses serve longer sentences than their un-diagnosed counterparts and are at risk of victimization for bad behavior. Even if these individuals are lucky enough to receive proper treatment in jail, once leaving jail, they no longer have access to healthcare and benefits (Carroll). Furthermore, criminal sanctions make it more difficult to get a job or find funded housing (Fisher et al., 2007), leaving these underserved individuals with limited options and a high rate of recidivism.

Fifty to fifty-five percent of mentally ill inmates have served at least three prior sentences or probation (Schaefer, 2003). This could be because many inmates across the nation are released “without money, medications, insurance (insurance is generally lost to those incarcerated), prescriptions or treatment plans... Without proper care, medication and support, the unavoidable happens: The mentally ill person decompensates, becomes violent and returns to jail again” (Schaefer, 2003, p. 45). This leads to incredibly high rates of recidivism, longer prison sentences,

and a negative impact on the rest of the jail. Mentally ill inmates are more likely to harm themselves and be victimized and abused by other inmates (Schaefer, 2003). Evidently, although it is vital for inmates to receive high-quality care, most do not (Leahy, 2003, p. 295).

Summary

Almost 7% of all police contacts involve individuals with mental illnesses (Lamberti, 2004). But, because of the absence of change in the system, most officers face an extreme lack of education and training about mental illness and effective interventions (Lamberti, 2004). This could primarily be because treating individuals with mental illnesses was never the intention of the police force. Secondly, there is an egregious lack of communication between agencies (Lamberti, 2004, p. 153). Because officers do not know better and have nobody to consult with, they take the individual to jail, even if it is not the best option.

Future Vision for Programs

LEAD and CIT are the two main national diversion programs, with LEAD being a progressive program that diverts individuals with mental illnesses and low-level offenders and CIT being a way to address individuals in crisis. Both programs share the same goal: keep individuals who will not benefit from jail out of the criminal justice system. By simply comparing these two programs with the current system of arrest, it is clear that they appear to foster more positive outcomes than the system as it currently is. Now, not every individual may benefit from these programs or even be eligible for them, but by allowing these programs to be an option, jurisdictions are better equipped to more efficiently serve a typically underserved population. There are many other diversion programs with completely different structures that also lead to positive outcomes, but most programs are built using similar components. There is

no single solution to diverting individuals with behavioral issues or substance use disorders. But, the criminal justice system is not effective in treating these individuals.

In the future, all jurisdictions should have diversion programs. LEAD programs and CIT programs should work in tandem within each jurisdiction. CIT should address all situations in which an individual is in crisis and has not committed a crime. If the individual has committed a crime and has a mental illness, then LEAD should respond. In this way, CIT programs can provide immediate treatment to those in crisis. But, LEAD programs can provide long-term treatment to individuals who either are not eligible for CIT programs or for whom CIT programs and short-term treatment have not been effective. In the long-term, diversion programs could become so effective, that police would no longer be the first responders to typical scenarios with individuals with mental illnesses or substance use disorders.

Discussion

It appears that diversion programs, at least the two national umbrella programs, have more positive outcomes for individuals with mental illnesses and substance use disorders than the current criminal justice system. These programs have the ability to treat and rehabilitate individuals without punishing them for their uncontrollable behavior. Diversion programs may also reduce the amount of criminal sanctions a person faces. In other words, individuals who go to jail may lose their housing because they are unable to pay for it, lose their job because they are unable to attend, and lose their social network. These various support structures can be the difference between life and death and can prevent unemployment, poverty, and homelessness.

If diversion programs really lead to positive outcomes, they should become more common and expansive. First and foremost, programs could lead to an increase in public safety.

If individuals who go through diversion programs are less likely to be re-arrested, this implies they are involved in less criminal activity. Furthermore, if diversion programs introduce individuals to needed services, treatment might be able to subside that person's symptoms and allow them to live a full life. If all individuals with mental illnesses were diverted from jail and treated, they could likely hold a job, pay for a place to live, and live on their own. Likewise, if individuals for low level crimes are diverted, they may be able to keep their job, continue to pay for their housing, and escape the prison to homelessness pipeline. Diversion programs appear to address the root of people's issues. Rather than simply arresting them, punishing them with a sentence, and releasing them, diversion programs can change the way a person thinks and acts, preventing them from committing crimes in the future and increasing their overall quality of life.

More importantly, diversion programs can help provide individuals whose lives were sidetracked by their illnesses, with a second chance. They should not be forced to live a life on the streets or stuck in their own psychotic episode. Every individual deserves happiness and peace within their daily life and not to be stuck in the revolving door of recidivism. Sending an individual with mental illness to jail increases the amount of isolation, fear, and negative symptoms, thus increasing the overall likelihood of suicide and negative health outcomes. Subjecting individuals with mental illnesses to all these consequences seems unjust because they are not typically violent criminals, just individuals struggling with the false reality their illnesses cause (Hiday & Moloney, 2014).

Conclusion

Now that attention has been drawn to the potential success of these diversion programs, more analysis is needed. Diversion programs should conduct research on their own programs and

publicize their findings. Programs should make outcome measures and results more easily accessible and share their successes and failures so other programs can learn from them. Furthermore, programs that have proven success should try to recreate their successes in other jurisdictions or provide technical support to jurisdictions trying to implement similar programs.. Ultimately, all programs should communicate and collaborate with each other, rather than existing singularly or competing with one another. More than one program can, and probably should, exist within a jurisdiction, each with their own specialty. Future research should compare the components of diversion programs with their outcome measures to discover the most effective components. Then, more research should be conducted to see if the theoretical best program is actually the best program. If it is, it should be determined if it is applicable or feasible everywhere. Finally, research should be in touch with the individuals being diverted in order to analyze and implement the services and outcomes that would be most beneficial to them.

Diversion programs have the potential to solve problems ranging from the mental health crises and drug addiction to overcrowding in jails to homelessness and poverty, providing us all with hope for a future in which police officers are no longer the first-responders to calls regarding an individual in crisis or with suspected behavioral issues.

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Appendix

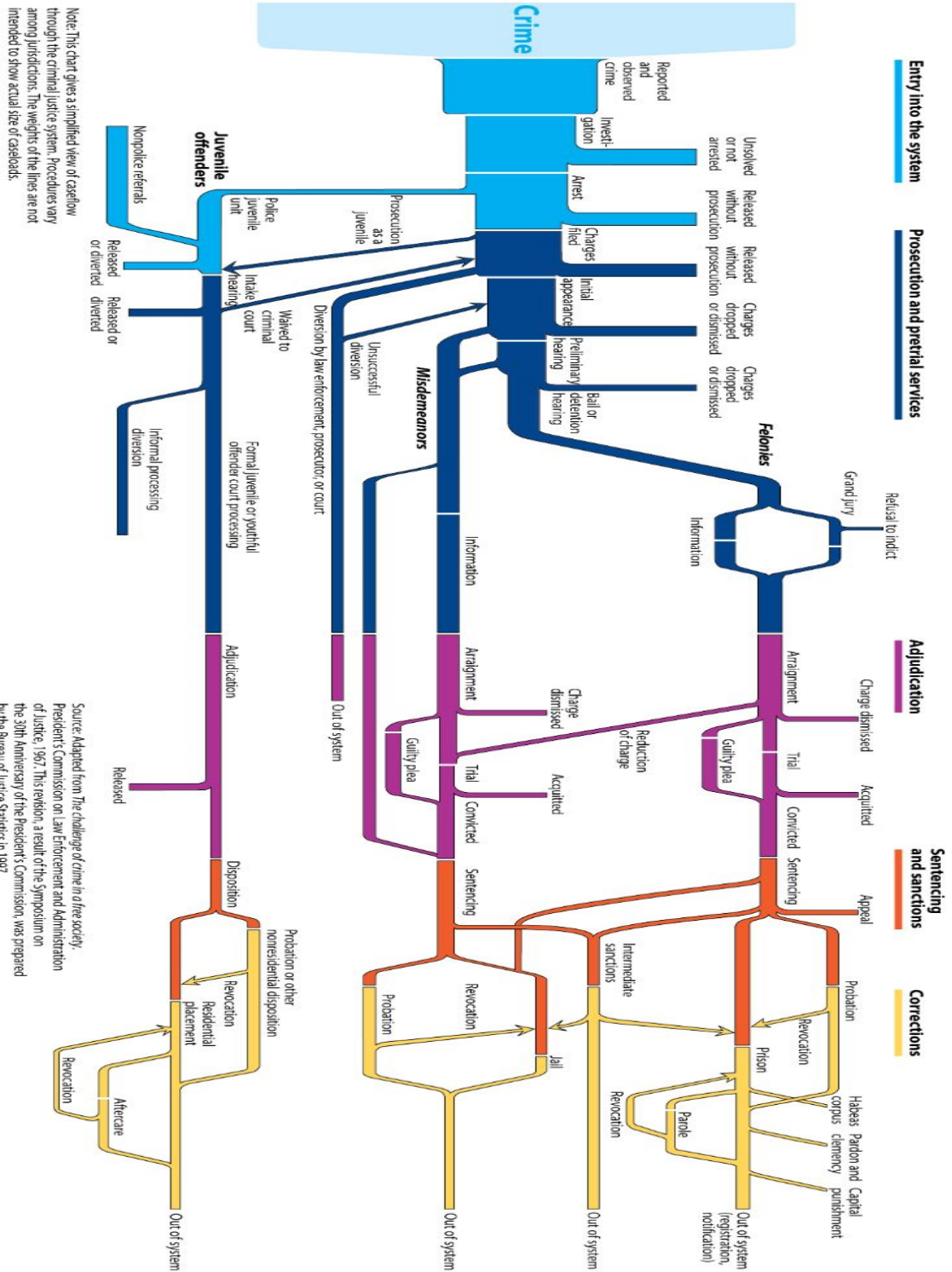


Figure 1: Various branches and paths of the criminal justice system as it functions currently.

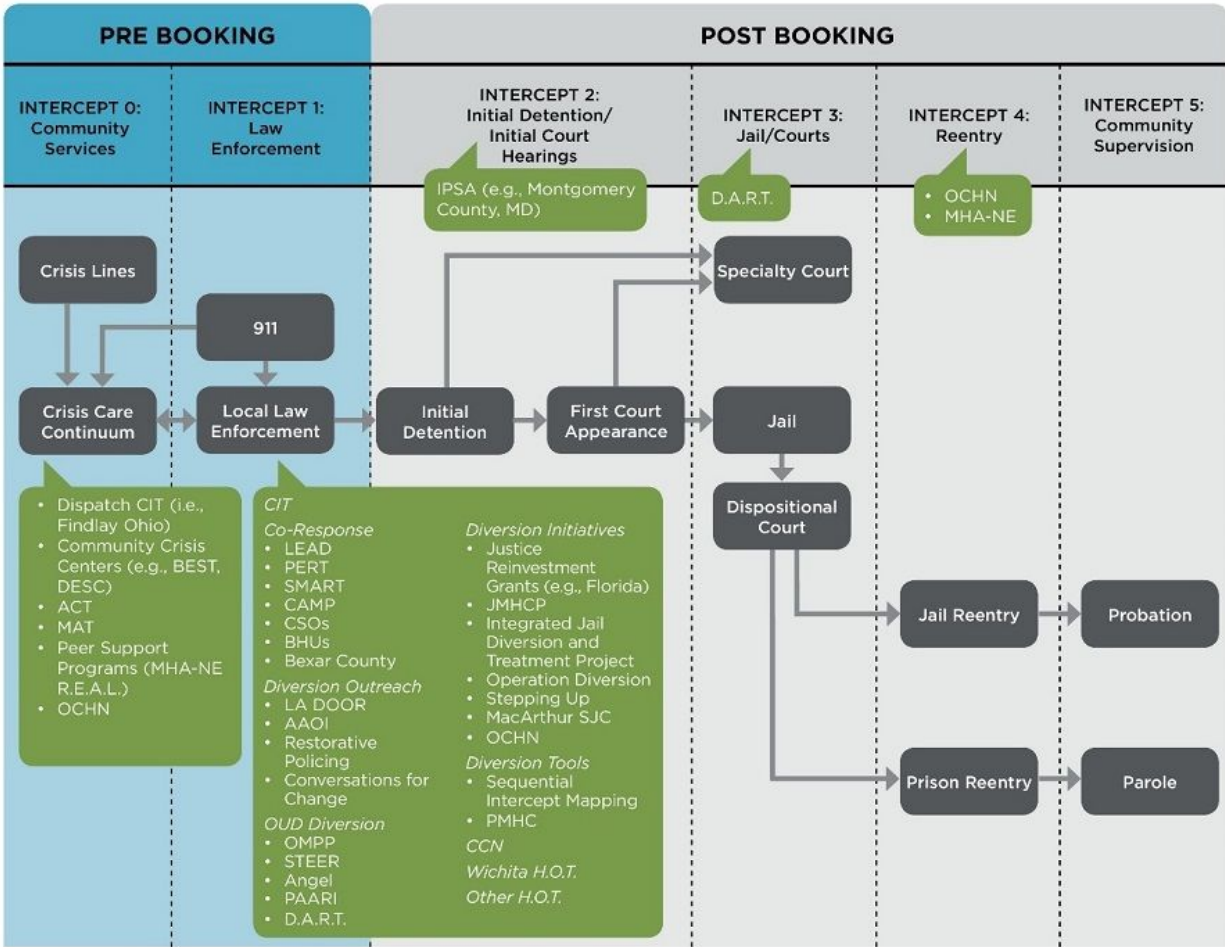


Figure 2: A portrayal of the Sequential Intercept Model and examples of programs that occur at different stages.