The Diversion of Mentally Ill Persons from Jails to Community-Based Services: A Profile of Programs

Henry J. Steadman, PhD, Suzanne M. Morris, MA, and Deborah L. Dennis, MA

ABSTRACT

Objectives. A major proposal for appropriately treating persons with mental illnesses who have been arrested is to divert them from jail to community-based mental health programs. However, there are few available definitions, guidelines, and principles for developing effective diversion programs. The goal of this research was to determine the number and kinds of jail diversion programs that exist, how they are set up, and which types of programs are effective.

Methods. On the basis of information gathered during a national mail survey (n = 1263) and follow-up telephone survey of 115 responding jails, 18 sites were selected for on-site interviews based on perceived effectiveness and presence of a formal diversion program.

Results. Data are presented from a national sample of jail diversion programs (n = 18). Key factors for developing diversion programs and descriptors of effective programs are presented.

Conclusions. It is clear that controlled, longitudinal studies of these programs' effectiveness, using client-based and organizational outcome measures, are badly needed. (*Am J Public Health.* 1995;85:1630–1635)

Introduction

There are more persons with mental illnesses in US jails today than ever before, if for no other reason than there are more Americans in jails than ever before. As of June 1992, there were 444 584 citizens held in the approximately 3350 US jails.[1] This represents a 154% increase in the number of jail detainees nationally between 1980 and 1992.[1] Beyond this huge increase in the jail population, research has shown that there is a substantially higher percentage of severe mental disorders among jail detainees than among the general population.[2]

Teplin found that 6.1% of male detainees admitted to the Cook County (Chicago) jail had a severe mental disorder.[3] Among female Cook County detainees, the percentage of mental illness was even higher (12.3%) (L. Teplin, unpublished data, 1994). Based on Teplin's figures extrapolated to all US jails, approximately 6.6% of US jail detainees have a serious mental illness. There are approximately 10.1 million jail admissions per year[4]; thus, nearly 670 000 inmates with severe mental disorders are admitted annually to US jails.

Various explanations ranging from deinstitutionalization[5] to changing perceptions[6] have been put forth to explain these numbers. Regardless of one's preferred interpretation, it is clear that there are far fewer public sector mental health beds available across the United States[7] and that there are large numbers of persons with mental illnesses in US jails who require appropriate treatment.

While some persons with mental illnesses must be held in jail because of the seriousness of the offense and should receive mental health treatment within the jail, many persons with mental illnesses who have been arrested for nonviolent crimes may be diverted from jail to community-based mental health programs. Rogers and Bagby have argued that "diversion efforts may be the only viable alternative to the rapid cycling of patients within the criminal justice and forensic mental health systems."[8] One of the strongest recommendations of the recent report by Torrey and colleagues was that "jail diversion programs should be set up to minimize the number of individuals with serious mental illness who end up in jail."[5] Likewise, a recent National Coalition for the Mentally Ill in the Criminal Justice System report stated that "mentally ill misdemeanants whose illegal behavior usually is survival behavior should be diverted into appropriate mental health treatment services."[9]

There has been much discussion of diversion as something that is badly needed, but the literature offers few definitions, guidelines, or principles for developing effective diversion programs. Therefore, it is useful to first clarify what is meant by diversion. In a previous article,[10] we defined diversion programs as specific programs that screen defined groups of detainees for the presence of a mental disorder; use mental health professionals to evaluate those detainees identified in screening; negotiate with prosecutors, defense attorneys, community-based mental health providers, and the courts to produce a mental health disposition as a condition of bond, in lieu of prosecution, or as a condition of a reduction in charges

The authors are with Policy Research Associates Inc, Delmar, NY.

Requests for reprints should be sent to Henry J. Steadman, PhD, Policy Research Associates, 262 Delaware Ave, Delmar, NY 12054.

This paper was accepted March 29, 1995.

Editor's Note. See related editorial by Torrey (p. 1611) in this issue.

(whether or not a formal conviction occurs); and link the detainee directly to community-based services.

Based on this definition, here we describe (1) the characteristics of existing programs that appear to be effective and (2) how effectiveness varies by key program characteristics such as jail size and the types of linkages that exist between jails, the mental health system, and the judicial system.

Methods

Three procedures were used to examine the number and kinds of jail diversion programs that exist, how they are set up, and which types of programs are effective: a national mail survey, a follow-up telephone interview of selected respondents, and site visits.

The first phase of the research consisted of a national mail survey of all US jails with a rated capacity of 50 or more detainees. The survey was distributed to 1106 jail systems. The minimum size of 50 detainees was chosen because smaller jails are not likely to have formal diversion programs. Diversion in smaller jails tends to be informal and managed on a case-by-case basis. A total of 685 responses were received (a response rate of 62%). Responses were received from all 50 states and the District of Columbia. The responding jails ranged in size from capacities of 54 to 15 592. Slightly more than one third (34%) of the respondents indicated that they had a formal diversion program for mentally ill detainees (n = 230).

Responding jails were then classified by size (small = 50 to 249, large = $\geq$250) and the type of diversion program they operated (prearraignment, postarraignment, or mixed). This created a six-cell sampling frame from which a random sample of half of the jails in each cell was selected for the telephone survey (n = 115).

The telephone interviews were conducted with the person most familiar with the diversion program. In addition to obtaining a program description, the interview collected information on the range of mental health services provided in the jail. Interviews took approximately 30 minutes to complete. Two additional 5-minute telephone interviews (one with the jail administrator and one with the mental health contact outside the jail responsible for mental health services in the diversion program) were then conducted to confirm the information given by the diversion program directors and to obtain some basic background information on the jail and on local mental health services.

The third phase of the study consisted of 18 site visits. All programs given the telephone interview were classified by program type (prearraignment, postarraignment, or mixed) and jail size (small or large). From each of these six cells, two programs rated as highly effective and one rated as not highly effective were selected. Perceived effectiveness was calculated by using the average rating (on a five-point scale) of the jail diversion program's effectiveness given by all three interviewees (program director, jail administrator, and mental health contact). Programs receiving an average score of four or above were rated as "highly effective." This resulted in a set of 18 sites representative of jail diversion programs in the United States.

Site visits were conducted by two-person teams. Semistructured protocols were used in conducting 127 interviews across the 18 sites; those interviewed were diversion program directors, diversion program case managers, jail administrators, judges, public defenders, prosecutors, probation staff, community mental health service staff, and residential services providers. Site visits ranged in length from 1 day (in small counties) to 4 days (in one large county).

The six key factors discussed in the following section emerged from our on-site observations, interviews, and prior research.

Results

Program Types

The first step in our interpretation of the program data was to create a typology by which the wide array of programs we encountered could be organized. In order to understand how diversion programs are structured and why some programs are perceived to be effective, it is essential to understand the types of diversion programs that exist and their key elements. There are two main types of diversion programs: prebooking (police based) and postbooking (court and/or jail based). Within postbooking programs, there are three subtypes: prearraignment diversion, postarraignment diversion, and mixed. Table 1 displays the types of existing diversion programs and the core issues, principal organizations, and key staff involved in their operation.

Although both types of programs outlined in Table 1 are important, our research focused exclusively on postbooking programs. A study of prebooking diversion would require a research design entirely different from the one used here (e.g., a field study of police decision making with regard to mentally ill persons similar to that done by Teplin and colleagues[11]). Our focus was on programs that attempted to divert persons who, upon booking in a jail, appeared to be mentally disordered and who were eligible for diversion based on their booking charges.

Key Factors

After reviewing the results of our 115 telephone interviews and our field notes from the 127 interviews during the 18 site visits, we identified six factors that were consistently found among the most effective jail diversion programs: (1) integrated services, (2) regular meetings of key agency representatives, (3) boundary spanners, (4) strong leadership, (5) early identification, and (6) distinctive case management services. Table 2 displays the study sites by size and indicates which of the key factors were present in each. Five jails were visited and determined not to have a formal diversion program (data not shown).

Integrated services. In order to effectively divert detainees with mental illnesses from jail to appropriate mental health treatment, agencies within the criminal justice and mental health systems regularly coordinate their activities, even when their goals and expectations appear to conflict. Integrating services at the community level with corrections, mental health, judiciary, and social services systems (e.g., housing and entitlements) requires a high level of cooperation between all parties. Recent suggestions for closing the gaps between systems have included the improvement of communication channels, creation of linkages between systems, and an increase in resources allocated specifically to promote system interactions.[12,13]

Consistent with these recommendations, respondents clearly recognized the need for integrated services. Among the factors most frequently cited by program directors as important to the success of the diversion program were cooperation (25%) and communication (19%) between the principal agencies. One respondent specifically noted that an essential factor for success was "integrating the jail diversion program in the entire county's

TABLE 1—Major Types of Diversion Programs for Mentally Ill Jail Detainees

Type of Program	Principal Organizations	Key Staff	Core Issues
Prebooking	Police Emergency rooms Mobile mental health crisis teams	Officer on the beat Nurses/psychiatric residents Clinicians/case managers	Obtaining mental health, substance abuse, and other support services in lieu of arrest
Postbooking			
Prearraignment	Jails	Booking officer/classification officer/health screener/boundary spanners	Negotiating entry into mental health and other support services/obtaining client compliance/obtaining court concurrence
	Pretrial service agencies	Pretrial administrators/staff	
	Courts	Judges/liaison staff	
	Special diversion programs	Boundary spanners/case managers	
Postarraignment	Jails	Jail mental health staff/classification officer/health screener/correctional staff/boundary spanners	Obtaining necessary mental health evaluations/negotiating treatment plan/obtaining program and client agreement/obtaining satisfactory community supervision mechanisms for the court
	Community mental health center	Boundary spanners/case managers	
	Courts	Judges/liaison staff	
	Probation/pretrial services	Probation officers/pretrial services officer	
Mixed	Full combination of both prearraignment and postarraignment organizations, staff, and issues.		

service operation" and that "agencies must work out their availability of services to one another." When we asked respondents to identify the essential elements of effective diversion, 50% of the program directors said that "formal supports" such as interagency agreements were essential for success.

In one innovative program, a multidisciplinary team of 10 staff members works intensively with up to 100 forensic clients at a time. The team was created to integrate the mental health and criminal justice systems with other systems and to leverage the expertise and resources of these other systems to the benefit of persons with severe mental illnesses. Although the team's services are delivered by the community mental health center, the key players in the project also include judges, the county mental health director, the public defender's office, the district attorney's office, the probation office, and the jail services supervisor. An important element of this program is that the team members initially become involved when the client is evaluated at the jail and remain involved through the client's eventual transition to mainstream mental health treatment services.

Regular meetings. Various approaches for integrating services were observed among the programs, but the most effective programs held regular meetings of the key players. Among program directors, 63% considered regular meetings to be "very important" to the success of the diversion program. Two levels of meetings of key players often occur: (1) meetings of interagency administrative staff (e.g., judges, jail administrators, public defenders, and district attorneys) to discuss issues such as funding and staffing and (2) meetings of direct service providers to discuss individual treatment plans and other day-to-day activities of the program.

Five (38.5%) of the 13 diversion programs we visited hold regular meetings between key agency representatives to encourage coordination of services and sharing of information. Typically, these meetings begin in the early stages of planning and implementing the diversion program. In one program, weekly meetings are held to review inmates screened during the previous week and to decide who needs further evaluation. Members of the committee include a bail-bond/pretrial officer, a probation officer, a drug/alcohol specialist, a mental health caseworker, a judge, and a psychiatrist. The committee's weekly meetings keep criminal justice and mental health workers informed about what is going on, who is coming in and out of the jail, and which services are required.

Boundary spanners. Another way to encourage integration of services is to have a liaison or "boundary spanner" who directly manages the interactions between the correctional, mental health, and judicial staff.[14] Effective boundary spanning of these systems is accomplished in various ways among 8 (61.5%) of the 13 diversion programs we visited. One program created a staff position to link the community mental health center to the jail. Whether or not a specific position is created, an experienced person who has the trust and recognition of people from each of the systems is needed to bridge the three main systems involved in diversion. Among the program directors we interviewed, 44% reported that program staff were in contact with the district attorney's office from one to four times per month, and 54% reported that staff were in contact with a community-based case management agency daily or almost daily. The level of contact with courts among diversion program case managers who were interviewed was even higher; 60% reported contact with the district attorney's office from one to four times per month and with the public defender's office daily or almost daily.

In one program, the jail's forensic liaison was described to us as the "glue" that holds the various program components together. She acts as a link to detainees, shares information with other parties, meets with judges to discuss options, holds weekly meetings to develop plans for detainees at discharge, and

TABLE 2—Profile of Study Sites: A National Sample of Jail Diversion Programs

Program, by Size	Integrated Services	Regular Meetings	Boundary Spanners	Strong Leadership		Early Case Identification	Distinctive Case Management	
				Individual	Institutional		Cultural Diversity	Intensive
Large programs								
Program 1	Yes	Yes	Yes		Yes	Yes	Yes	
Program 2			Yes			Yes		
Program 3			Yes			Yes	Yes	Yes
Program 4	Yes	Yes	Yes			Yes		Yes
Program 5	Yes	Yes	Yes	Yes		Yes	Yes	Yes
Program 6	Yes		Yes		Yes	Yes		Yes
Program 7			Yes			Yes	Yes	Yes
Program 8	Yes	Yes	Yes	Yes		Yes	Yes	Yes
Small programs								
Program 1	Yes	Yes	Yes	Yes		Yes		
Program 2	Yes	Yes	Yes	Yes		Yes	Yes	Yes
Program 3			Yes	Yes		Yes		
Program 4	Yes		Yes			Yes		
Program 5			Yes			Yes		

Note. Although 18 sites were selected for on-site interviews based on perceived effectiveness and presence of a formal diversion program, it was later determined, upon observation, that 5 sites did not actually have a diversion program. These 5 sites are not included.

coordinates with the mental health system, psychiatric hospitals, and the probation office to move detainees through the system.

Strong leadership. A strong leader with good communication skills and an understanding of all system components and the informal networks involved is another important element, especially in smaller programs in which diversion is often dependent on the skills of a single individual. We observed five (38.5%) programs that had a particularly effective leader. In one case, the program director spent several months, prior to the start of the program, planning and networking in order to prepare both the criminal justice and mental health communities for diversion. Nearly everyone interviewed in this program praised the director for his unique ability to "sell" his program to a wide variety of people. The importance and difficulty of bridging the two systems were highlighted by a county mental health director who commented, "There are different sets of cultural relationships, and what works in the informal mental health system is the opposite in the formal criminal justice system."

In two sites, the jail diversion programs had become institutionalized. Support for the program was found at the highest administrative levels in multiple arenas: the judiciary system, jail administration, and the mental health authority. When leadership evolves from a single individual to broad-based institutional support, the long-term survival of the program is more likely to be realized. In order to begin an effective diversion program, it is necessary to have a strong leader who can involve the key players and can put all of the necessary pieces into place. On the other hand, as a result of the natural transitions any organization goes through, the diversion program must eventually become sufficiently institutionalized to outlive any particular individual.

Early identification. A crucial step in the diversion process is the early identification of detainees with mental health treatment needs who meet the diversion program's criteria. This is done through the initial screening and evaluation at the jail. Most detainees spend very short periods of time in jail and may not be screened for mental health problems, or these problems may be masked by drug or alcohol intoxication. It is important that persons who meet the program's criteria be identified and screened in the first 24 to 48 hours of detention. Screening and evaluation is usually a three-step process: routine medical screening at intake, more in-depth mental health screening within the first 48 hours of admission, and follow-up mental health evaluation when deemed necessary.[15]

All 13 diversion programs we visited had formal case-finding procedures for early identification of detainees in need of mental health services. Rapid and regular use of both the mental health and criminal justice information systems to learn more about an individual's prior criminal justice and mental health treatment histories is crucial for systematic case identification. In 8 of the 13 diversion programs visited, program staff can check a detainee's prior treatment history using a computerized management information system if the detainee is identified as having a need for mental health treatment. Similarly, program staff often check the daily roster of jail inmates to find clients and relink them to mental health treatment.

Case management. Research on the role of case management in the care of persons with mental illnesses has shown that, "for many clients, extended mental health treatment in concert with active case management is the key to keeping them out of jail."[13] Case managers perform various critical functions within jail diversion programs, including client identification and outreach, evaluation of a client's mental health service needs, direct consultation to the courts, development of an appropriate treatment plan, linking of clients with necessary aftercare services, monitoring of service delivery, client advocacy, and direct service provision.[16]

First and foremost, diversion case managers should have experience in both

mental health and criminal justice, with educational degrees being of lesser importance. When respondents were asked to describe the kind of case manager who works well in the diversion program, 56% considered knowledge and experience in both criminal justice and mental health to be ideal.

Traditional case managers with advanced degrees and specialized training may not be as valuable to a diversion program as someone with a variety of relevant criminal justice system experience and no college degree. When our respondents were asked about the type of education required for effective diversion case management, 44% said that no formal education was necessary. However, 60% considered specialized training to be important. For the most part, the knowledge and level of understanding needed when working with detainees who have mental disabilities are distinctive and require "hands-on" experience.

We found case management to be a component of diversion services in 8 (62%) of the 13 diversion programs visited. However, the case management we observed in 4 of the most effective programs was different from that offered by more traditional mental health programs. What distinguished these 4 programs were the cultural diversity of the case managers and the intensity of involvement with each client.

Qualified, culturally diverse case managers are among the most important components of effective diversion. A prime example of a program with such distinctive case management services was a court-based program with four case managers. The case managers, two women and two men, were each from a different ethnic group that was heavily represented among detainees in the county jail. Since ethnic and racial minorities are overrepresented in US jails, constituting 57% of the country's jail population,[1] diversion programs must be designed and implemented on the basis of the cultural experiences of the people they are meant to serve. Moreover, since English is not the primary language for many detainees, bilingual case managers are often essential.

The other factor that distinguished the case management in this program was the high level of involvement of case managers with each client. As discussed by Anthony and colleagues, "the linking activity is more than referring and forgetting. After the client has been accepted for service, the case manager monitors whether or not the client is being assisted and, if not, implements action steps to remove any barriers to service use."[17] For example, in one program we visited, case managers take clients from their court appearance to their mental health appointment on the same day and sit in the waiting room until clients are called in for their appointment. They also call each client to remind him or her of upcoming court dates, and, as time is available, they call to see how the client is doing. They may visit clients who have been arrested or institutionalized and provide transportation if a client needs help in getting to court.

Discussion

Jail diversion programs have various ways of defining diversion and defining their particular mission in terms of diverting mentally ill detainees from jail. For example, diversion in one metropolitan jail was defined as "anything that's done to reduce potential time in jail and replace it with involvement in the mental health system." In contrast, another program's definition of diversion was stated in terms of the following formal mission statement:

> To insure greater public safety and protection through a specialized, centrally-administered, community-based program for targeted mentally disordered offenders. This is accomplished through an intensive level of mental health treatment and supervision directed toward the prevention of reoffense.

At least one program had as its sole goal "keeping mentally disordered persons out of jail to prevent jail overcrowding and disruption," and this program seemed to accept no responsibility for whether follow-up services were actually received by the referred detainees. The program viewed treatment to improve the client's well-being as an issue for the mental health system rather than one for the jail. This perspective was rare among the diversion programs we visited.

In fact, discharge planning and follow-up were almost always seen as critical to the success of a diversion program. Effective jail mental health diversion did not end when the detainee left the jail. Nonetheless, very few of the programs we visited had specific follow-up procedures for diverted detainees. Even in instances in which careful attention was placed on linkage to community-based services, few programs had any mechanism to ensure that the initial linkage was maintained. However, several programs were working to ensure that once detainees with a mental illness left the jail, there was a place for them (through case management, residential placement, and outpatient services). In addition to the basic diversion services, these transitional programs help clients to locate permanent housing, develop life skills, and find suitable employment.

In many ways, this study of jail and court diversion programs for detainees with mental illnesses underscores the same principle as that of our earlier research on jail mental health programs: "the mentally disturbed jail inmate must be viewed as a community issue."[18] Diversion programs for detainees with mental illnesses will not work without coordination of appropriate services. The most effective diversion programs are those that are part of a comprehensive array of other jail services, including screening, evaluation, short-term treatment, and discharge planning (i.e., linkage), that are integrated with community-based mental health, substance abuse, and housing services.

In many ways, these core services for jail mental health diversion programs are quite similar to the key elements of good prison mental health programs. Obviously, the speed and duration with which screening, evaluation, and, especially, treatment need to be provided are quicker and shorter in jails than in prisons. However, there are direct parallels to mental health services for inmates in prisons and jails. This is particularly true with regard to the piece most often missing in both types of institutions: linkage to community-based services on release. In terms of long-term gain, institution-based correctional mental health services are doomed to failure without effective linkages to community-based services.

For jail diversion, these linkages are the essence of effective programs. Specifically, these programs do not simply keep people with mental illnesses out of jail. Their clients are seen as citizens of the community who require a broad array of community-based services, including mental health, substance abuse, residential, and social services. These programs recognize that individuals come in contact with the criminal justice system as a result of fragmented service systems, the nature of their illnesses, and the lack of social support and other resources. By organizing a comprehensive array of mental

health and other support services, diversion programs can break the unproductive cycle of decompensation, disturbance, and rearrest. □

Acknowledgments

This research was funded by a grant from the National Institute of Mental Health, Legal Studies Research Program (R01-MH48523).

The work of Sharon Steadman Barbera, Kristin P. Jones, Joseph P. Morrissey, PhD, and Annee Roschelle, PhD, during the data collection phases of this project and Bonita M. Veysey, PhD, during the analysis and write-up phases of the project is gratefully acknowledged.

References

1. Bureau of Justice Statistics. *Jail Inmates 1992.* Washington, DC: US Dept of Justice; 1993.
2. Teplin L. The prevalence of severe mental disorder among male urban jail detainees: comparison with the Epidemiological Catchment Area Program. *Am J Public Health.* 1990;80:663–669.
3. Teplin L. Psychiatric and substance abuse disorders among male urban jail detainees. *Am J Public Health.* 1994;84:290–293.
4. Bureau of Justice Statistics. *Jail Inmates 1990.* Washington, DC: US Dept of Justice; 1991.
5. Torrey EF, Stieber J, Ezekiel J, et al. *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals.* Washington, DC: Public Citizen's Health Research Group and National Alliance for the Mentally Ill; 1992.
6. Steadman HJ, Ribner S. Changing perceptions of the mental health needs of inmates at local jails. *Am J Psychiatry.* 1980;137:1115–1116.
7. Schlesinger M, Dorwart RA. Privatization of psychiatric services. *Am J Psychiatry.* 1988;145:543–553.
8. Rogers R, Bagby M. Diversion of mentally disordered offenders: a legitimate role for clinicians. *Behav Sci Law.* 1992;10:407–418.
9. Steadman HJ, ed. *Effectively Addressing the Mental Health Needs of Jail Detainees.* Seattle, Wash: National Coalition for the Mentally Ill in the Criminal Justice System; 1990.
10. Steadman H, Barbera S, Dennis D. A national survey of jail mental health diversion programs. *Hosp Community Psychiatry.* 1994;45:1109–1112.
11. Teplin L. The criminalization of the mentally ill: speculation in search of data. *Psychological Bull.* 1983;94:54–67.
12. Casey P, Keilitz I, Hafmeister T. Toward an agenda for reform of justice and mental health systems interactions. *Law Hum Behav.* 1992;16:107–128.
13. Cervantes NN, Kaulukukui M, Poulson J, Kaufman H. Diverting the mentally ill from a county jail. *Am J Public Health.* 1987;77:367.
14. Steadman HJ. Boundary spanners: a key component for the effective interactions of justice and mental health systems. *Law Hum Behav.* 1992;16:75–87.
15. *Psychiatric Services in Jails and Prisons: Report of the Task Force on Psychiatric Services in Jails and Prisons.* Washington, DC: American Psychiatric Association; 1989.
16. Rog D, Andranovich G, Rosenblum S. *Intensive Case Management for Persons Who Are Homeless and Mentally Ill: A Review of Community Support Program and Human Resource Development Program Efforts.* Washington, DC: Cosmos Corp; 1987.
17. Anthony WA, Cohen M, Farkas M, Cohen BF. Clinical care update: the chronically mentally ill: case management—more than a response to a disfunctional system. *Community Ment Health J.* 1988;24:219–228.
18. Steadman HJ, McCarty D, Morrissey J. *The Mentally Ill in Jail: Planning for Essential Services.* New York, NY: Guilford Press; 1989.