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The Cal-DSH diversion guidelines

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Abstract

The Cal-DSH Diversion Guidelines provide 10 general guidelines that jurisdictions should consider when developing diversion programs for individuals with a serious mental illness (SMI) who become involved in the criminal justice system. Screening for SMI in a jail setting is reviewed. In addition, important treatment interventions for SMI and substance use disorders are highlighted with the need to address criminogenic risk factors highlighted.

Introduction

Nearly three times as many people detained in a jail have a serious mental illness (SMI) when compared to community samples.[1]

Once an individual with SMI gets involved in the criminal justice system, they are more likely than the general population to stay in the system, face repeated incarcerations, and return to prison more quickly when compared to their nonmentally ill counterparts.[2] Confronted with this harsh reality, the inevitable question must be posed:

Is there a better way to intervene with individuals with an SMI who become involved in the criminal justice system?

By the 1970s, the concept of "diversion" emerged in response to the increasing number of individuals with a mental illness who became incarcerated. Diversion models attempt to identify those detained individuals with an SMI who may be better served outside the justice system through linkage to community-based treatment.[3] Although definitions of SMI may vary, the National Institute of Mental Health's definition of SMI typifies many organizations' definition and reads as follows:

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.[4]

Some states add specific diagnoses to the broader definition provided above. For example, the New York City jail system notes that jail inmates diagnosed with schizophrenia spectrum and other psychotic disorders, bipolar spectrum disorders, depressive disorders, and posttraumatic stress disorder all qualify for SMI.[5]

Diversion programs have a goal of decreasing criminal recidivism. Therefore, understanding why individuals with SMI become involved with criminal justice is critical to the success of diversion interventions. Two key theories have evolved to help explain the relationship of individuals with SMI to criminal offending. The first theory is known as the "criminalization of the mentally ill" hypothesis. According to this hypothesis, several factors increase the risk that individuals with SMI will be involved in the criminal justice system. These factors include stricter involuntary commitment laws with fewer psychiatric patients receiving inpatient care, poorly funded community mental health treatment services with undertreatment of mental illness, and the discharge of large numbers of psychiatric patients from psychiatric hospitals into the community with limited treatment resources.[6] Based on this "criminalization of the mentally ill" theory, untreated mental illness is the primary explanation as to why those with SMI are involved in the criminal justice system.

Table 1. Central Eight Criminogenic Risk Factors[10]

1.	Established criminal history
2.	Antisocial personality pattern
3.	Antisocial cognition
4.	Antisocial associates
5.	Substance abuse
6.	Employment instability
7.	Family problems
8.	Low engagement in prosocial leisure pursuits

Under this hypothesis, enhanced mental health programs were developed and included diversion programs, mental health courts, forensic assertive community treatment (FACT) teams, and reentry programs. These approaches have been called "first-generation" criminal justice interventions.[7] If a causal relationship between the lack of mental health treatment and criminal involvement by those with SMI exists, then programs primarily focused on treating mental illness would be expected to have fewer criminal arrests from persons enrolled in their program. Despite these first-generation diversion programs assisting in the treatment of individuals with SMI, the evidence does not indicate that these programs have had a lasting impact on decreasing criminal recidivism. Likewise, research evidence does not indicate that dual-diagnosis treatment programs for this population have resulted in a decrease in involvement in the criminal justice system.[6]

One noted concern is that the "criminalization of the mentally ill hypothesis" does not adequately explain or address nonclinical factors that result in individuals with mental illness becoming involved in the criminal justice system.[6] In fact, only 10% to 20% of criminal behavior committed by individuals with mental illness symptoms has been attributed to mental illness symptoms.[8,9]

Clearly mental health and substance use treatment are important components of any diversion program for individuals with an SMI. However, to further reduce criminal recidivism, is there another perspective that should be considered? The answer to this question is a strong "yes." More recently, research has emerged emphasizing the importance of risk factors for criminal justice involvement that play a primary role for both individuals with and without an SMI. This approach is known as the "criminogenic risk perspective."[6] Andrews and Bonta proposed a model known as the risk-need-responsivity (RNR) model, and this model has served as an important foundation for the criminogenic risk perspective. Under the RNR rehabilitation model, treatment interventions address each person's identified risks, their dynamic treatment needs, and their responsivity to treatment.[10] Eight criminogenic risk factors have been identified under the RNR model and are listed in Table 1.

The first four criminogenic risk factors listed in Table 1 are known as the "Big 4" as they have demonstrated the strongest relationship to future criminal offending.[10] These criminogenic risk factors are relevant to individuals with and without an SMI. The remaining four risk factors have a moderate, though less robust, association with criminal justice involvement. To further improve outcomes for individuals enrolled in diversion programs, addressing criminogenic needs in addition to utilization of evidence-based treatments for both mental illness and substance use is more likely to be effective than standard community mental health treatment alone. This combined intervention approach represents a "second generation" of services and is relevant for delivery of care at all stages of a person's involvement with the criminal justice system.[6]

An important component to assist in diverting individuals with SMI away from the criminal justice system is identifying various stages where alternative programs can be introduced to either prevent involvement in the criminal justice system or provide programming to keep persons with SMI from returning to jail or prison. One recognized model in identifying such intercepts is known as the Sequential Intercept Model (SIM).[11]

The SIM covers six different intercepts, numbered 0 to 5, each of which identifies an alternative solution or strategy that can be offered to divert someone with mental illness out of the criminal justice system (Figure 1).

The basic assumption of the SIM is that criminalization of the mentally ill can be curtailed by recognizing points of interception "at which intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system."[1] Early identification of psychiatric disorders allows individuals to be diverted into appropriate community care where symptoms can be treated and behaviors that invite criminal justice involvement can be reduced.

This continuum includes programs such as Crisis Intervention Training (CIT) to help police officers communicate and interact with individuals with mental illness (Intercept 1) to improved parole/probation contacts for individuals with mental illness (Intercept 5). Empirical studies of the interventions across the six intercepts demonstrate varying levels of effectiveness, with some community-based alternative services showing strong support such as FACT teams while others require further evaluation.

The SIM can also help guide policy development by providing a framework for stakeholders to understand what gaps exist in their provision of services and programs for individuals with mental illness and criminal justice involvement. Communities are encouraged to review local SIMs with pertinent stakeholders, including but not limited to county behavioral health departments, District Attorneys, Public Defenders, judicial representatives, probation, and local law enforcement. These stakeholders could utilize the SIM to assess and identify where improvements can be made in service provision to increase the likelihood of positive change with criminal justice-involved persons with mental illness.

This article aims to summarize 10 key aspects of suggested treatment goals and interventions for diversion programs that can be incorporated throughout the SIM stages to maximize treatment of diverted individuals and minimize their risk for future involvement in the criminal justice system. These treatment goals and the methods to achieve them are summarized in Table 2.

Obtain Housing

The rate of mental illness is higher in the homeless population than in the general population.[12] Providing stable housing for individuals in diversion programs is critical to their achieving success and to avoid a return to the criminal justice system. Literature identifies two major paradigms for providing housing to homeless individuals: the linear model[13] and the Housing First model.[14,15]

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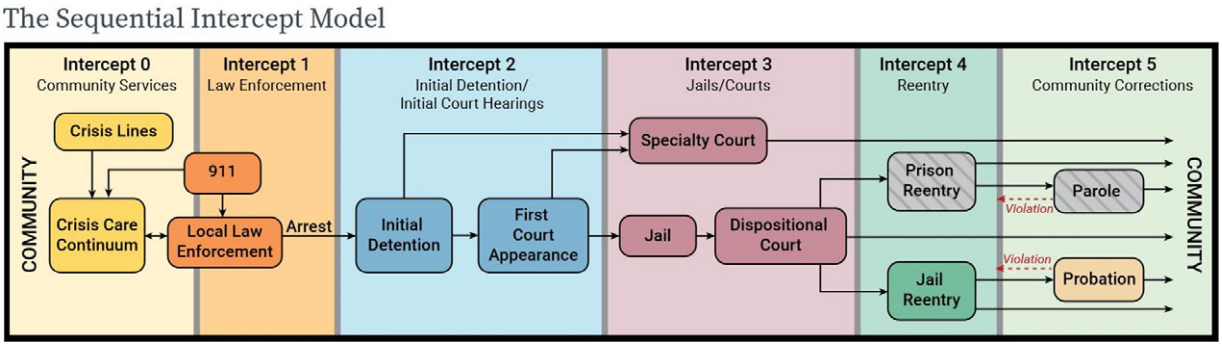

Figure 1. The intercept model.

Table 2. Ten Key Aspects of Diversion Treatment

Treatment goal	Methods
Obtain housing	Explore temporary vs permanent housing options
Prescribe appropriate psychotropic medications	• Continue or initiate evidence-based treatments for serious mental illness
	• Use long-acting injectable antipsychotic medications for treatment-responsive patients
	• Use clozapine for treatment-resistant patients as indicated
Treat substance abuse disorders	• Engage individuals in substance abuse treatment, using motivational techniques
	• Use pharmacological supports to reduce harm
	• Use peer supports to maintain engagement
	• Monitor individual's progress
Provide trauma-informed interventions	• Carefully screen for trauma history
	• Provide trauma-informed care (TIC) interventions throughout SIM stages
Address the "Big 4" criminogenic risk factors	• Use established scales to evaluate criminogenic risks and antisocial cognitions
	• Provide treatment targeted for antisocial personality patterns
	• Provide CBT-type treatments for antisocial cognitions
	• Encourage prosocial contacts and discourage antisocial contacts
Provide cognitive and social cognitive training	• Computerized interventions are inexpensive and easy to deliver with demonstrated efficacy
	• Adherence and engagement with these interventions can be monitored
Provide functional skills training and vocational rehabilitation	• Initially target skills required to sustain independent residence in the community
	• Enhance employment-related skills
Provide social skills training	• Recognize the importance of social interactions
	• Adopt a systematic social skills–training approach
	• Use social networks to reinforce progress in diversion
Provide family psychoeducation	• Provide relevant family members with education regarding mental illness, recognition of warning signs of relapse, and the association between relapse and reinvolvement in the criminal justice system
	• Enlist family members in patient monitoring and patient support
Utilize a court liaison	• Engage with diverted individual, the court, and community programs to maximize community success

Abbreviations: CBT, cognitive behavior therapy; SIM, Sequential Intercept Model.

The linear model provides temporary housing and operates along a continuum that includes emergency shelters and transitional housing programs, any of which may lead to independent housing. A key feature of the linear model is its requirement for individuals to maintain participation in substance abuse and mental health treatment.[16] In the linear model, individuals with mental illness who are reentering the community from hospitals, jails, or prisons are placed in a shelter or group homes first. The three basic types of group homes are transitional housing, supportive housing, and supported housing.[17] *Transitional housing* is a classic group home where the individual lives in one house or building with other residents and staff and is usually up to 24 months in duration.[18] The residents are supervised and receive medication assistance, daily living skills, meals, assistance paying bills, transportation, and treatment management. The goal is for residents to learn skills needed for independent living. *Supported housing* includes rental

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units in one location that typically maintain on-site around-the-clock crisis support services. Additionally, the residents have access to other off-site support. These residents can generally perform daily living tasks for themselves, but staff visit frequently. Residents in supportive housing can have part-time jobs or participate in a day treatment program. Supported housing consists of individual apartments that are part of the same program but not in the same location. The residents live mostly independently. They receive limited assistance and infrequent visits by staff members but can contact staff if needed. The linear model has been criticized for requiring sobriety and treatment engagement. Studies have found little or no evidence that these requirements affect outcome.[19,20]

The Housing First model provides permanent housing for individuals, but sobriety and participation in treatment are not requirements.[15] Two models of Housing First are *rapid rehousing* and *permanent supportive housing* (PSH).[21] Rapid rehousing is used for people and families to quickly obtain housing. In rapid rehousing, the housing may be initially temporary, but the goal is to provide services and keep the participants permanently housed. Housing First PSH is used more commonly with homeless individuals with substance abuse or/and severe mental illness. Housing First PSH is diverse from multiunit dwellings to scattered sites, and individuals live along with housing staff. Housing First PSH addresses mental health and medical needs through community-based teams such as ACT or intensive case management (ICM).[22] Sobriety or active participation in mental health treatment is not required so that if individuals relapse, they do not lose their housing. Housing is also put on hold for individuals if they leave housing for short periods of time.[23] Pathways to Housing in 1992 was the initial model for Housing First. Pathways to Housing was initially located in New York and required patients to pay 30% of their income and to participate in two case management visits per month.[23] Participants in the Housing First PSH achieved better housing outcomes and showed faster improvements in community functioning and quality of life than treatment as usual.[15] The improvement in community functioning and quality of life was seen in Housing First programs that used ACT[24] but not seen in those that utilized ICM.[25]

Prescribe Appropriate Psychotropic Medications

Diversion programs have been historically recognized to involve a critical transition of individuals from jails or detention centers to community treatment settings.[26,27] While many factors can affect the continuum of care of diverted forensic patients, eg, communication of information among involved clinicians, timely transmission of relevant documents, active coordination of services, etc., availability of formularies aligned with respect to pivotal medications such as clozapine and long-acting injectable (LAI) antipsychotics and coordinated pharmacy services plays a central role in patients continuing to receive appropriate medications.[28] A critical element in the successful completion of such transfers and continued stability of the diverted patient's mental disorders is the ongoing availability of the pharmacological agents that provided stabilization of the patient, including long-acting second-generation injectable antipsychotics. Formulary restrictions that restrict the use of evidence-based medications may result in greater rates of decompensation and greater long-term costs.[29] Indeed, failure to continue medications has been identified as the most common cause of relapse among persons suffering from chronic mental illness.[30]

Mood stabilizers, antipsychotic medications, and antidepressant medications are the mainstay medications when considering likely diagnoses in diverted individuals. In their study of New York's jail diversion program, Gill and Murphy reviewed the diagnoses in all individuals diverted from jail over a 5-year period. The most common diagnosis was bipolar disorder (40%), following by schizophrenia or schizoaffective disorder (33%), depression (17%), and anxiety (5%). The authors also found that 57% met criteria for a dual diagnosis of either drug and/or alcohol diagnosis.[31] Overall, schizophrenia spectrum disorders (schizophrenia, schizoaffective disorder) and bipolar I disorder, combined with substance use disorders, are the most prevalent diagnoses enrolled in diversion programs; therefore, treating clinicians must have expertise in managing these disorders using evidence-based options.[32]

Schizophrenia spectrum and other psychotic disorders afflict the bulk of chronically mentally ill individuals who are arrested and jailed.[33] Thus, antipsychotic medications form the core of pharmacological treatment in diverted forensic populations.[34] Unfortunately, adherence to oral antipsychotics in outpatient settings, even when defined as taking only 80% of prescribed doses, is consistently less than 50%.[35,36] Due to enhanced adherence, LAI antipsychotics have proven superior to their oral counterparts in reducing crime and violence.[37–40] Obtaining plasma antipsychotic and mood stabilizer levels can also assist the practitioner in monitoring compliance as well as adjustments to assist in achieving a therapeutic response.

An estimated 30% of schizophrenia spectrum patients are deemed treatment resistant by having failed to respond adequately to two nonclozapine antipsychotics despite verified adherence; moreover, recent community samples indicate that up to 50% may be classified as having treatment-resistant schizophrenia.[41,42] Clozapine is an essential medication for stabilizing patients with treatment-resistant schizophrenia and schizoaffective disorder.

In these treatment-resistant schizophrenia patients, the response rate to clozapine is approximately 50%, while response rates to other antipsychotics are under 5% and for olanzapine, 7% to 9%.[43] Clozapine also has data supporting use in treatment-resistant mania associated with bipolar I disorder and for reduction in suicidality and treatment of persistent aggression in schizophrenia spectrum patients.[44–46] In addition, research data demonstrate that extended delays in clozapine prescribing are also associated with decreased response rates.[47] Moreover, jurisdictions that demonstrate a persistent pattern of clozapine underutilization also risk administrative or legal actions from overseeing bodies or patient advocacy groups.[48]

A complete discussion of all aspects of clozapine prescribing, monitoring for and treatment of hematological and nonhematological adverse effects, is extensive and beyond the scope of these guidelines. For this reason, the reader should consult published resources[49] and consider registering at smiadviser.org to receive answers to clinical questions.

Treat Substance Abuse Disorders

As summarized above, in their 5-year study of inmates diverted from New York county jails to the community, 57% had a co-occurring alcohol and/or drug diagnosis.[31] This high rate of co-occurrence further complicates the treatment needs for individuals interfacing with diversion programs and plays a significant role in a person's entrance into and successful diversion from the criminal justice system. Due to the intricate nature of factors that either contribute to or are the result of substance abuse, treatment is

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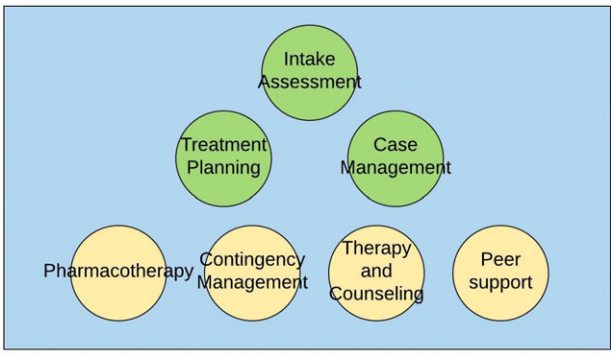

Figure 2. An integrated approach to substance abuse treatment.

often multifaceted, as shown in Figure 2 below as adapted from the National Institute on Drug Abuse.[50]

Many of these areas are consistent with general approaches to providing comprehensive, wrap-around treatment of diversion participants: intake processing/assessment, clinical and case management, and overall treatment planning. Unique factors specific to targeting substance use include pharmacotherapy, contingency management (CM) interventions, therapy/counseling, and self-help/peer support group.[50] Best practices for each of these four categories are described below, but note that a multisystemic, multipronged approach (such as medication-assisted treatment for opioid use disorder) [51] shows the greatest efficacy in improved treatment outcomes.[52]

Pharmacotherapeutic interventions can be used to supplement psychosocial treatments depending on the diverted individual's drug of choice. Specifically, practice guidelines have been developed for practitioners treating individuals with opioid use disorders.[53] Readers are referred to these guidelines, given the nuanced recommendations for the use of methadone, buprenorphine, and naltrexone. Similarly, Connor and colleagues[54] produced guidelines for use of medications in the treatment of and abstinence maintenance of alcohol use. This document reviews the efficacy of medications for acute management of withdrawal (ie, benzodiazepines) and relapse prevention (naltrexone, acamprosate, and disulfiram).[54] Of note, in the early intercepts of the SIM, individuals with a substance use disorder may be at an increased risk for withdrawal. Therefore, particularly attention should be given for appropriate detoxification to enhance the diversion candidate's willingness to take advantage of diversion options.

In addition to substance treatment programs and pharmacological interventions, contingency approaches also may be used to support substance abuse rehabilitation. CM interventions are the provision of tangible, voucher, or monetary incentives/rewards when an individual demonstrates objective behavioral goals. This could include, for example, provision of gift cards to a local grocery store when a person has negative urine drug screenings. A thorough review of 69 studies examining CM for various substance use disorders found moderate to large effect size.[55] These findings were consistent with previous meta-analyses of CM interventions which found interventions to be efficacious in decreasing substance use during and, to a lesser degree, after treatment cessation.[56,57]

Therapy and counseling should adhere to principles of Motivational Interviewing and the Stages of Change Model,[58] especially when treated individuals also experience severe mental illness.[59] These principles include assessment and recognition of the different phases of a person's decision-making when considering behavioral changes in their substance use: precontemplation, contemplation, preparation, action, maintenance, and termination. Using Motivational Interviewing in individual therapy sessions can reduce the frequency of a person's substance use compared to those who do not receive Motivational Interviewing techniques.[60] Traditional cognitive-behavior therapy (CBT) interventions have also been found to improve outcomes for individuals with substance use disorders including decreased substance use,[61] as have other CBT-based treatment modalities such as Acceptance and Commitment Therapy[62] and Dialectical Behavior Therapy.[63]

An important CBT-like approach treatment for individuals with a stimulant use disorder, such as methamphetamine, is known as the Matrix Model. The Matrix Model derives from the National Institute on Drug Abuse and Substance Abuse and Mental Health Services (SAMHSA) blended treatment approach that combines CBT in individual and group settings along with 12-step program participation and Motivational Interviewing. This 16-week program follows manualized therapy and has demonstrated efficacy in decrease of methamphetamine use.[64]

Peer support also plays an important role. Outcomes research shows positive outcomes for peer support in substance use treatment but acknowledges that most studies lack strong scientific rigor.[65,66] Nonetheless, existing studies show promising outcomes using "peer coaches," "peer support staff," and/or "substance abuse peer counselors" to deliver either short-term or long-term interventions with targeted populations.[65] The use of peer support services also appears to be embedded in many larger service-based provisions programs, as a means of developing more consistent, long-term relationships to aid in the treatment of chronic substance abuse conditions.[67] Additionally, 12-step recovery programs have been shown to be effective in decreasing substance use in 3-year longitudinal studies,[68] highlighting the importance of social support as a protective factor in relapse prevention.[69]

Provide Trauma-Informed Care

Recent studies show 88% to 96% of men and women already in jail diversion programs reported significant trauma history prior to incarceration.[70,71] According to the SAMHSA, trauma is "an almost universal experience among people who use public mental health, substance abuse, and social services, as well as people who are justice-involved or homeless."[18] Multiple studies demonstrate that a significant number of individuals with an SMI also warrant a diagnosis of posttraumatic stress disorder (PTSD), although a minority are diagnosed with any trauma-related co-occurring disorder. Underrecognition of PTSD in the presence of a "primary" psychiatric disorder is common. In one multisite study, 43% of 275 patients with SMI qualified for a diagnosis of PTSD upon evaluation, but only 2% were identified with the disorder per the medical record.[72]

Diagnosis of PTSD in the presence of a serious psychiatric disorder can be challenging. Severe trauma symptoms may be misinterpreted as evidence of personality disorder and/or psychosis. Additionally, trauma symptoms may exacerbate expression of comorbid conditions: co-occurring PTSD has been associated with increased psychopathology, positive symptoms, neurocognitive impairment, and lower general functioning and quality of life in patients with schizophrenia.[73]

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The link between trauma exposure and poor mental health outcomes is supported by research across various healthcare settings. In individuals diagnosed with SMI, trauma is associated with increased symptom severity, relapse, comorbid substance abuse, violence risk, and worsened prognosis over the long-term. A growing body of research also reveals a relationship between early trauma and later violence. A recent meta-analysis, for example, indicated that individuals with psychosis and histories of maltreatment in childhood were twice as likely to be violent as psychotic individuals lacking that history.[74]

Some traumatized SMI persons engage in behaviors that have developed over time as survival strategies or fear responses, which may take them to unwanted contact with the criminal justice system.[75–79] Applied to diversion, a trauma-informed lens offers the opportunity to identify and address trauma-related sequelae that may contribute to individuals' psychiatric and behavioral instability, substance use, poor treatment response, relapse, unwanted contact with law enforcement agencies, recidivism, and other poor outcomes. Embedding TIC principles into the intercept model can alleviate the effects of trauma on individuals, minimize retraumatization, and stem the flow of individuals with SMI into the criminal justice system by addressing primary or contributory sources of problem behavior.

Systems that fail to recognize and acknowledge the role of trauma contribute to retraumatization, disengagement, relapse, behavioral incidents, and an overly criminalized view of multiply-determined behaviors. Broad-based benefits have been demonstrated in settings where relationship-based care is provided in a trauma-informed milieu and supported by congruent policies and procedures. TIC experts therefore advocate for a comprehensive approach that informs screening, assessment, crisis intervention, treatment programming, risk management, milieu development, and provision of primary medical care.

SAMHSA's Treatment Improvement Protocol defines TIC as "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and one that creates opportunities for survivors to rebuild a sense of control and empowerment."[80–82] In trauma-informed systems, the impact of trauma is recognized at all levels, and proactive policies/procedures are employed to mitigate harm and reduce the risk of retraumatization. TIC is associated with improved mental health outcomes, more effective behavior management, and enhanced safety for consumers and their care providers. Specifically, implementation of TIC has been linked to marked reductions in violence, fewer containment-related injuries, less frequent use of seclusion and restraint, and increased positive outcomes in public and private mental health settings. For example, a review of TIC programs found: reduced utilization of seclusion and restraint; reduced use of sedative hypnotics; improved measures of patient stress; increased patient satisfaction, compliance, and participation rates; decrease in trauma-related symptoms; increased effectiveness of coping skills; and decrease in substance use/sexually risky behaviors after trauma-informed practices were adopted across various settings.[83]

In recent years, SAMHSA established the GAINS Center for Behavioral Health and Justice Transformation to provide information and skills training at local, state, and national levels. The overarching goal of the center is to enhance partnerships between the mental health and criminal justice systems to avoid retraumatizing individuals, increase community safety, reduce the risk of criminal recidivism, and link individuals with trauma-informed services and treatment.

Address the "Big 4" Criminogenic Risk Factors

As highlighted in the introduction, criminogenic factors play a substantial role in reoffending behaviors of individuals involved in the criminal justice system. The four criminogenic risk factors with the greatest association with recidivism are known as "The Big 4." Brief definitions of these criminogenic risk factors and suggested evaluation/interventions are summarized below[10,84]:

1. Established criminal history—This factor includes a person's past criminal history.

Intervention: As the best predictor of future behavior is past behavior, the evaluator should review self-reported history of law violations and aggression, Record of Arrests and Prosecution (RAP) sheets, and obtain collateral information from third parties (ie, family or other knowledgeable persons) to gain as accurate understanding as possible of a person's criminal past. Reviewing factors that increase the risk of future violence should be noted and include age of offending onset, diversity of offending behaviors, and failing probation and/or conditional release.

2. Antisocial personality pattern—Andrews, Bonta, and Wormith (2004) describe the individual with this criminogenic factor as one who has poor self-control, is aggressive, and focuses on self-pleasure.[85]

   Intervention: Provide programs that focus on problem-solving, anger management, and impulse control along with interventions that address problematic personality traits.[84]

3. Antisocial cognition and antisocial associates—These individuals have attitudes that support their criminal behavior, and they generally feel justified in violating the law or the rights of others. They may also feel entitled to special treatment or material items that they want and often interpret innocent comments as threats.[84,85]

   Interventions: Evaluators should consider using self-report instruments to help assess antisocial cognition. Two known scales include the Psychological Inventory of Criminal Thinking Scale (PICTS) and the Criminal Sentiments Scale.[84] Morgan et al utilized these scales to evaluate the percentage of inmates with mental illness that endorsed antisocial cognitions. They found that 66% of this sample self-reported thoughts and attitudes that supported a criminal belief system, indicating that this way of thinking is very common in offenders with mental illness.[86] Providers should implement CBT programs that address the criminogenic thinking in individuals who have antisocial cognitions. Validated CBT programs for this purpose include Reasoning and Rehabilitation,[87] Moral Reconation therapy,[88] and Thinking for a Change.[89]

4. Antisocial associates—Spending time with other individuals involved in criminal behavior.

   Intervention: Clinicians can work with diversion participants to identify primary social networks that may include antisocial associates and work to develop a network of people who engage in prosocial behavior. Some diversion programs also utilize

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prosocial peers as part of the support and programming for enrolled individuals.[84]

Provide Cognitive Rehabilitation

Individuals with SMI commonly find themselves trapped in an extended cycle of arrests, incarceration, abbreviated psychiatric treatment, release to the community, and rearrest. Unaided, this cycle is often very difficult for SMI individuals to break. The cycle requires completion of complex legal tasks, adherence to psychological treatments, and coordinated improvements in psychosocial organization to reassure the criminal justice system that the individual can safely return to living in the community. Unfortunately, individuals with SMI typically have cognitive and social cognitive deficits that impede them from securing and then sustaining the requisite supports to extricate them from the criminal justice system. Research has demonstrated that after adjustment for premorbid intellectual functioning, essentially everyone with schizophrenia shows some degree of cognitive impairment.[90,91] For individuals with SMI in the criminal justice system, there are major problems associated with having decreased cognitive abilities, including reduced effectiveness of evidenced-based psychosocial treatments,[92,93] reduction in community functioning,[94,95] and increased aggressive behaviors.[96]

Social cognition describes an individual's cognitive abilities to understand, process, and respond to social situations. These core abilities have been parsed in various ways, but most theories approximate the model put together by Horan, Roberts, and Holshausen,[97] which describes the major domains of social cognition as emotion processing, social perception, mentalizing (theory of mind), and social cognitive bias. Social cognitive deficits, commonly seen in SMI individuals, are associated with impairments in various community outcomes, including independent living, relationships, obtaining and maintaining work, and engaging in recreational pursuits. The main influence of social cognitive deficits is in the domain of interpersonal functioning. As criminal justice involvement typically involves interpersonal challenges, social cognition is a critical treatment target. Further, social cognition and neurocognition are closely linked,[98] but nearly all domains of social cognition exert influences on social outcomes beyond the influences of neurocognition. Social cognitive deficits can contribute to aggression[99,100] and subsequent risk for involvement in the criminal justice system. In addition, O'Reilly et al[101] found that when social cognition is looked at in conjunction with neurocognition, social cognition has an independent effect on aggression and also mediates the relationship between neurocognition and aggression.

Computerized cognitive training (CCT) is now widely accepted as having efficacy for improving cognitive performance in schizophrenia. Several studies have suggested that CCT can reduce violent incidents, even in forensic populations. These interventions, like virtual reality assessments, can be administered by individuals with reduced levels of professional credentials. Further, these interventions are very low cost, as subscriptions for individuals receiving training cost less than $10.00 per month on average.

Social cognitive training is also available in computerized formats as well as in person manualized treatment strategies. Social cognitive training has also been shown to be associated with reductions in violent behavior on the part of people with severe mental illness. In addition, combining social cognitive and CCT has been shown to lead to greater benefits in both domains compared to either intervention alone. This is likely because social cognitive tasks also require neurocognitive skills and that enhancement of these skills may speed the acquisition of the typically more complex social cognitive tasks. Computerized social cognition training (CSCT) interventions have the benefits of convenience and coadministration with CCT.

Provide Functional Skills Training and Vocational Rehabilitation

Functional skills training has typically been delivered in person, such as in supported employment programs, social skills training, and other teach-type interventions such as functional adaptation skills training (FAST). While these interventions may be feasible in forensic inpatient settings, the lack of access to these interventions on an outpatient basis is one of the major clinical problems in the treatment of severe mental illness. It is estimated, for example, that less than 1% of the people with schizophrenia in America are enrolled in Individualized Placement and Support (IPS), the best evidence-based strategy to support work outcomes. Skills training interventions are often unavailable in community settings, and some state departments of vocational rehabilitation are unavailable to individuals with SMI. This deficiency should be corrected because it is well known that working is associated with better outcomes in many domains, including substance abuse, homelessness, psychotic symptoms, cognition, and relapse. Although there are technology-based interventions available to improve functional skills, they are not commonly used in jail diversion programs.[102]

Vocational rehabilitation has been one of the mainstays of community-based treatment for SMI and with good reason. In reviews of SMI individuals engaged in vocational rehabilitation programming, results indicated an improvement in global functioning, reduced depressive symptoms, increased self-esteem, and improvement in quality of life.[103–105] Results have not only been seen on assessment instruments but also in the experience of the individuals with SMI. When individuals with schizophrenia were surveyed about what would define recovery, 62% reported that independence in self-care and returning to work as the factors most important to them. Further, the majority of SMI patients report a desire to work.[106] In addition, work by itself has been shown to be beneficial for cognitive abilities as people age or go through a debilitating disease.[107]

Despite the benefits that come from vocational rehabilitation, the employment rates for SMI individuals remain relatively low.[108,109] In a systematic review of the barriers for SMI individuals involvement in vocational rehabilitation, Tsang et al found that cognitive functioning was a significant predictor for enrollment and success within vocational rehabilitation services.[110] Liberman and Green also described information processing problems as "rate-limiting" factors in successful social and occupational functioning.[111]

To address the role that cognitive deficits have in vocational rehabilitation, many clinicians and researchers have employed cognitive remediation programs to improve outcomes in vocational rehabilitation settings. Van Duin recently completed a meta-analysis of combined cognitive remediation and rehabilitation programs.[112] Results indicated significant improvement in employment rates, hours worked, job duration, and quality of performance in work. One of the most important studies on cognitive remediation and supported employment demonstrated that the addition of cognitive rehabilitation to supported

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employment interventions increased hours worked, wages earned in a competitively obtained employment.[113]

Provide Social Skills Training

Social skills reference how individuals interact with each other. Societies develop their own general guidelines as to what is considered normal or socially sanctioned behaviors. Such behaviors run the gamut of human interaction and involve how a person talks, what they say, how they express their emotions, and even what interpersonal distance is considered appropriate.[114] Although a range of mental disorders can impair the individual's social skills, social dysfunction in schizophrenia is very common, fairly stable across the lifetime, and often remains when other symptoms are stabilized such as hallucinations and delusions.[115] Social skills deficits account for a large variance in a person's ability to fulfill meaningful roles, such as the ability to establish and maintain social and intimate relationships and sustain employment.[114,115] Some examples of these social deficits may include difficulty with conversations, trouble expressing one's needs, and in interpersonal behaviors that others may consider odd.

Two specific treatment recommendations to assist with social skills for persons diagnosed with a schizophrenia spectrum disorder are social skills training (SST) for Schizophrenia and Cognitive Behavioral Social Skills Training (CBSST) for schizophrenia. The Schizophrenia Patient Outcomes Research Team (PORT) and the US Department of Health and Human Services recommend SST and CBSST as evidenced-based psychosocial interventions for schizophrenia.[22]

SST is an evidence-based practice for improving social functioning for people with schizophrenia and related severe mental illnesses. SST is based on social learning theory. It is a structured format for teaching interpersonal skills that incorporate modeling, roleplays, and other behavioral learning activities. SST is skill-based and designed to create a fun and supportive environment. SST targets three interrelated functions: (1) social perception: the ability to accurately perceive social cues, (2) social problem solving: the ability to correctly analyze the social situation and identify an effective response, and (3) behavioral competence: the ability to effectively implement the response. SST covers nine key social skills, which include (1) basic social skills, (2) conversation skills, (3) assertiveness, (4) conflict management, (5) communal living, (6) friendship and dating, (7) health maintenance/communicating with provider, (8) vocational/work, and (9) coping skills for drug and alcohol use. Within these nine broad categories are very specific practical exercises. The approach has followed the same format since its inception.

CBSST is a newer treatment than SST developed in the early 2000s. CBSST is a recovery-oriented psychosocial rehabilitation intervention targeting improved functioning and negative symptoms that combines cognitive behavioral therapy (CBT), SST, and problem-solving.[116] Taking into consideration the potential efficacy of both CBT and SST for schizophrenia, a combined approach was developed. CBSST is a manualized treatment with three modules: Cognitive skills, social skills, and problem-solving. Each module begins with a goal setting session, and the modules are six sessions in length. For many patients, completing the treatment program twice is recommended.[117]

There continues to be ongoing research on CBSST. More recently, CBSST was implemented individually within assertive community treatment (ACT) teams in San Diego County Mental Health System and two private multiservice behavioral health agencies located in the southwestern metropolitan area.[116,117] Publications thus far on this integration of services have focused on treatment implementation factors. Recent research on implementing CBSST on ACT teams offers some additional implementation strategies. Researchers assessed how well CBSST and ACT were expected to fit using the Tool for Integrating Multiple Interventions (TIMI).[117] The TIMI looks at six intervention domains to determine how likely services are to align. These six domains include: (1) Target population, (2) intervention content, (3) frequency/duration, (4) context/setting, (5) service delivery format, and (6) primary outcomes. Findings from stakeholder feedback suggest that it is crucial to access structural fit of CBSST within the ACT model and warrant modifications as needed and that the implementation must have organizational support.[117] This research study highlighted the importance of tailoring to specific systems and organizations. This includes the needed elements for successful implementation: leadership buy-in, effective embedding mechanisms, flexibility, training supports, and adaptations to the practice and system when needed. These implementation recommendations are likely beneficial for the integration of varied interventions.[118]

Provide Family Psychoeducation

Family psychoeducation (FPE) is an umbrella term describing one facet of family involvement in the treatment of mental illness. Unlike family therapy, FPE targets the illness itself rather than the family as the focus of treatment.[119] The foundation of FPE is a collaboration between consumer, family, and professional aimed at assisting the consumer in his/her recovery. The goal is to equip families by teaching day-to-day skills for managing mental illness and providing support on topics such as grief and burden.[120] FPE models vary from brief to long term and between single family or multifamily formats. Sessions typically involve education about mental disorders, early warning signs, and relapse prevention strategies, as well as skills coaching in the areas of goal setting, communication, coping, and problem-solving.[121,122] Other family education programs exist which are peer-led rather than facilitated by treatment professionals, such as the National Alliance on Mental Illness (NAMI) Family-to-Family program available throughout the United States.[121,123] Programs of this nature, in combination with professionally led FPE, should be included in any program designed to maintain people with mental illness in the community.

For individuals with serious and persistent mental illness, FPE and support can be effective complementary interventions to decrease the risk of psychiatric relapse.[124] A meta-analysis reviewing 53 randomized or quasirandomized control trials found that family interventions for people with schizophrenia can not only decrease psychiatric relapse but may also reduce hospital admissions and improve medication compliance.[125] These findings are likely generalizable to a diversion setting for individuals treated in the community with family members or caregivers willing to participate. Although initial FPE and support studies in the 1980s and 1990s indicated the primary goal of this treatment was to decrease high expressed emotion,[126] recent adaptations move toward a CBT-based model of providing family members with coping, communication, and problem-solving skills.[127] Additionally, recent literature review suggests pairing supportive interventions from both professionals and family members with lived experience (eg, NAMI) may provide the most overall benefit.

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Utilize a Court Liaison

The role of a court liaison can vary tremendously depending on the unique factors of any given court. Broadly, a court liaison engages with diverted individuals to facilitate engagement in mental health treatment with the ultimate goal of remaining out of the criminal justice system.[128] In some courts, a liaison functions independently with limited engagement aside from providing treatment resources. Alternatively, court liaisons can be embedded within larger diversion programs and/or function on interdisciplinary teams, eg, FACT teams, providing in-depth wrap-around services to diverted individuals.[129]

Steadman coined the term "boundary spanner" to highlight the important role that mental health professionals can play in bridging communications between the court clinic's and mental health professionals in the community.[130]

General tasks of a court liaison include organizing and ensuring communication of court activities to diverted individuals. Other administrative tasks can include providing referrals for housing, employment, substance abuse treatment, mental health treatment, or any other social services that could improve a diverted individuals' quality of life.[128] There is no specific discipline or minimum level of education/classification for a court liaison, but a working knowledge of the law, court proceedings, and mental health services is imperative. Programs often utilize social workers and/or staff associated with local law enforcement to serve in court liaison positions.[131]

Holistic defense programs are an expanded and comprehensive variation of court liaison utilization. Counties that support holistic defense programs offer interdisciplinary teams to provide both legal and social services[132] to provide stabilization. In these programs, a clinician (ie, social worker) pairs directly with a public defender to provide services to support individuals in the criminal justice system. These services could include provision of employment support, housing, and social service linkages. Outcomes studies have found that holistic defense programs support safe release of individuals into the community without increasing recidivism rates and decreasing taxpayer costs for jail days.[128]

Community Management and Support of Diverted Individuals

The range of services and interventions outlined above represent general approaches for diversion programs with the dual goal of decreasing the mental health distress burden and risk for future offending of those diverted. These services can be provided through ICM, ACT, or some combination of both.

ICM for severely mentally ill individuals has its origins in two models of care: ACT and case management.[133] In ICM, the services are provided by a single case manager, while in ACT, the services are provided by an interdisciplinary team.[134] The goal of ICM is to provide community-based services to prevent hospitalization to patients that are more functional than those receiving services with ACT. An intensive case manager typically has a small case load of patients and is responsible for assessing the patient's needs, developing a plan of care, and connects the patient with community services. The case managers usually see their patients frequently, as determined by their current clinical needs. ICM aims to develop the patient's functional autonomy, personal skills, social skills, and community living. When ICM is compared to standard care, ICM reduces hospitalizations, improves social function, and increases patient involvement with care, but it is less clear what effects it has on mental state and quality of life.[135] A strong case manager–patient alliance appears to be associated with reduction of symptoms and improved global functioning.[136] Forensic Intensive Case Management (FICM) provides the same services as ICM but has the additional goal of preventing the patient from having further involvement with the criminal justice system.[137]

ACT is an outpatient evidence-based program for chronically ill, often severely ill, mental health patients.[134] In many settings, ACT programs dedicated to the criminal justice population are termed FACT programs. Overall, however, ACT is the most common name for this outpatient, multidisciplinary, individualized, holistic, and intensive intervention for severely ill mental health patients with criminal justice involvement.[138]

The ACT model consists of a multidisciplinary team that works together and provides services around the clock to severely mentally ill individuals who are at high risk for relapse, rehospitalization, and housing instability.[138] The ACT teams are mobile and usually include a psychiatrist or other licensed prescriber, a nurse, and several master level clinicians or psychologists. The team provides community-based services, in which they collaborate closely and have low staff-to-patient ratios. Services provided by the team include treatment of the psychiatric disorder, treatment of medical illnesses, support with practical living needs, rehabilitation, and psychosocial interventions. The team ensures that the patient receives the appropriate treatment for their psychiatric disorder, often involving adherence to psychotropic medications. The team also addresses co-occurring substance use disorders. The team nurse collaborates closely with primary care to treat the patient's medical comorbid illnesses. Practical living services include helping and teaching the patient to pay bills, shopping for food and clothing, using public transportation, and maintaining their residence. Psychosocial intervention includes social skills training and managing living with mental illness.

The goal is to maintain the patient living in the community and receiving community-based treatments. The team typically meets daily to discuss the needs and progress of each patient. The team then prioritizes which member will be seen based on severity of symptoms and functional capacity. The ACT team provides services 24/7 and has contact with the patients usually daily but at least weekly. As noted above, an adaptation of ACT that is used with justice-involved patients is called FACT. One approach that has gained significant support examines not only the patient's mental health needs but also their specific criminogenic needs and risks. This dual-targeted approach matches the patient's intensity of services to the most prevalent treatment goals present: clinical impairment or criminogenic behaviors.[139] Studies have shown that after participation in ACT, the rates of ambulatory mental health follow-up increased while rates of psychiatric inpatient hospitalizations decreased.[140] ACT patients have fewer convictions for new crimes, less time in jail, and more time in outpatient treatment among justice-involved patients than those receiving treatment as usual.[141]

Summary

Diversion programs represent a meaningful opportunity to improve the lives of individuals with SMI involved in the criminal justice system as well as decreasing unnecessary and potential harmful incarcerations. Because individuals of color are drastically overrepresented in all stages of the criminal justice system, diversion programs should pay attention to any bias against the selection of minorities to participate in diversion programs.[142]

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Table 3. The Stepping Up Initiative Key Questions

1.	Is our leadership committed?
2.	Do we conduct timely screening and assessments?
3.	Do we have baseline data?
4.	Have we conducted a comprehensive process analysis and inventory of services?
5.	Have we prioritized policy, practice, and funding improvements?
6.	Do we track progress?

As diversion programs have evolved, the need for multimodal interventions in addition to good mental healthcare has become clear. In addition, counties should consider the six questions noted in Table 3 provided by The Stepping Up Initiative when developing diversion programs.[143]

At first blush, some of the various treatment interventions outlined above may not appear precisely related to the treatment of diversion candidates. However, being familiar with a wide range of evidence-based treatments for treating individuals with SMI is important to ensure that a "one size fits all" approach does not become the diversion default.

Progress has been realized by diversion programs yet more progress can be achieved. First- and second-generation research give directions that are critical to moving forward. Our guidelines utilize 10 key principles that serve as a roadmap to help achieve that desired destination—a diversion program that works to improve the life of individuals with SMI and diversion approach that reflects a society willing to treat the vulnerable with dignity and hope.

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