




Advocates
Caring Partners. Creative Solutions. Better Lives.

Advocates
Jail Diversion Program
A Step-by-Step Toolkit

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Diane Gould
President and CEO

In 1992, the National Alliance for the Mentally Ill (NAMI) and Public Citizen's Health Research Group released a report entitled *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*, which revealed alarmingly high numbers of people with serious mental illnesses incarcerated in jails across the country. Jump ahead ten years to 2002 when the *Criminal Justice / Mental Health Consensus Project Report* was released and reported that little had changed in how people with mental illness were treated in the criminal justice system. This unprecedented report went on to outline specific recommendations that local, state, and federal policymakers and criminal justice and mental health professionals, could use to improve the criminal justice system's response to people with mental illness.

In responding to this perfect storm of advocacy groups increasing public awareness and funders and legislators seeking solutions, we were fortunate to have in the Town of Framingham, the right people in the right place at the right time. In 2003, Advocates in collaboration with the Framingham Police Department launched the first Jail Diversion program in the state of Massachusetts. At the heart of our model is the relationship between the police personnel and the emergency clinical responders. Our model of cross training, co-location, and jointly responding to calls builds true system integration, effectively diverts people with mental illness from the criminal justice system, and is cost effective. In our 12 years of operation at the Framingham Police Department, we have diverted over 1,500 people from the criminal justice system to treatment. We currently operate Jail Diversion programs in seven communities and have adapted this model to deliver services regionally. Our model has been recognized as best practice by two state Governors, several legislators, funders, and advocacy groups.

With this guide, we extend our knowledge to other communities with the hope that this model can be implemented in other willing communities.

We give special thanks to our partners at the Framingham Police Department and our original funders whose foresight into the treatment of people with mental illness in the criminal justice system was crucial for that fledgling program. We also wish to thank Senator Karen Spilka who has championed this model in the legislature alongside the Department of Mental Health who currently funds Advocates' Jail Diversion Program and other models state-wide.



Sarah Abbott, Ph.D.
Jail Diversion Program
Director at Advocates

Preface

The essence of this jail diversion program (JDP) model is the police/mental health collaboration. This lies at the heart of its success. This concept originated in Framingham, MA with Craig Davis (Deputy Police Chief) and Dr. Chris Gordon (Advocates) who knew that the presence of a trained mental health clinician would transform the way that the police delivered services. Since 2003, it has been my distinct pleasure to serve in the role of a Framingham Jail Diversion Program clinician and presently as a guide for other skilled and capable clinicians who have co-responded to thousands of calls with our dedicated and compassionate police partners. The mutual trust, respect and understanding of each other's role — facilitated by this program design — is what makes it so special to all who participate. A variety of stakeholders, community partners, funding sources, legislative champions and state wide advocacy groups have helped ensure the

longevity of the co-responder model and helped facilitate its successful replication. We are very thankful to all our partners for the ongoing support and encouragement.

We give special thanks to the MetroWest Health Foundation for their support of this program model and for the development of this manual. As one of the original funders of the Framingham JDP, they also believed that there was a better way that the police could respond to individuals with mental illness. We extend our gratitude to the Massachusetts Department of Mental Health for their sustained financial and programmatic support of our currently operating JDP programs. Lastly, we are grateful for the tireless jail diversion advocacy work by the National Alliance for the Mentally Ill (NAMI) and for the sustained support and legislative efforts of Massachusetts Senator Karen Spilka.

This manual has been created with the hopes that other communities will be able to utilize this as a guide; a step-by-step toolkit with which to launch a successful police based co-responder jail diversion program.

Sarah Abbott, Ph.D., serves in the role of Jail Diversion Program (JDP) Director at Advocates. Dr. Abbott helped the Framingham Police Department launch the Framingham Jail Diversion Program more than a decade ago and her experience and knowledge of jail diversion programming is recognized statewide. In addition to overseeing the Framingham JDP, Dr. Abbott replicated the model in the Marlborough Police Department (2008) and again in the Watertown Police Department (2011). In 2015, Dr. Abbott developed and launched a new regional JDP program serving four small Massachusetts communities — Ashland, Sherborn, Holliston & Hopkinton (ASHH regional model).

In addition to her work at Advocates, Dr. Abbott serves as an Assistant Professor in the Justice Studies Department at Lasell College. Dr. Abbott's research has focused on evaluating the impact of the Advocates jail diversion model on police officer attitudes towards individuals with mental illness. The findings of this research reveal that officers working in those departments with jail diversion programs report greater tolerance and acceptance of individuals with mental illness living in their communities and more strongly endorse their role in managing individuals with mental illness than their counterparts in non- jail diversion program departments¹.

1. Abbott, S (2011). "Evaluating the Impact of a Jail Diversion Program on Police Officer Attitudes towards the Mentally Ill." Law, Policy and Society Dissertations. Paper 22. <http://hdl.handle.net/2047/d20000838>

Founding Funders

MetroWest Health Foundation
Poitras Foundation
Carlisle Foundation
United Way of MetroWest
Tenet Healthcare Foundation

Other Funders

Massachusetts Department Mental Health
Watertown Community Enrichment Fund
Watertown Community Foundation
Health Foundation of Central Massachusetts
Foundation for MetroWest
Disabled American Veterans
Town of Framingham Veterans Services
Lt. Scott Milley VFW Post
Massachusetts Executive Office Of Public Safety — Byrne / JAG grant

This manual was created with a grant and generous support of the MetroWest Health Foundation.

A CALL TO ACTION

Addressing the problem: The Emergence of Jail Diversion



When individuals with a mental illness are diverted from arrest and into community based treatment, they spend less time in jail, pose a lower risk to society, and have the opportunity for a better quality of life than those who are arrested.

Steadman and Naples, 2005

Section One:

Why Jail Diversion Programs are Needed

In 1999, the Council of State Governments (CSG) responded to calls for assistance from several states on how to respond to individuals with a mental illness who were coming in contact with the criminal justice system. In 1999, the CSG facilitated the first meeting of a small group of leading police and mental health policy makers from across the nation. Following this meeting, a steering committee was created that developed and

Many police departments have responded to deadly encounters between police and persons with psychiatric illness by increasing mental health training for officers.

led an 18-month initiative with a wide range of stakeholder agencies, including the Police Executive Research Forum and the National Association of State Mental Health Directors. Together, they developed policy and practice recommendations to improve the criminal justice response to individuals with a mental illness. The subsequent report produced by the Criminal Justice/Mental Health Consensus Project (2002) summarizes weeks of meetings, surveys

administered to governmental officials in 50 states, hundreds of hours of interviews with directors of innovative programs, and thousands of hours reviewing research, promising programs and legislation.

One of the empirical findings of the Consensus Project report² is that there is a direct link between inadequate community mental health services and the growing number of mentally ill who are incarcerated. Front line law enforcement officers and mental health advocates agree that individuals with a mental illness come into contact with law enforcement as a result of the mental health system having failed. Furthermore, members of the project agree that if those individuals with a mental illness actually received the services they needed, they would typically not find themselves charged with a crime, arrested or jailed. The Consensus Project recommends the development of partnerships between police departments and local mental health providers. In addition, policy statements recommend changes to increase the effective and efficient use of police resources.

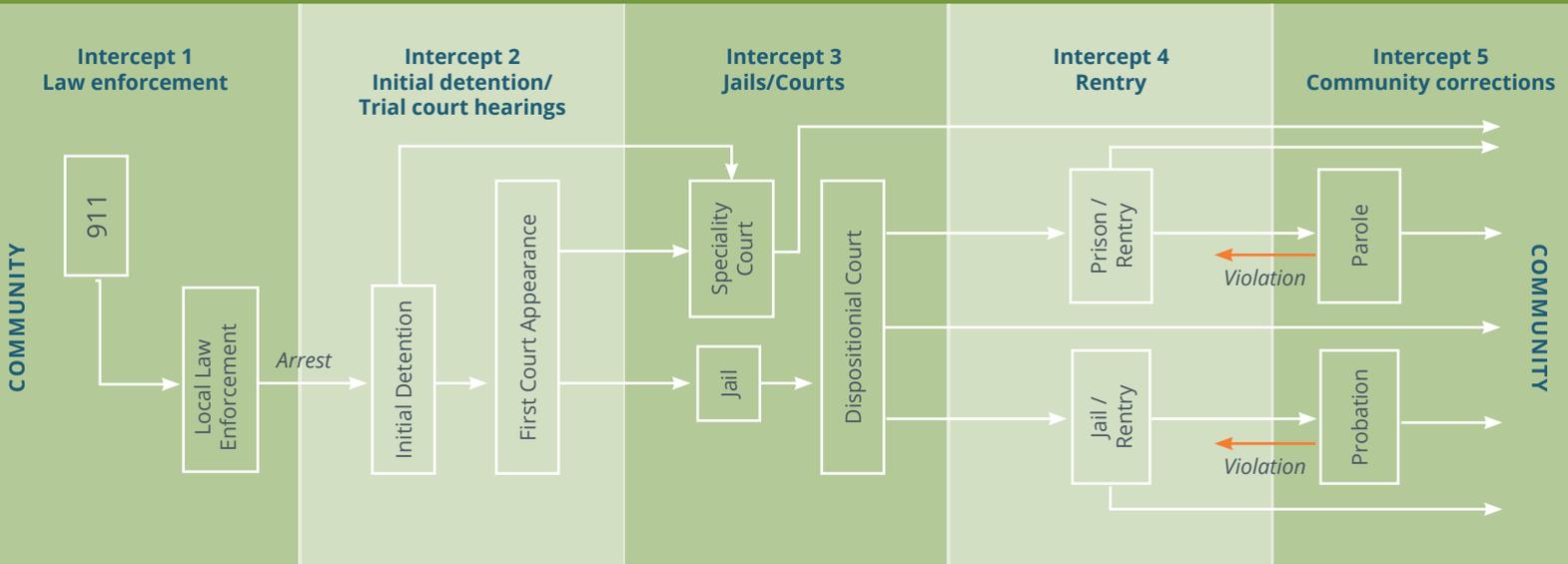
Types of Jail Diversion Programs

As shown in the Sequential Intercept Model³ on the next page, there are five possible intercept points in the criminal justice system during which an intervention could occur. Advocates jail diversion programs occur at the first intercept (law enforcement/pre-arrest).

2. Criminal Justice / Mental Health Consensus Project. (2002, June). Council of State Governments: Criminal Justice / Mental Health Consensus Project. Retrieved March, 2015, from <http://consensusproject.org>

3. Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D. *Psychiatric Services* 2006 57:4, 544-549

The Sequential Intercept Model of Jail Diversion



The Sequential Intercept Model of Jail Diversion; Psychiatric Services 57:544-549, April 2006.

Other US police departments have responded to deadly encounters between police and persons with mental illness by increasing and improving mental health training for police officers. In states where police have shot and/or killed individuals with mental illness, the mental health community has echoed these calls for change. The Memphis, Tennessee Police Department significantly enhanced their training practices in 1998 after police officers, responding to a 911 call, shot and killed a man with mental illness. Memphis created around-the-clock specialized Crisis Intervention Teams (CIT). Officers assigned to these teams spent 40 hours training with representatives of the mental health system. The CIT training included learning how to talk to persons with mental illness during standoffs and studying the effects of various medications.

“With input from a trained clinician, police no longer have to shoulder the burden of making decisions without all the relevant information or resources at their disposal.”

In addition to training, the CIT model encourages partnerships between local stakeholders and supports policy and practice development. The CIT model has been replicated in hundreds of law enforcement agencies nationwide.

When considering what would be the best fit for the Framingham Police Department, the police administration decided that CIT training alone would not be the best fit for their department and requested that alongside enhanced mental health training, that an Advocates Emergency Services Program clinician be ‘embedded’ in their department. They believed that having a masters-level clinician co-respond with their officers increased the likelihood of arrest diversions and immediate access to treatment. This model became the Advocates pre-arrest co-responder jail diversion program.

The Framingham Jail Diversion Program: A police/mental health partnership

In 2002, local mental health provider Advocates joined forces with the Framingham Police Department to respond to the Consensus Project report’s ‘call for action.’ Advocates is one of the largest service providers in Massachusetts offering quality human services and health care alternatives. Advocates partners with people with disabilities, elders, and those with other challenges to overcome personal obstacles and societal barriers so that they can obtain and keep homes, engage in work and other meaningful activities, and sustain satisfying relationships. The mission of Advocates⁴ is to help people achieve their hopes and dreams within the fabric of their communities. The Framingham Police Department is a medium-sized department with over 150 employees and an annual call volume of approximately 50,000. Framingham is a large, economically diverse town located twenty miles west of Boston. As of the 2010 U.S. Census⁵, Framingham had a resident population of 68,318.

⁴ www.advocates.org

⁵ United States Census Bureau. (n.d.). Framingham CDP QuickFacts from the US Census Bureau. Retrieved June 9, 2014, from <http://quickfacts.census.gov/qfd/states/25/2524960.html>

The Advocates Jail Diversion Program was created to respond to police officers' concerns about calls involving people with mental illness in the community. Jail Diversion Program clinicians have been recruited and trained to assist the police in responding to these calls, first, by helping to de-escalate individuals who present in psychiatric crisis and second, by providing additional assistance with respect to assessment, referral, and placement. The program provides police officers immediate access to trained in-house clinicians for on-scene responses, follow up care and case consultation. By providing alternative disposition options for police, JDP clinicians facilitate access to therapeutic placements for people with mental illness who are committing low level offences versus an arrest. With input from a JDP clinician, police no longer have to shoulder the burden of making decisions without all the relevant information or resources at their disposal. When the clinician co-responds to the scene, officers feel comfortable diverting from arrest, knowing that the individual will be receiving the appropriate treatment and support. By relieving the officer of the time spent unraveling complex psychiatric situations, they are free to return to patrol; responding to 911 and calls for service.

Replication activities

Due to the widely acknowledged successes of the Advocates Framingham Jail Diversion Program, additional police agencies have approached Advocates to replicate the Framingham model. Given that these departments fall within the geographic 'catchment' area of the Emergency Services Program (ESP); replication was possible. The primary goal of the ESP is to make emergency behavioral health services accessible in the community. Every ESP provides behavioral health crisis assessment, intervention, and stabilization services, 24 hours per day/7 days per week/365 days per year and covers a designated geographical region in Massachusetts. The ESP therefore is the natural partner for the police to work with when developing and replicating this model and the ESP provides back up to the JDP programs when that clinician is not on duty.

Members of the Advocates JDP team have successfully replicated the JDP at the Marlborough Police Department (2008) and at the Watertown Police Department (2011). In 2015, funding was received to support Advocates newly developed regional jail diversion program which serves Ashland, Sherborn, Holliston and Hopkinton (ASHH JDP).

Advocates JDP Chronology: 2002—2015

2002

Jail Diversion Program (JDP) model jointly developed by Framingham Police & Advocates

2003

Framingham Jail Diversion Program launched with foundation funding

2003

Governor Romney recognized the program at the State House

2004

Cross Training of Police Hostage Negotiators on crisis team phone lines

2006

Framingham Program received state funding through Department of Mental Health

2008

Replication of Advocates JDP model at the Marlborough Police Department

2011

Replication of Advocates JDP model at the Watertown Police Department

2015

Development of the ASHH regional program occurred due to funding from DMH.



Left to right: the Governor Mitt Romney, Dr. Chris Gordon (Advocates), Dr. Sarah Abbott (Advocates), Karen Spilka, State Senator.



The Jail Diversion Program is founded on the understanding that by working together, mental health clinicians and police officers can respond more appropriately to the needs of individuals in the community with a mental illness and that clinicians can offer the police an alternative to arrest.

THE ADVOCATES JAIL DIVERSION PROGRAM

Core Components:

The ride along

Training

Operations Meetings



CASE STUDY

A Ride Along

A late summer evening shift was punctuated by a call; officers were dispatched for a “suicidal male with a knife.” Several cruisers responded to the call and because I was on a ride along, I accompanied my police partner to the call. This officer has former military experience and was an active member of the department’s SWAT team. We rode together with some frequency and we had responded to many calls together in the past. He typically deferred to me to de-escalate individuals in crisis.

When we approached the apartment building, he told me that because there were weapons involved, he would have me “stand by” outside the apartment door. The apartment was at the top of a three story building and I took my position while the officer entered. I could hear the dialogue quickly escalate as the suicidal male was threatening to kill himself and the officer. He was asking the officer to shoot him; said he wanted to die. The officer started to ask the individual about himself; his name; why he was upset and told him he didn’t want him to die. This changed the dynamic immediately.

The individual started to calm down—he was really responding to the officer’s attempts to engage and empathize with him. He refused to drop the knife but was no longer threatening the officer or his own life. Other officers quickly arrived and took physical control of the individual in crisis. A decision was made by the officer that the individual needed mental health treatment and he was diverted from arrest.

Once the suicidal male was safely in the ambulance heading for the hospital, we got back into the cruiser and talked about the call. The officer stated that due to his involvement with the jail diversion program; the training he had received through the program and his active participation in ride alongs; he felt that he had the skills and experience to de-escalate the standoff with an individual who was suicidal and threatening him. It was a powerful example of the impact of the Jail Diversion Program’s formal and informal training upon police officers’ attitudes and behaviors.

Section Two:

The Advocates Jail Diversion Program

The presence of the clinician on a police ride along allows for an immediate on-scene joint response. Police officers who ride with the clinicians appreciate their presence. They report that it is helpful for the clinician to experience the nuances of the call; the sounds, smells, and behaviors first hand. Frustration for police officers occurs when (without the clinician's presence) they send an individual with mental illness to the hospital emergency department for assessment, only to see them back in the community, a few hours later. Clinicians report that they can make more informed decisions about the call disposition when they are able to experience the crisis, in the moment and first hand.

“The police academy does not adequately prepare cops to respond to the mentally ill. Before the JDP, we were ‘on our own’ out here. In the JDP clinician we have our own ‘in-house’ set of resources at our disposal.”

911 police responses are fluid situations. Dispatchers send patrol officers to calls with minimal information and rely upon the officer's experience and judgment to assess the situation upon arrival. Having clinicians accompany the police on all calls-not just mental health calls-encourages their involvement in the situation. Clinicians can be helpful as a resource for police to assist with individuals experiencing emotional

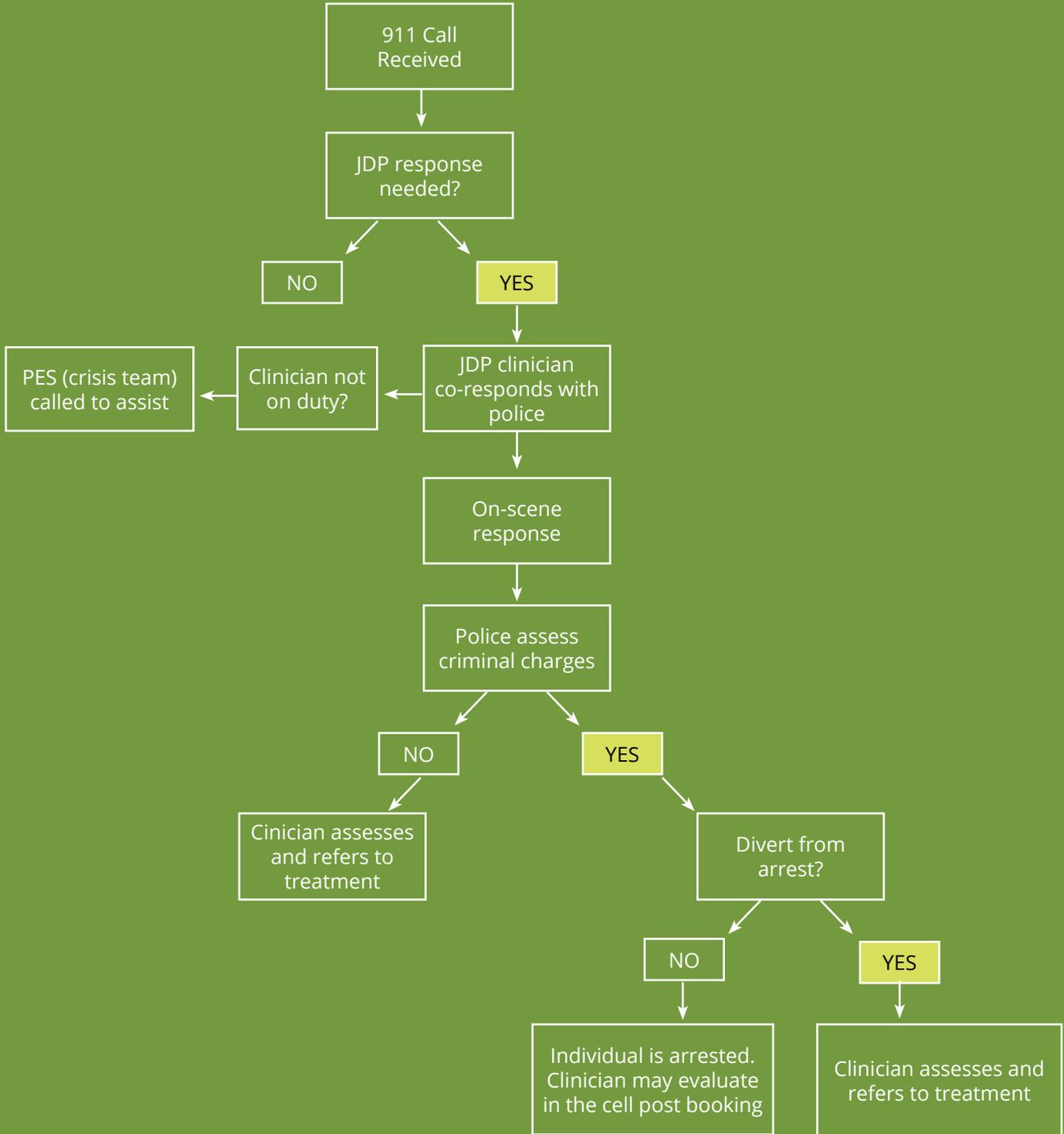
distress. Different from psychiatric crisis, emotional distress is circumstantial and is often present during 911 responses. Officers regularly utilize the skills of the clinician to de-escalate individuals who are extremely upset and having difficulty communicating their needs while in crisis.

The Role of Discretion

Police officers have considerable discretion when determining what their response to a misdemeanor/nuisance offence should be. Without clear and available alternatives to arrest, police officers may feel that arrest is their only option. However, “substantial discretion in arrest decisions raises some questions about equal justice. Without appropriate guidelines, similar behaviors could easily be described as criminal or psychiatric.”⁶ By providing an alternative disposition option for the police, clinicians can facilitate a therapeutic placement for the individual with a mental illness versus an arrest. With input from a trained clinician, police no longer have to shoulder the burden of making decisions without all the relevant information or resources at their fingertips.

6. Cooper, V. G. (2004). Dispositional Decisions with the Mentally Ill: Police Perceptions and Characteristics. *Police Quarterly*, 7(3), 295-310. doi: 10.1177/1098611104267733

JDP Intervention Process



If the clinician is available and responds to the scene, the officer can feel comfortable with an arrest diversion, knowing that the individual will be receiving appropriate and needed treatment. The officer can therefore be freed up more quickly to continue with the ‘real’ police work; avoiding time spent arresting, booking and guarding the individual for a typically minor offence. If the offense is more serious, the officer can revert back to arresting the individual.

Officers who have used the JDP clinician to divert individuals from arrest report being extremely satisfied with the program. One could argue that discretion is only as good as the available alternatives. The resources and treatment options provided by the JDP clinician on the scene of a call may provide the officer a way to exercise their discretion, while still ensuring that the situation is addressed; with treatment rather than incarceration.

The Ride Along

The most important ‘ingredient’ of this model can be found in the relationship that the clinician develops with the officers. Over time, this relationship is strengthened through

“By providing an alternative disposition option for the police, clinicians can facilitate a therapeutic placement for the individual with a mental illness versus an arrest.”

the ride along component. Conversation and exchanges regarding shared professional experiences fosters trust. Officers report that the more familiar they are with the JDP clinician, the more likely they are to participate in a ride along, call for their assistance or request their follow up on situations. Clinicians feel that without the close relationship and bond with the individual officers, there is no program. Clinicians report that the process of being accepted into a police environment takes time

but that once trust is earned by the JDP clinicians, officers become more comfortable utilizing them on calls. Officers themselves report that the most crucial component of the model is the ‘ride along.’

Experience has shown us that for optimum program success (and to address potential concerns of police unions) officer participation in the jail diversion program must be voluntary. Typically, there are a handful of police officers who welcome the presence of the JDP clinician on a ride along and regularly volunteer for this. For those officers who do not wish to have the clinician in the cruiser for their entire shift, they can request the clinician’s presence on individual calls and ride solo once that call is resolved. Lastly, police officers can make referrals for the clinician to follow up on a situation after the police involvement ends. Flexibility around officer utilization of the clinician is crucial.

Training for Police

In addition to the on-scene assessment, JDP clinicians regularly participate in formal and informal police training. A variety of clinical training topics can be helpful for police



Dr. Sarah Abbott performing in-service training for the Framingham Police Department

officers. At program inception, an orientation to the Advocates social service agency and the Jail Diversion program model were provided to all Framingham officers. This included the role of clinician, how to access them and the backup services of the ESP. The expanded focus of subsequent trainings at the police department has included; signs and symptoms of mental illness, commonly prescribed medications, and de-escalation techniques. More advanced topics covered have included statutory issues (commitments for mental health and substance abuse), death notifications, and hoarding.

A more nuanced form of informal training also occurs during the ride along. Clinicians have reported that they are able to talk freely with officers and answer their questions about psychiatric disorders during the down time between calls, while on patrol. Police officers are exposed to a myriad of techniques used by the JDP clinician during their encounters with individuals with mental illness and have reported that through repeated exposure to the clinicians, they have learned a great deal through ‘osmosis’ — a subtle and gradual absorption.

Training for Clinicians

Although police and social work culture share some commonalities, there are distinct differences that must be acknowledged and addressed. Upon program inception, it is recommended that Emergency Services clinicians (who provide backup responses when the JDP clinician is not available) receive an orientation to the culture of police agencies. Of particular importance is an overview of the department’s chain of command and the roles and responsibilities of patrol officers. Emergency Services clinicians should also be introduced to police protocols and policies governing the role and responsibilities of a social worker in a police environment. Embedded JDP clinicians should receive additional training on radio procedures, how to handle CORI information and more in-depth review of patrol procedures.

Operations Meetings

The purpose of monthly operations meetings is to review program data and ensure that



The Framingham police department would not be able to fulfill its mission of keeping Framingham safe without the Jail Diversion Program (JDP). Unfortunately, we encounter so many people in need of assistance with their mental health and substance abuse problems. The JDP clinicians — working on the ground with the beat officers — allow us the opportunity to provide timely, quality mental health services to those we encounter. The ability to immediately divert low-level offenders away from arrest — and into treatment — benefits everybody.

Kenneth Ferguson
Chief of Police
Framingham Police Department

the program is achieving the desired outcomes. These include diversions from arrest, referrals into appropriate treatment and a reduction in the inappropriate use of police and emergency department resources. Local service providers, JDP clinicians and the police participate monthly to discuss cases that involve the police. Information about the individual's recent involvement with the police is discussed. All clinical information is kept confidential and is shared only with the individual's consent. When consent is not provided, the group discusses the individual in general, hypothetical terms. Where appropriate, the individual also is given the opportunity to meet with this group to review what has been helpful, what could have been done differently and to share their own insights about what happens when they come in contact with the police.

Operations Meetings

The following operations meetings are scheduled monthly and quarterly. These meetings ensure that the operational business regularly occurs while larger stakeholder involvement continues on a quarterly basis.

	SUGGESTED PARTICIPANTS	TOPICS
MONTHLY AND QUARTERLY	<ul style="list-style-type: none"> • JDP clinician • High ranking police representative • Veterans Agent • Court personnel • Representative from the crisis team 	<ul style="list-style-type: none"> • Program updates • Data and statistics • Challenging cases • Operational Challenges • Success stories
QUARTERLY	<ul style="list-style-type: none"> • Local social service providers • Representatives from hospital ER • Advocacy groups e.g. NAMI • School personnel/School resource officers • State mental health department representative 	<ul style="list-style-type: none"> • Program updates • Summary of data and trends • Community issues • Sharing training and resources • Agency updates

Diverted from Arrest

The JDP became involved in a case of two elderly siblings when the police attempted to serve a warrant to the brother, for failing to appear in court on charges of failing to maintain his property. Responding to the scene with the police, the JDP clinician found that neither individual had taken their daily medications recently, medication bottles were found spread around the house, pills were mixed in with pet food and the most recent bottles were last filled two years prior.

The only food found in the house was decomposing, covered with cobwebs and dirt; there was a severe odor of urine permeating the house and outside the home; a cat was found on the floor which had clearly been dead for months; there was no running water or sewer system in the house; there were multiple fire hazards-stacks of newspapers from the floor to ceiling filling rooms, propane camping lamps were hanging from the ceiling; and there was no evidence of any financial, social or familial supports for these siblings. The police officer asked if the JDP clinician could perform an assessment with the siblings.

Due to the condition of the home, their inability to care for themselves and the possibility that dementia was present; the siblings were immediately hospitalized by the JDP clinician on a geriatric psychiatric unit. It was fortunate that they could be placed together on the same unit. It was suspected that they had never been apart for a significant period of time in their lives.

The issuing Judge *dismissed the warrant* on the condition that the siblings received psychiatric treatment.

Following the psychiatric hospital placement, the sibling pair was placed together in a supported elderly housing situation where they remain together today.

The Police Response to the Jail Diversion Program

Over the last decade, a combination of qualitative and quantitative methods have been used to assess officer satisfaction with and attitudes towards the Advocates Framingham Jail Diversion Program. An overwhelming majority of police officers who participated in focus groups value the program and those who have used it the most, value it the highest. It was not unusual to hear officers report, “before the Jail Diversion Program we used to get repeat calls to the same individuals...we just don’t get those anymore.” Officers consistently report that they view the clinician as another ‘tool on the belt’ and believe that having the program ‘transforms the face of the police department.’ Another common theme raised in interviews and focus groups is how ill equipped officers feel when responding to individuals with mental illness. Officers reported that police academy training was insufficient and inadequate in preparing them for these types of calls.

One officer stated that, “in the academy you learn how to shoot and drive fast but that’s not the skill we need the most; we need to communicate with people better.”

Police supervisors consistently described the JDP as a great resource for the patrol division. A young officer remarked, “everyone I’ve used the program to divert from arrest has succeeded.” A sergeant reported that, “by having a jail diversion program, we show the citizens that we care.” A common theme in the police feedback has been that the immediacy of the clinician’s response to the scene has been a significant contributor to officer satisfaction with the program. In busy departments, calls easily stack up and trying to understand the nature of a complicated mental health call can take a lot of time. That call time is reduced when a highly trained clinician is assisting. Another essential ‘ingredient’ of the program that the police unanimously cited was familiarity with the individual clinician. It has been repeatedly observed that knowing and subsequently trusting the clinician allowed officers to feel comfortable asking for their help and accepting their input on calls. Officers described a mutual understanding and respect that was cultivated during ride alongs and many felt that the JDP clinician is ‘part of the police team.’



Focus group at the Marlborough Police Department led by Dr. Sarah Abbott



The Jail Diversion Program is founded on the understanding that by working together, mental health clinicians and police officers can respond more appropriately to the needs of individuals in the community with a mental illness and that clinicians (as gatekeepers to the mental health system) can offer the police an alternative to arrest.

CASE STUDY

The Coffee Shop

This case involved a 39 year old single white male who was diagnosed with schizophrenia. This individual called 911 after an argument with the coffee shop barista. The individual reported that he was being denied a cup of coffee. The caller then became belligerent and threatened the store clerk. He was agitated and yelling inside the store while still on the phone with the 911 dispatcher.

This individual was clearly disorderly inside the store and in public.

The Framingham Police were called and the JDP clinician co-responded to the scene with the police. After consultation with the clinician, the officer decided to use his discretion and asked the barista if he wanted to press charges or if they would be satisfied with a referral for secure treatment for this individual.

The barista responded that he would be satisfied if the individual was referred for mental health treatment and did not want him arrested. The JDP clinician assessed the individual and determined that he had not been taking his medications as prescribed and was actively psychotic. It was decided that he met the criteria for inpatient level of care. The individual was diverted from arrest and placed in a local mental health facility where he received intensive treatment.



The Jail Diversion Program also recognizes that through training and ride alongs, there lies an opportunity to enhance officer understanding of mental illnesses and offer alternative in-the-moment tactics for de-escalating situations without resorting to the use of violence.

Steadman et al, 2000⁷

REPLICATION

A guide to Implementing a Police-based Jail Diversion Program

7. Steadman, H. J., Deane, W., Borum, R., & Morrisey, J. P. (2000). Comparing Outcomes of Major Models for Police Responses to Mental Health Emergencies. *American Journal of Public Health*, 51(5), 645-649.

Section Three:

Replication: Steps to Implementation

Step One: Developing a partnership

1 The identification of willing police departments and their clinical counterparts is critical to the success of the program. Both partners have to be open to working together towards the betterment of the community.

Essential to success will be a police department culture that recognizes:

- The need for a different way to respond to individuals with mental illness
- The need for partnership with a behavioral health agency
- There are alternatives to arrest and finds ways to integrate this in their department

The mental health agency should be:

- Flexible and mobile with crisis service response
- Willing to understand the police perspective and role in the community
- Open to learning police protocols and adapt their delivery of crisis work accordingly

Once this partnership has been established, the community need must be more deeply understood.

Step Two: Establishing the need¹

2 When developing a new jail diversion program, data is required to identify the need for the program (in one or more police departments).

Evidence of need should include one complete year's worth of the following call data:

- Number and nature of police responses to people with mental illness
- Number of arrests of suicidal individuals
- Identification of “frequent utilizers”— individuals whom the police have frequently and repeatedly encountered during mental health related calls

Once gathered, this baseline data will inform the following programmatic decisions:

- Shift/hours: days and hours during which the clinician should be on duty
- Model type: full time clinician housed in one department vs. one shared between two or more departments (regional model)

¹The Advocates Jail Diversion Program model can be modified to work across several participating police departments.

Once the need has been established, efforts to secure funding should begin. Engagement with the local and state legislators at this stage is also encouraged.

Step Three: Securing Funding

3 Advocates JDP programs have traditionally launched with local philanthropic and foundation funding. These grants are typically short term seed funding (1-3 years). Once the program's efficacy has been established, longer-term/continuation funding has been provided to Advocates JDP's by the Commonwealth of Massachusetts Department of Mental Health (DMH). Given the dual agency involvement, operational funding could be sought of mental health and/or public safety funds or a combination of both. It is recommended that proposals for new JDP programs have letters of support from all involved agencies and community stakeholders.

Once funding has been secured, program implementation can begin.

Step Four: Selecting a JDP clinician

4 Perhaps the most important step in establishing a jail diversion program is the selection of the clinician. The importance of a good 'fit' for the police department cannot be underestimated. While there is no 'profile' which a JDP clinician must fit, there are characteristics which the ideal clinician should possess.

Qualities of the ideal candidate:

- **Sense of humor:** working in a law enforcement environment can be stressful and emotionally draining. Humor is a well-recognized coping mechanism which can break the tension and help first responders cope with their difficult duties. Clinicians entering this environment need to be able to adapt, with humor, to the circumstances they are presented with.
- **Thick skin:** Once embedded in a law enforcement environment, clinicians will be exposed to a very different culture than exists in the most clinical settings. Police officers can seem abrupt and direct when establishing order in chaotic and potentially dangerous scenarios. Clinicians need to be able to read these cues and not personalize them. Initially, police officers may well be suspicious/concerned about the presence of a clinician and until a relationship is established, may not be overly welcoming. The ability of the clinician to understand this and stay the course is therefore essential.
- **Flexibility:** Working as a clinician in a busy police department requires a flexible attitude. Initially, the schedule is developed based upon somewhat limited dispatch call data. Once operational, the clinician's hours may need to be adjusted to ensure that

they are working during the busiest times and when they can be the most effective. These are often non-traditional hours and outside of the 9am-5pm schedule.

- ***Adaptability:*** Police responses to individuals in crisis are changeable and evolving scenarios. They can escalate quickly and change dramatically in a matter of seconds. Given this, JDP clinicians have to be adaptable and flexible. If a situation becomes violent, the clinician needs to be able to move out of the way quickly. Once the situation has de-escalated, the clinician may be asked to get involved again. Occasionally, the clinician may disagree with an officer's decision to make an arrest, especially if the individual presents with mental illness. The clinician must be able to accept their limited role in these situations.
- ***Confidence:*** Clinicians in law enforcement settings need to possess confidence. Police officers exercising their discretion and referring cases to the JDP clinician must be confident that the clinician will manage the case well and find an appropriate disposition. Clinicians therefore need to project confidence in their abilities and the skills that they possess.
- ***Compassion:*** Clinicians who are embedded in a police agency need to maintain their compassion when working with individuals whom the police may well be exasperated by; due to past repeat and time consuming encounters. Maintaining and modeling compassion can influence the dynamics of the call and lead to a more effective resolution.
- ***Excellent judgment:*** Clinicians are expected to make rapid life or death decisions while at the scene of complicated psychiatric presentations. A clinician who possesses excellent clinical judgment can work creatively to resolve these calls quickly and effectively.
- ***Excellent Boundaries:*** A concern of police administrators may be the potential for inappropriate relationships forming between the (mostly) female clinicians and the (mostly) male police officers. While not completely avoidable, clinicians should be carefully screened and the issue of boundaries should be explored thoroughly during the hiring and orientation process.
- ***Qualifications:*** In Massachusetts, the JDP clinicians are Masters level social workers. Ideally, the candidate will also have experience working with individuals in emotional/psychiatric crisis. The Advocates model employs the JDP clinicians under the umbrella of the Emergency Services Program. Once hired and trained, they are assigned exclusively to the police as JDP clinicians.

Process of Hiring: It is crucial that the hiring of the JDP clinicians be a process that includes representatives from the police department and the mental health agency. Due to the co-responder component of the program, the police must feel comfortable with whomever is hired.

The Hiring Process

	WHO PARTICIPATES?	COMMENTS/SUGGESTIONS
1 POST THE POSITION	Mental Health Agency Human Resources JDP Director/ JDP Project Manager	Minimum of 1 year post graduate crisis work experience (preferably in law enforcement environment)
2 FIRST ROUND INTERVIEWS	Mental Health Agency JDP Director/ JDP Project Manager	Clinical skills, adaptability and crisis experience are assessed. Discussion occurs around working in a law enforcement environment. 2-3 top tier candidates will be offered joint second interviews.
3 SECOND ROUND INTERVIEWS	Mental Health Agency JDP Director/Project Manager Representatives from Police Department	Discussion is led by the police. Suggested topics to explore include: use of force, police culture, boundaries, and ethics.
4 BACKGROUND INVESTIGATION	Mental Health Agency Police Department	Both agencies may wish to engage with background investigations. Police personnel often have a more robust background investigation process- including drug testing.
5 RIDE ALONG	Potential Hire/s	Candidate should participate in a four hour ride along prior to being offered/ accepting the position.
6 CLINICIAN IS HIRED	Mental Health Agency- Human Resources personnel	Police ID is issued for clinician. Access to police department & information technology is provided.

Step Five: Orientation to the Mental Health Agency

5 The newly hired JDP clinician should start their training within the mental health agency. They will eventually need to perform rapid assessments on the scene of psychiatric crises and they must be proficient and confident about the process before entering the law enforcement environment.

A typical JDP clinician training curriculum is as follows*:

- Emergency Services Program training- orientation to the culture and practices of the team and broader agency
- Psychiatric assessment - conducting supervised assessments until confident with the process and required paperwork
- Orientation to the available programs, resources and treatment providers in the community
- Understanding of insurance coverage and how to access treatment and obtain the necessary authorizations
- Existing JDP program ride along and observation shifts-the JDP clinician should shadow their peers in similar programs (if available)

Following the orientation and training at the mental health agency, the clinician will establish themselves at their designated police department. This process is greatly aided by the assignment of a police liaison for the Jail Diversion Program.

Step Six: Program Implementation & Operation

6 **Equipment Needs:** The clinician should be provided with the following equipment at the police department.

- A desk, chair, computer, phone, cellphone, iPad and access to a fax machine
- A police issued radio for monitoring calls
- A department directory of police personnel and their contact information
- A locking file cabinet for housing forms, paperwork and resource materials

Presence at roll call: The clinician should attend roll call during every shift that they work. The officer in charge of the shift should introduce the clinician to the officers and request volunteers for patrol ride alongs. Over time the clinician will develop relationships and this step should no longer be necessary.

* 4-6 weeks in duration

Ongoing operations: Once embedded, the real work of the program clinician begins.

Police officers can take the clinician on a ride along and use them on calls they co-respond to and/or they can request the assistance of the clinician for additional follow up once their involvement with the call is over.

Not all police calls involving individuals with a mental illness are criminal in nature but due to their presence, JDP clinicians will frequently assist with these calls also. Clinicians should assess the needs of the referred individual and make treatment recommendations

The psychiatric assessment process

During the psychiatric assessment, the JDP clinician should gather the information needed to recommend treatment services. The assessment considers the natural support network available to the individual, the individual's ability to reliably contract for safety and the individual's current access to services. Additional information gathered during the assessment should include:

- Presenting problem, including onset and duration of symptoms
- Current safety issues, including plan and means
- History of safety issues, including suicidal ideation, homicidal ideation, self-injurious behavior, and assaultiveness
- Medications (including dosages), allergies, and medical problems
- Support system and outpatient providers
- Substance abuse, if applicable
- Legal history

Recommendations for treatment referrals may include:

- Emergency Medication Evaluation
- Outpatient psychiatry and counseling
- Drug/Alcohol Detoxification program
- Partial Hospitalization Program
- Inpatient, traditional psychiatric hospital setting
- Acute Residential Treatment for youth
- Family Stabilization services
- Crisis Counseling

At the conclusion of the assessment, the individual should be presented with a treatment recommendation plan.

This plan may include:

- Referrals with appointments to appropriate outpatient, rehabilitation, day treatment, psychiatry and case management services
- A plan for support and behavioral interventions
- A crisis management plan
- A recommendation for any involved case manager, therapist or inpatient unit to follow up with entitlements, if needed

Upon conclusion of the assessment, the JDP clinician should document the call on the required clinical paperwork and log the assessment and associated details in a dedicated JDP database for data analysis and program grant reporting purposes.

OUTCOMES



Through my years of working directly with police officers responding to calls and emergency situations, I have come to appreciate the role police play with the most vulnerable members of society. I now realize that social workers and police officers have far more in common with each other than differences. Fundamentally, we both want to help people and co-responding allows us to bring our respective strengths and skills to each intervention. The police are invaluable partners in this work.

-JDP Clinician

Section Four:

Data Collection and Analysis

The identification, collection, and analysis of program outcomes is necessary to aid with the measurement of the jail diversion program's success, impact and identify emergent needs. Additionally, the ability to articulate the outcomes of the program will aid with securing sustainable funding and is useful for replication efforts.

Before operations commence, program goals should be set. Below are the three core goals of the Advocates jail diversion program model.

GOAL 1: Identify persons with mental health disorders, addiction disorders, or other behavioral issues who have committed non-violent low level crimes and/or nuisance crimes and divert them from the criminal justice system to the community-based behavioral health system.

GOAL 2: To make more effective use of limited police department resources. Police time spent on non-violent incidents that involve individuals with behavioral health disorders will be reduced, making them available for other community needs.

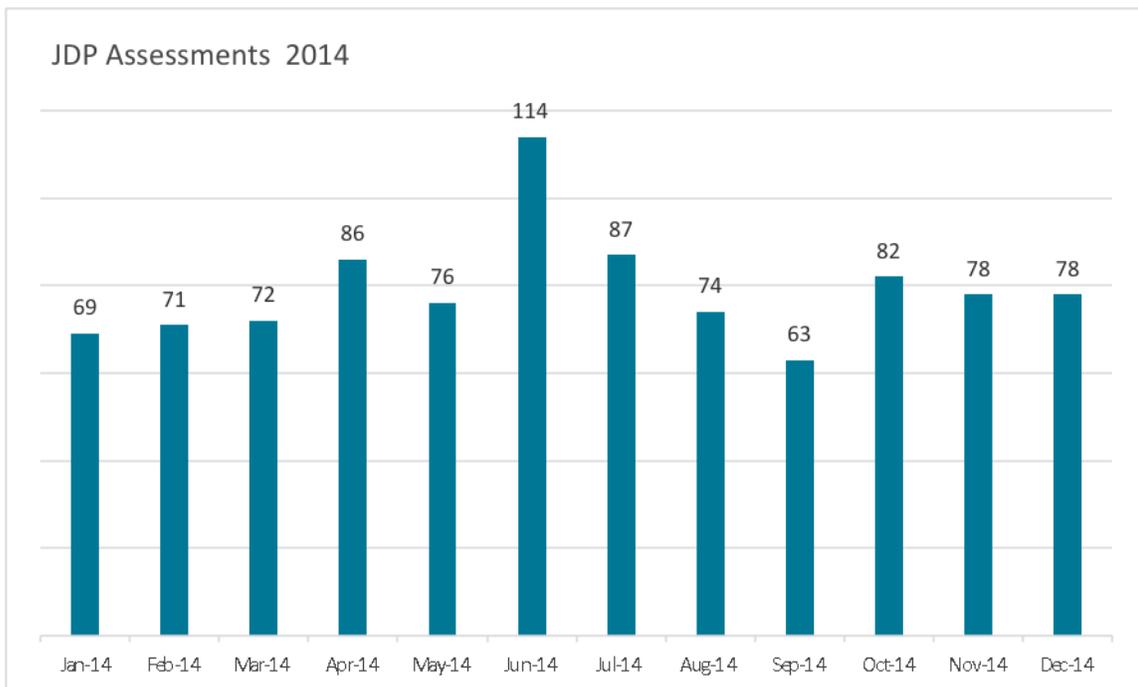
GOAL 3: To increase collaboration among community-based treatment and social services providers and the police department.

Regular reporting of program outcomes and successes should be produced and shared with program stakeholders and funding sources. The following is an example of a 2014 annual report generated by Advocates describing the outcomes of the Framingham Jail Diversion Program for that year.

Advocates Framingham Jail Diversion Program Summary of Program Operations 2014

Chart 1 represents the 950 psychiatric assessments performed as the result of a referral to the Framingham Jail Diversion Program during 2014. All psychiatric assessments result in assistance with accessing the appropriate treatment and resources.

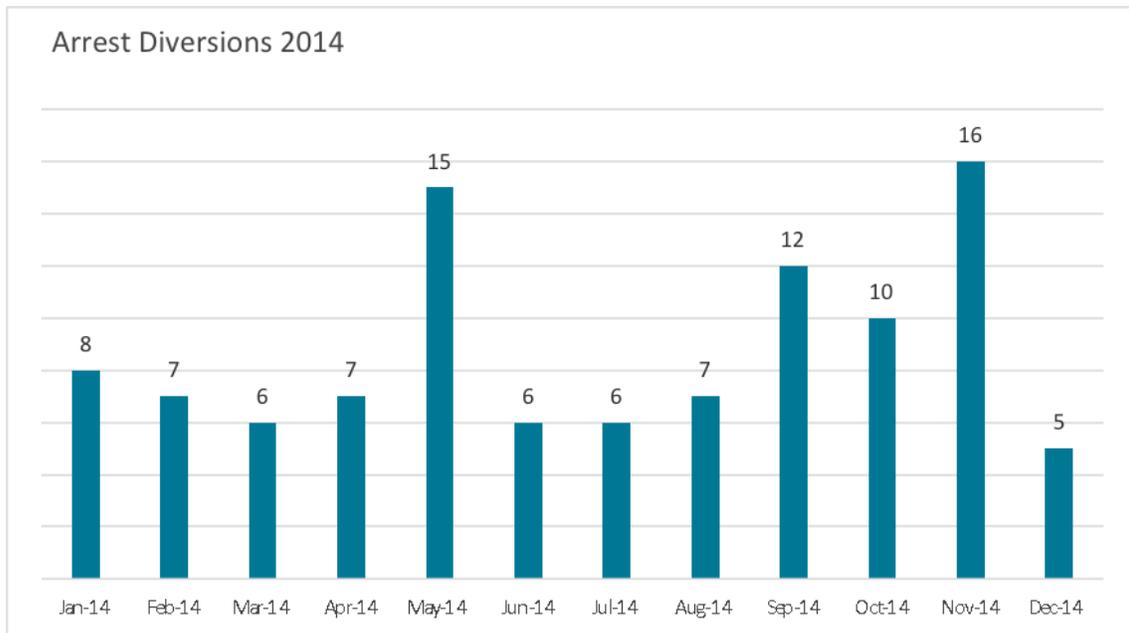
Chart 1: Number of FJDP assessments by month



Diversions from Arrest

The primary goal of the Advocates Jail Diversion Program is to divert low-level offenders away from the criminal justice system and into more appropriate mental health/substance abuse treatment. Chart 2 shows that there are a significant percentage of individuals with a mental illness each month that the Framingham police officers deem appropriate for a diversion to more appropriate community based mental health treatment. During 2014, 105 unnecessary arrests were diverted as a result of the Framingham JDP.

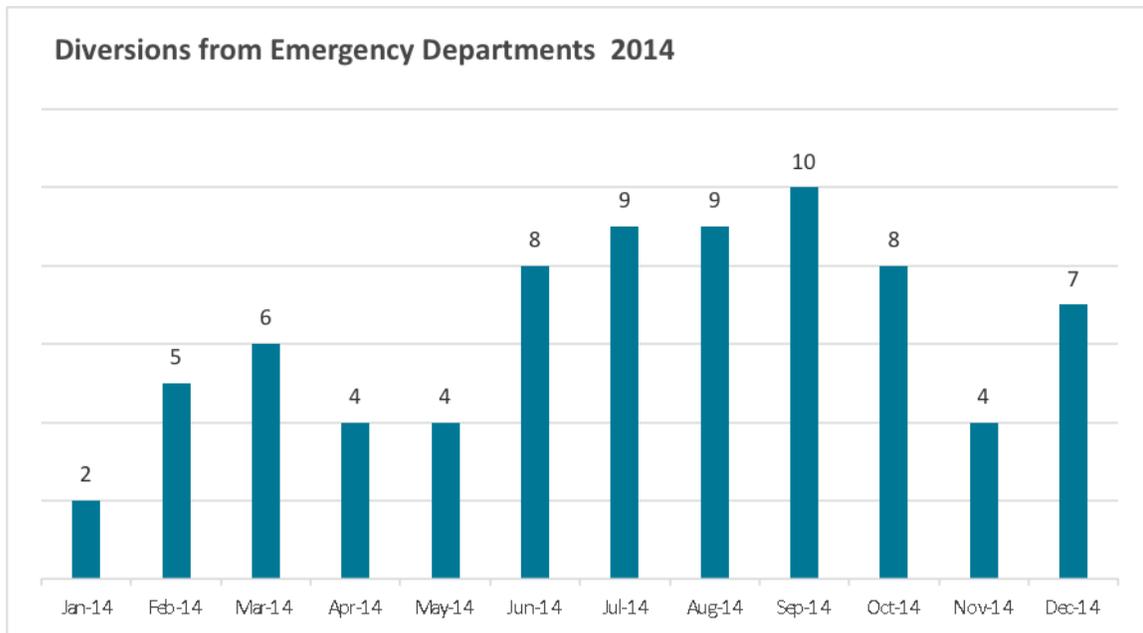
Chart 2: Number of arrests diverted



Diversion from the Emergency Department

A secondary outcome of the JDP clinician's ability to provide on-scene assessments, is diversion from costly admissions to hospital emergency departments. Without immediate access to trained clinicians, police officers often choose to direct the individual to the Framingham Emergency Department for an assessment (usually by ambulance). These are often unnecessary admissions which are costly, resource intense, time consuming and can be traumatizing to the individual receiving care. Chart 3 represents the 76 diversions from the Framingham Emergency Department which resulted from the on-scene JDP response.

Chart 3: Number of individuals diverted from the Framingham emergency department



Cost Savings/Shifting

As table 1 demonstrates, having trained masters level clinicians accompany police officers on calls involving individuals with a mental illness, makes good fiscal sense. By diverting from costly and time consuming transports/admissions to hospital emergency rooms and unnecessary and labor intensive arrests, bookings and court costs; community resources are saved and/or shifted back to more urgent community needs.

Table 1: Estimated costs savings/shifting-2014

FRAMINGHAM

Arrest Diversions*	ED Diversions*	Total JDP Cost Savings
\$210,000	\$266,000	\$476,000

FORMULA USED

Arrest Diversions	Average Savings per Event	\$2,000
ED Diversions	Average Savings per Event	\$3,500

*Formula cited in Massachusetts Department of Mental Health Forensic Services 'Pre-Arrest Law Enforcement-Based Jail Diversion Program Report'. January, 2014.

CONTACT US

Thank you for your interest in
our Jail Diversion Program.
For more information,
please contact us at:

Framingham Jail Diversion Program
1 William Welch Way
Framingham, MA 01702



(508) 532-5904



SAbbott@Advocates.org



www.Advocates.org



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