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### Mental Health Jail Diversion: A Therapeutic Approach to Offending in Twenty-First Century America

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Mental Health Jail Diversion:

A Therapeutic Approach to Offending in Twenty-First Century America

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### **Abstract**

This analysis is concerned with understanding the facets of criminal justice diversion programs that successfully improve the mental wellbeing of participants and, as a subsequent effect, reduce offending amongst the mentally ill populous in the United States. An inquiry of pre-program and post-program data from both adult and juvenile mental health specific programs reveals that participation amongst both groups shows a meaningful reduction in new/repeat offending in comparison to non-participants. The data shows that the expansion of law enforcement Crisis Intervention Team's (CIT's) has a compounding effect to the positive results. A review of these programs in Australia indicates that an expansion of like-programs would reduce offending in less invested nations such as the United States. A consideration of the aggregated data prompts a discussion about the benefits of further development.

*Keywords: jail diversion, therapeutic jurisprudence, crisis intervention, reoffending, mental health court, juvenile mental health, co-response.*

## **Mental Health Jail Diversion: A Therapeutic Approach to Offending in Twenty-First Century America**

There is an unfortunate reality that affects individuals suffering from mental illness across the United States and around the globe. This is that these individuals are more likely to appear in court and have to answer for the criminal charges levied upon them. In recent years there has been a growing recognition that the punitive approach to criminal offending is inadequate in tackling the issue of criminality amongst this segment of the population (Payne, 2006). People suffering from mental illness in all its forms are a large segment of society. According to the National Institute of Mental Health (2018), one in five Americans suffer from a mental illness. Moreover, one in twenty-five Americans live with a serious and debilitating mental illness. The conventional system of justice in the United States has been overwhelmed by the inability to adequately provide a sense of justice to those who, on a vast spectrum of severity, have cognitive barriers that render an inability to distinguish right from wrong.

The first mental health specialty court emerged in Broward County, Florida in 1997. The court was established on the heels of disturbing grand jury findings that showed jail overcrowding and major shortfalls in community mental health treatment programs. Despite only applying to misdemeanor offenses, the program did allow many offenders to partake in diversion programs that were designed to be restorative and therapeutic. Many jurisdictions followed suit (Trawver and Rhoades, 2013). Since the mid 1960's, there has been a major shift away from institutionalizing those suffering from mental illness. This was prompted by movements such as the National Alliance on Mental Illness (NAMI) and the National Institute of Mental Health (NIMH) who furthered the understanding that state hospitals were not improving the quality of

life for their clients, mostly due to private sector profit goals (Yohanna, 2013). Today, approximately 90 percent of the mentally ill population lives in their respective communities (Yohanna, 2013). Throughout the years, the federal government has extended Medicare payments and social security funds to individuals suffering from serious and debilitating illness. Moreover, the 1963 federal Community Mental Health Construction Act paved the way for establishing local mental health centers through administering federal grants to the various states. They were intended to provide treatment at the local level as state hospitals were downsized (Yohanna, 2013).

The emphasis on treating mental illness from within the community has presented numerous problems, especially for the criminal justice system. Local law enforcement has been inundated with calls for service and have often times been left with few avenues but to arrest mentally ill people who are in crisis. From within the courts, judges have had to navigate around the lack of funding for treatment programs and are often times being told that there are no beds available for the people who need them. This has led to a vast increase in the number of mental health patients who have been incarcerated for their crimes. The percentage of people with severe mental illness serving time in jail and penitentiaries is estimated to be 16 percent of the total prison population (Barrenger, Draine, Angell and Herman, 2017). In recent years, mental health specialty courts have emerged at a fast pace. So too has the development of Crisis Intervention Teams that collaborate the efforts of law enforcement, non-profit organizations and clinical staff to assist those in crisis and divert them away from the criminal justice system.

## **Review of Literature**

### **Mental Health Diversion Courts in Australia**

There are many examples of earlier efforts at mental health diversion than exist in the United States. Australia serves as a prominent example and an examination of earlier international programs may provide a forecast in determining the effectiveness of similar programs in the United States. The Magistrates Court Diversion Program (MCDP) of South Australia was established in 1999, serving as the country's first mental health court. The aims of the program are to (1) reduce mentally ill offending, (2) improve the participants health and wellbeing, and (3) improve the criminal justice systems response to mental illness (Lim, 2014). Lim and Day (2014) of Deakin University in Victoria, Australia have conducted two independent studies of the MCDP program, one in 2014 and another in 2016. In the first study, they gauged the effectiveness of the program by examining 219 individuals, 131 males and 88 females. The majority of participants suffered from mood disorders like bipolar and depression (42.5%). The remaining suffered from illnesses like schizophrenia, anxiety and personality disorder (26.5%) (Lim & Day, 2014). After accounting for the 44 individuals removed from the program, it was found that of the individuals who completed the program and had re-offended, most re-offending took place within the first twelve months. The mean time to re-offend was 9 months. The data showed that those who completed the program re-offended sooner than those who did not. However, overall participation shows that half of the participants did not re-offend, regardless of completing. Furthermore, of those who did re-offend, the severity of the offense was greatly reduced. The predictors for post-program re-offending included gender, substance use, and criminal history. Overall,

the results showed that programs like the MCDP are effective in reducing both the likelihood of re-offending and the severity of offenses perpetrated post-program (Lim & Day, 2014).

The second study examined 111 individuals with a similar breakdown of specific diagnoses as was the case in the earlier study. However, Lim (2016) notes that a majority of participants also had a secondary diagnosis, the majority of which was substance use disorder. Most abused alcohol. As was the case in 2014, approximately half ( $n = 62$ ) of participants did not reoffend within the first twelve months. However, of those who completed the MCDP and re-offended, the data showed a significant reduction in the severity of the offenses they committed. The average time to reoffend also dropped to 5.7 months. Unlike the prior study, the data showed no significant reduction in overall symptomology. Quality of life for physical health was also indicated for those who completed the program in its entirety. Those susceptible to serious offending remained on par with their pre-program levels. However, low and moderate offenders showed a significant reduction in their likelihood to re-offend, consistent with the first study (Lim & Day, 2016). A culmination of the data from both studies indicates that the severity of overall offending is greatly reduced by participation in the MCDP program. Less satisfying is the recidivism rates which are improved only marginally by participation.

Skrzypiec (2004) conducted a much earlier study of the MCDP program which found that there was an overall reduction in post-program offending within the first twelve months as opposed to the twelve months pre-program. Two-thirds (66.2 %) of the 157 participants did not re-offend at all. Just over three-quarters (76.4%) of participants either became non-offenders or engaged in less criminal activity than the preceding twelve months prior to program initiation. Approximately 12.7% of participants engaged in as much criminal activity as before and a little

over 10% engaged in more than before. Perhaps the greatest distinction between this study and the two later examinations was that serious offenders were found to be substantially less likely to re-offend, even more than less serious offenders. The later studies indicated very little improvement amongst this group.

Overall, the data from the three MCDP program studies indicate that the earliest mental health court in Australia was effective in reducing re-offending amongst its participants and also reducing the severity of the offenses committed post-program, although the effectiveness had reduced over time.

### **Crisis Intervention Teams**

A major component of criminal justice diversion is occurring from within the community with the formation of Crisis Intervention Teams (CIT's). These are teams made up of law enforcement professionals, mental health clinicians, social workers, registered nurses, psychiatrists, court advocates, probation officers and non-profit organizations. Their aim is to serve as a task-force that can quickly mobilize and respond to a mentally ill individual in crisis. They have proven effective in ensuring that people are accessing the help they need, staying on top of their medications and attending their day-programs.

Kirst, Narrandes, Matheson, Young, Niedra, and Stergiopoulos (2015) identified a number of challenges for CIT training participants that have also been outlined in other studies. In particular, nurses and police officers attending the training had a limited understanding of one another's professional cultures and identified the effects of not having enough cross-training as a barrier to effective CIT performance. In a personal interview, a retired probation officer and CIT



member suggested that a major shortfall in the initial implementation of a South-Eastern Massachusetts program was the unwillingness of both the police and clinical team members to make concessions (Bigley, 2019). This was ultimately resolved by finding the right representative who was open minded to a collaborative approach suggesting that agency representatives ought to be carefully vetted prior to selection. Similarly, Kubiak, Comartin, Milanovic, Bybee, Tillander, Rabaut and Schneider (2017) found that the lack of a team coordinator maintained the barrier to integrating various professional perspectives from each field. Noting the evolution of police officer perceptions about mental health, clinical co-responder Steve Beason identified that about half of the officers he worked with demonstrated an unwillingness to change their approach in the initial years of the co-response program in a metro-west Massachusetts city (2019). He describes the situation today as having been greatly improved in part due to increased training and awareness. Separately, both Beason and Bigley described the police as the least willing to embrace a clinical approach to mental health related offending, thus causing resistance in the effective implementation of the their respective programs (2019).

The few studies examining the cost of administering CIT services have indicated overall savings to the communities. Watson, Compton, and Draine (2017) indicated net savings of \$1.24 million dollars annually in Louisville, Kentucky. The savings came in the form of deferred hospital and jail costs. However, the same study used data from the Memphis CIT program to show that an increase of \$6,576 per person resulted in the CIT program costs outweighing the reduced jail costs. The efficiency and extent of these two conflicting programs was not delved into for further analysis. Bigley (2019) suggests that data collection is important as state funding is largely data driven and policy makers rely heavily on positive results as a condition of their support.

He does however warn that there is an over-dependance on reduced recidivism rates being the foremost indictor of success. Additionally, Beason describes less hospitalizations and medicine compliance as far superior measures of effectiveness over recidivism rates (2019). Due to this, city CIT teams in south eastern and metro-west Massachusetts have turned to private organizations like NAMI and United Way as sources of funding when recidivism data is weak (Beason, 2019).

The aggregate data shows that mentally ill individuals are substantially less likely to face arrest when CIT trained officers respond. Franz and Borum (2011) cite a 3% arrest rate amongst CIT officers in Central Florida. The study further suggested that this data is similar to data in other parts of the country. Between the 2001 and 2005, the number of post-contact arrest fell from a high of 22 to zero, despite the number of mental health disturbance calls remaining relatively the same during the period. Watson and colleagues (2017) showed similar findings in reduced criminal justice involvement and a positive link between CIT officers responding and patients getting access to long term mental health services in Portland, Oregon and Memphis, Tennessee. Alternatively, Taheri (2016) found that the response of CIT trained officers had a null effect on the probability of being arrested in her examination of the Memphis model. Furthermore, the data rendered a null effect on the use of force between being trained and not being trained in CIT.

Most of the research has been concerned with the satisfaction of law enforcement officers and mental health consumers. A majority of the police officers who underwent CIT training stated that they felt it was necessary to mandate treatment as an alternative to jail diversion. They further emphasized the importance of CIT training for police dispatchers (McGuire & Bond,

2011). Watson and colleagues (2017) suggested that CIT trained officers are far better versed on social-stigma and psychiatry-congruent beliefs when compared to non-trained officers. CIT officers consistently score better when interacting with someone with psychosis or suicidality. This sentiment is furthered by Kubiak and colleagues (2017) who found that CIT officers retained the training after seven months and were far more willing to assist consumers to crisis centers in comparison to non-trained officers. Krist and colleagues (2015) further indicated that participants in CIT (non-consumers) would be more effective with an increased emphasis on cross training and role clarity between partners, but that the overall sentiment is that the teams are effective and work well together over time. Ken Bigley described his own experience as a probation officer serving on a CIT team. He stated that in-person case conferences helped as they served as an opportunity for team members to engage in an interpersonal manner and learn from one another's experiences. This ultimately fostered a cohesive working environment over time (2019).

### **Youth Specialty Courts**

Unlike conventional juvenile justice issues, mental illness amongst America's youth is a pressing issue, as youth with mental illness experience much higher rates of crime (Cuellar, McReynolds, & Wasserman, 2006). An examination of the Texas Special Needs Diversionary Program (SNDP) showed that those youth enrolled in mental health diversion had a lower probability of re-offending across all crime categories. Furthermore, over a 12-month period, 63 fewer arrests occurred per 100 youth served. The results are profound when applied to all youth across the nation, 11 percent being diagnosed with a mental illness (Cuellar et al., 2006). However, Juvenile Mental Health Courts (JMHC's) are not yet a national phenomenon with only 15 states

having such establishments (Callahan, Coccozza, Steadman, & Tillman, 2012). Callahan and colleagues (2012) found that 86% of JMHC's worked directly with local mental health agencies. Furthermore, 71% of families served reported gaining access to outpatient services that they did not have before. This appears to be an effective mechanism in identifying mental illness in youth.

### **Adult Mental Health Courts**

McNeil and Binder (2007) conducted a comprehensive analysis of the San Francisco Behavioral Court and found that reductions in the likelihood of new offending post-program completion in the first 12 months was high. Furthermore, it was shown that these reductions strengthened over time. This was especially the case with violent offenders and those who successfully graduated the program with reduced recidivism being maintained after their supervision period ended. Steadman (2011) found similar results. In an analysis of four different sites, he found that those who participated in a diversion program had a 49% likelihood of reoffending compared to 58% of non-participants. Interestingly, the Minnesota site showed a null effect of participating in the MHC program. This is similar to Skrzypiec's (2004) analysis of the MCDP in Australia that served as an outlier amongst the other analyses. Perhaps this ought to prompt further analysis of the changes in the MCDP between 2004 and 2014 and the differences in the Minnesota site from the other three.

Sarteschi (2011) acknowledged the importance of graduating from MHC programs as the aggregate data showed that participants who do not graduate from the program were substantially more likely to re-offend. Herinckx (2005) affirmed this and suggested that the majority of individuals who quit the program returned to court and were subjected to traditional punitive mea-

asures. He further outlined that only 2.8% of graduated participants re-offended in a study of the Clark County Mental Health Court in Nevada. As well as showing reduced recidivism, Frailing (2010) was able to show that drug and alcohol use was also reduced upon successful completion of the program in Washoe County, Nevada. Access to mental health services was also shown to be substantially increased by involvement with a MHC, regardless of program completion. In Broward County, Florida, court transcripts revealed that in 82% of cases, there was an explicit treatment-linkage between court involvement and mental health services (Boothroyd, 2003). Unlike the relatively inconclusive data on the cost-benefit of CIT programs, MHC's have been shown to save money using data on reduced jail time. In Washoe County, Nevada, the average cost to house 106 pre-program participants was \$566, 243 over a 12- month period. That cost was reduced to \$25,290 in the year post-program for the same group.

### **Methodology**

The primary data collection method in this policy analysis will be achieved through telephone interviews with practitioners who have been involved in the implementation of CIT co-response teams in Massachusetts. A policy analysis is an in-depth examination of the effectiveness of an approach to a defined problem within a given field (Kraft, 2012). In this study, I will investigate whether CIT training for police officers and other mental health co-responders, mental health courts, and other diversion initiatives have had the effect of lowering involvement in the criminal justice system on the part of mentally ill offenders.

**Verify, define, and detail the problem:** The first step of this analysis is to define and outline the issue itself. In general, law enforcement in the United States has been slowly adopting arrest di-

version and crisis intervention programs to deal with the prevalence of crime being committed by mentally ill perpetrators. This has become an issue in recent years due to the deinstitutionalization of mental health across the nation. With that, upwards of two-thirds of the mentally ill population is now living within the community (Acquaviva, 2006). The influx of mental health related crime into the communities has ultimately become a criminal justice issue due to insufficient community-based services. The jailing of mentally ill criminal offenders has produced a 'revolving door' of people who are not receiving the treatment they need. This special segment of the population is simply grouped in with the rest of society, adding to a fivefold increase in the U.S. prison population since 1970 (Acquaviva, 2006). Community-oriented treatment has been shown to drastically improve the quality of life for this segment of the population. This analysis is primarily conducted with human participants, particularly those participating in diversion programs from the various jurisdictions that have already been examined. Participants include those who withdrew from the program prior to the start date, those who withdrew during the program and those who graduated from the program. Other subjects include police officers and clinical staff who underwent Crisis Intervention Training (CIT). Nurses and Mental Health staff who completed CIT are also included as they are integral members of the response team. Individual members of Massachusetts co-response teams will be interviewed to attain qualitative data as part of this analysis.

The Magistrates Court Diversion Program (MCDP) of South Australia will be used as an international example to show that the conclusion derived from the analysis may be suitable to other countries in their efforts to address community based mental health issues. Established in 1999, the MCDP was Australia's first endeavor to initiate early intervention of mentally ill of-

fenders by diverting them into the appropriate treatment and rehabilitation programs rather than a formal legal process (Lim, 2014). Likewise, the United States saw its first mental health courts emerge in 1997, but the response was slow and it took many years to revolutionize national policy (Steadman, 2011). Today, there are over 250 mental health courts nationwide. This expansion has been the counterbalance to a move to de-institutionalize mental health that was sparked in the mid-1960's. According to Acquaviva (2006), 16% of inmates nationwide suffer from a mental illness. Following closely, Juvenile Mental Health Courts (JMHC's) emerged to address the mental health needs of juvenile offenders. According to Callahan (2012), 65%-70% of youths in the juvenile justice system experience mental disorders that require treatment. This is often combined with a co-diagnosis for substance abuse.

In congress with the emergence of mental health courts is the development of CIT. Kirst (2015) suggests that mental health crisis response is not traditionally the job of police officers, yet they have ultimately filled the void that originated following the closures of mental institutions nationwide. A metro-west Massachusetts city implemented their co-response model on the heels of a substantial uptick in police involved involuntary hospitalizations (Beason, 2019). The CIT model, despite being popular overall, has been criticized for challenges relating to long wait times in emergency rooms, lack of education for police and dispatchers, as well as inadequate staffing.

**Establish Evaluation Criteria:** The materials in this analysis needed to be grouped so that the data parameters are on par with one another in order to determine how success will be measured. Of the nine studies used to evaluate mental health treatment programs, the common span of time

used to analyze re-arrests was 12 to 18 months after the completion of the specific treatment program. Additionally, the studies evaluate the program based on initial participation, incompleteness (for any reason), and completion. For instance, participants who did not complete their respective program will not be grouped into any data that compliments the overall effectiveness of the program. The same criteria will be used for juvenile court cases which consist of three separate studies that follow the same evaluation criteria. However, the analysis of juveniles will also consider the type of crime and the commission of prior offenses. Other criteria that is suggestive of successful public safety outcomes are the results of alcohol and drug tests in the 15 months post program completion, using monthly test data. The number of days spent in jail pre- and post-program completion will also be used as an indicator of success.

The data on CIT effectiveness will be grouped into two categories, professional attitudes and perceptions pre- and post- training and the effect on arrest rates following the implementation of CIT over a twelve- month period. Crisis center drop-off will also be used as a gauge to analyze the effectiveness of police officers pre and post CIT training. The effect of CIT on cost-saving measures will be considered as a positive agency-level outcome. Perhaps the most illuminating data will come from a careful examination of mental health disturbance calls and the arrests that occur before and after CIT training. A reduction in arrests post-training will be considered a positive public-safety outcome. Lastly, qualitative data attained from personal practitioner interviews will be grouped when like responses are detected. Outlier response may also be noted and discussed further.



**Identify alternative policies:** A program that has developed alongside CIT is Mental Health First Aid (MHFA). MHFA was developed in 2000 by educator and mental health consumer Betty Kitchener. It is aimed at providing help to a person who is developing a mental health problem or is currently in crisis. The MHFA certified responder is equipped to identify the symptoms of specific disorders and the types of crisis. They can offer initial help and direct a person to the appropriate treatments and other professionals who can develop a long-term care plan (Morgan, 2018).

Another alternative to training regular police officers in CIT would be the development of a mental health specific police force that would be on-call to mitigate mental health crisis' as they unfold. Much like Environmental, Fish and Game and School Resource Officers (SRO's), a mental health unit would be specifically trained to build a rapport with patients living in the community, check in with them on occasion and work hand in hand with clinical staff to ensure the subject is following his/her care plan.

**Evaluate alternative policies:** MHFA is an 8-hour course that is completed in one day. It is available in both youth and adult specific versions. The program also has a law enforcement track that is offered to individual police departments. Morgan (2018) found that the course is effective in increasing the knowledge base of participants regarding mental health issues and treatment as well as reducing stigma about mental illness. It is primarily targeted at the lay responder, perhaps a coworker of someone who suffers from mental health issues or those operating in a non-direct care role. Effectiveness of the training is unclear after the initial 6 months following its administration. Apart from the increase in knowledge about mental health issues, findings revealed a low to moderate impact on other test criteria such as problem recognition, effec-

tiveness of intervention and intentions and confidence in training after the initial 6 months (Morgan, 2018). Beason and Bigley, separately, described MHFA as being overused by police agencies as the primary mental health response training (2019). Beason went on to suggest that it is a cost-effective measure to ensure large numbers of department personnel receive training which mitigates liability concerns. It is, as he describes, an awareness level training that does little to train officers in the essential de-escalation techniques that are paramount to an effective crisis response (2019). Bigley (2019) suggests that it is better than not to offer MHFA in the absence of better alternatives but that crisis intervention programs are far superior in training officers to be effective and compassionate through the hands-on training that MHFA doesn't incorporate.

Mental health police officers would be trained specifically in how to handle mental health patients in crisis. Arrests would be a last resort. The creation of a mental health officer position would have to be considered by specific police departments and reflect the need for said officer. It would be based on call volume for mental health calls. There would surely be some communities that would not have the call volume to warrant such a position. In that case, a regional unit that would be responsible for a number of surrounding communities would be more appropriate. This would reduce the burden on regular patrol units that are often times overwhelmed and tied up with mental health calls. Often times units are forced to arrest due to a lack of resources and the need to clear calls in a timely manner. However, it is reasonable to assume that administrators would be slow to adopt such a position when patrol units are often times understaffed to begin with. Ken Bigley identifies this as a possible solution for larger cities but stressed that smaller municipalities could not justify the position based on call volume. He cited municipalities that do

share clinicians but noted that legislation would surely have to be passed in order to grant regional jurisdiction to a municipal officer, as would be necessary under such a program (2019).

**Display and distinguish among alternative policies:** Perhaps one of the most important considerations for police agencies is the cost of implementing specific programs and policies. Often times the cost of a specific position is not always outweighed by the benefit. The price-point per officer of administering MHFA training is considerably less than that of CIT training. Moreover, the creation of a specialized position that is tasked with participating in only certain types of calls is of little benefit to police agencies that are often times deficient in manpower to begin with.

The response has been to seek less intensive training for all patrol units. Programs like Mental Health First Aid (MHFA) and Crisis Intervention Teams (CIT) have been the response for most communities. MHFA is, however, problematic. The training is one day long and studies have shown that its effectiveness dwindles after the initial 6 months (Morgan, 2018). It is also a less practical experience for police officers. Police academies are placing an emphasis on mental health awareness that closely resembles MHFA. Spencer Beason is critical of the Massachusetts Municipal Police Training Committee (MPTC) for its over reliance of awareness based training for police recruits. Despite training hours increasing in recent years, the majority of the curriculum is focused on providing knowledge about specific diagnosis's rather than deescalation techniques and hands on sessions (2019). MHFA results are insufficient at best in mitigating the crisis situation as it unfolds. Apart from general knowledge about mental health issues, MHFA trained units could leave the training with little practical knowhow regarding their future response to a crisis call. In comparison, a mental health unit would be well versed in the area of mental health and more importantly, he would be familiar with most if the individuals he encoun-

ters. The long-term benefits to the patient would be far greater. Arrests would surely decrease as well. It would be expected of a mental health unit to refrain from arresting individuals in crisis. However, the inability of regular patrol units to recognize and diagnose crisis situations would lead to unnecessary public order arrests.

**Monitoring the implemented policy:** There are a number of ways in which police agencies could monitor their choice in policies. Perhaps the most obvious gauge would be to track the number of arrests taking place during mental health related calls. A reduction in the number of arrests would be considered a more effective response. However, to demonstrate the effectiveness of a lower inclination to arrest, one would have to track the actual response of the responding units and render judgement on whether or not their response was more or less effective than an arrest. An experimental design to test for different responses can be used to define what ought to be considered more effective than making an arrest. For instance, a crisis center drop-off or an emergency consultation with a clinician would be preferred. Use of force reports could also be tracked to measure a reduction on hands-in encounters. Qualitative data such as commentary by family members and individual officers should also be considered in appraising either the MHFA trained officer or the Mental Health Officer.

### **Conclusion and Discussion**

This analysis has been primarily concerned with appraising the extent to which modern policy has mitigated the intersection of mental illness with the criminal justice system in the United States. Policy solutions in the U.S. constitute the expansion of specialty courts and multidisciplinary teams made up of police, clinicians, psychologists and probation officials. Acquavi-

va (2006) suggests that if the primary goal of mental health courts is to increase the quality of life for patients then reductions in crime and better outcomes for the community as a whole will follow suit. Viable treatment in lieu of criminal sanctions is a win-win for all. What the aggregate data suggests is that criminal justice diversion programs are wholly effective in addressing multiple problems at both the societal and individual level. Crime rates are reduced, access to mental health screening and treatment programs are increased, and jail time is significantly depressed. A reduction in recidivism rates is an overall positive and serves as the foremost indicator of effectiveness for policy makers. However, over-emphasizing recidivism as a measure of success can lead to the misallocation of resources. According to Beason (2019), measuring recidivism alongside medicine compliance, meeting therapy goals and a reduction in illicit substance use would paint a more vivid picture as to the effectiveness of modern policy initiatives like therapeutic jurisprudence and community based co-response teams. This is the case for both adult and juvenile populations. Problems still exist such as the prevalence of participants who withdraw from programs provided through mental health courts. This begs the question: should we be mandating consumers into programs or is one's voluntary participation a key to success? Only time, further development, and increased funding will tell. It is, however, certain that these programs do work and represent a vast improvement when compared to conventional approaches to mental health related crime. It is the conclusion of this author that the CIT model is undoubtedly the most effective initiative in effect. Although it depends highly on collaboration amongst loosely aligned disciplines; it funnels easily identifiable subjects in crisis directly to treatment which reduces the likelihood of further trauma being induced via the criminal justice system. The CIT model depends highly on motivated representatives being selected from the various professions that ulti-

mately form a co-response team. A willingness to embrace teamwork, collaboration and compromise have been identified as the prerequisites to being a productive and meaningful member on a CIT. With most agencies having to satisfy union contracts that stipulate how applicants are chosen and ultimately assigned to specialty units, the assignment of improper personnel to CIT's is likely to continue. However, a summation of the aggregate quantitative and qualitative data definitively suggests that the trajectory established by MHC's and CIT's have had a profoundly positive outcome for mental health patients and should be expanded upon.

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