Volume III

Emerging Best Practices in Law Enforcement Deflection and Community Supervision Programs

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A1 Advancing Justice

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Emerging Best Practices in Law Enforcement Deflection and Community Supervision Programs

National Association of Drug Court Professionals
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Further information about Advancing Justice is available at NADCP.org/AdvancingJustice. Further information about the National Association of Drug Court Professionals is available at NADCP.org.

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VOLUME III

National Association of Drug Court Professionals

Carson L. Fox, JD, *Chief Executive Officer*
Carolyn D. Hardin, MPA, *Chief of Training and Research*

625 North Washington Street, Suite 212
Alexandria, Virginia 22314
Tel. (703) 575-9400
Fax (703) 575-9402
NADCP.org

Journal for Advancing Justice

The *Journal for Advancing Justice* provides justice and public health professionals, policymakers and other thought leaders, academics, scholars, and researchers a forum to share evidence-based and promising practices at the intersection of the justice and public health systems.

The journal strives to bridge the gap between what has proven effective and what is often considered business as usual.

Although the *Journal for Advancing Justice* emphasizes scholarship and scientific research, it also provides practitioner-level solutions to many of the issues facing the justice system. To that end, the journal invites scholars and practitioners alike to submit articles on issues of interest impacting global justice systems, particularly where they collaborate with public health systems.

Advancing Justice was created by leaders of the treatment court movement at the National Association of Drug Court Professionals (NADCP). Through NADCP, Advancing Justice harnesses three decades of credibility, expertise, and leadership responsible for the creation of more than 3,000 treatment courts throughout the world. With a constituency of thousands of justice and public health professionals spanning every intercept point in the justice system, from entry to reentry, Advancing Justice is positioned to lead a new era of global reform.

National Association of Drug Court Professionals

The National Association of Drug Court Professionals (NADCP) is the premier training, membership, and advocacy organization for the treatment court model, which now includes more than 3,000 programs found in every state and four territories of the United States, and over 20 countries. Since 1994, NADCP and its divisions—the National Drug Court Institute, the National Center for DWI Courts, and Justice For Vets—have trained hundreds of thousands of professionals spanning the legal, clinical, psychosocial, and law enforcement fields.

NADCP regularly publishes cutting-edge, research-based materials—including the groundbreaking *Adult Drug Court Best Practice Standards*—and the association works tirelessly to improve the response of the American justice system to people with substance use and mental health disorders.

NADCP is a 501(c)(3) organization.

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Introduction: Deflection—Police-Led Responses to Behavioral Health Challenges

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Illinois Criminal Justice Information Authority

This special issue of the *Journal for Advancing Justice* features papers that reflect critical issues in the emerging field of law enforcement deflection and prearrest diversion programs (hereafter collectively referred to as deflection). Deflection[1] is a collaborative intervention connecting public safety (e.g., police, sheriffs) and public health systems to create community-based pathways to treatment for people who have substance use disorders (SUDs), mental health disorders, or both, and who often have other service needs, without their entry into the justice system.

These deflection pathways, discussed later in more detail, facilitate connections to treatment, recovery, housing, and social services via case management. In this way, deflection provides a new, third option for police—an alternative to the traditional choices of making an arrest or taking no action—when encountering individuals whose behavioral health conditions may be factors underlying their contact with law enforcement, with or without the presence of criminal activity. Deflection can enable individuals to receive referrals to services without fear of arrest or can be offered in lieu of arrest when charges are present and an arrest would have otherwise occurred.

Evolving over the past decade, with almost all growth occurring during the last four years (2016 to 2020), deflection has manifold aims. It seeks to promote the well-being of individuals, improve public safety, address racial inequities, shift social service responses from police to behavioral health and housing, keep families intact, reduce jail overcrowding, and improve relations between police and the community. This special issue features articles focusing on how deflection program models operate and potential best practices for the field.

DEFLECTION: POLICE-LED RESPONSES TO BEHAVIORAL HEALTH CHALLENGES

In jurisdictions across the nation, behavioral health is a major societal issue with public health and criminal justice implications. In 2017, an estimated 19.7 million Americans aged 12 and older had SUDs, 46.6 million had a mental health disorder, and 8.5 million had co-occurring SUDs and mental health disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Research has consistently shown the effectiveness of treatment or therapeutic interventions for behavioral health conditions (Bahr et al., 2012; Gatens, 2019; Gleicher, 2019; Heilbrun et al., 2012; Jones et al., 2012; Police Executive Research Forum, 2016), medications for opioid and alcohol use disorders (Connock et al., 2007; Gibson et al., 2008; Mattick et al., 2009; Schwartz et al., 2013), case management (Ziguras & Stuart, 2000), and wraparound services such as housing and education (Suter & Bruns, 2009). However, barriers may impede access to treatment, including treatment waitlists (Fisher, et al., 2016; Grella, et al., 2004; Pullen & Oser, 2014; Redko et al., 2006), stigma (Parcesepe & Cabassa, 2013), financial barriers such as costs and lack of insurance (Ali et al., 2017), and transportation (Pullen & Oser, 2014).

Police are employing deflection to overcome such barriers, promoting public safety through improved service connections for individuals in their communities (Charlier, 2015). Officers often encounter individuals displaying behavioral health symptoms and who also appear to be in crisis and have basic needs, which makes deflection a natural extension of police work (Patterson, 2008). Police

serve as the referral source and point of contact for deflection initiatives, but they are not the providers of treatment, services, or case management. Table 1 presents five deflection pathways for law enforcement (three of which can also be performed by fire services and emergency medical services) to connect people to behavioral health treatment, recovery, housing, and other services (Bureau of Justice Assistance, 2018; Charlier, 2014).

Within this five-pathway typology, several named approaches to one or more pathways have emerged and have been replicated in other jurisdictions. These preestablished approaches are referred to as deflection "brands" and present themselves as a specific, off-the-shelf way of managing one or more deflection pathways for a specific purpose and/or with a specific target population. Some deflection sites use a combination of these deflection brands to implement multiple deflection pathways. Further, more deflection brands are on the horizon as the field continues its rapid growth and development. For example, the Civil Citation Network (CCN) reflects the officer intervention pathway. The program is operational in 86 jurisdictions, comprising 67 juvenile civil citation sites and 19 adult civil citation sites (T. Olk, personal communication, April 24, 2020). Law Enforcement Assisted Diversion (LEAD), a program that reflects the officer prevention and officer intervention pathways, has been implemented in 38 jurisdictions (LEAD, 2019). The Police Assisted Addiction and Recovery Initiative (PAARI) represents programs in over 550 jurisdictions using the self-referral pathway and the active outreach pathway (PAARI, n.d.). Finally, the Quick Response Team (QRT) program adopts the naloxone-plus pathway

Table 1: Five Deflection Pathways

Pathway	Definition	Initiator of contact	Initiation location	Program examples
Self-referral (also can be done by fire and emergency medical services [EMS] without law enforcement)	An individual voluntarily initiates contact with a first responder (a law enforcement, fire services, or EMS professional) seeking access to treatment—without fear of arrest—and receives a referral to a treatment provider.	Individual community member	Police department, fire station, EMS	• Angel • A Way Out • Safe Stations • Safe Passage
Active outreach (also can be done by fire and EMS without law enforcement)	A law enforcement officer or other first responder identifies or seeks out an individual in need of substance use or mental health treatment (can include housing and other services), and a referral is made to a provider who engages them in treatment (and ideally case management services are also provided).	Police officer, often with outreach personnel	In the community	• Arlington (Massa-chusetts) Outreach Initiative • Homeless Outreach Team (HOT)
Naloxone-plus (also can be done by fire and EMS without law enforcement)	A law enforcement officer or other first responder engages an individual in treatment as part of an overdose response, preferably at the point of overdose or as close to the point of overdose as possible, such as at the emergency department.	Team with a combination of police, social worker, peer recovery specialist, faith-based leader	In the community, hospital (emergency department), residence	• Quick Response Team (QRT) • Drug Action Response Team (DART) • Substance use disorder (SUD) co-responder models

Pathway	Definition	Initiator of contact	Initiation location	Program examples
Officer prevention (also can be done in a co-responder approach)	A law enforcement officer, alone or as a member of a co-responder team, initiates treatment engagement (which can also be directly to a case manager first), but no criminal charges exist or are present, and hence no criminal charges can be filed. Officer prevention occurs as part of police patrol duties including "on-view," citizen "flag down," or in response to a call for service.	Police officer and, if present in a co-responder approach, mental health, treatment, social worker, case manager, or peer	In the community, "on view," in response to a call, on patrol	• Stop, Triage, Engage, Educate and Rehabilitate (STEER) • Law Enforcement Assisted Diversion (LEAD)
Officer intervention (law enforcement required, also can be done in a co-responder approach)	A law enforcement officer, alone or as a member of a co-responder team, initiates treatment engagement (which can also be directly to a case manager first), and either charges are filed and held in abeyance or a citation with treatment requirement is issued. **Note:** This is not the same as citation in lieu of arrest, as it involves some type of mandated treatment assessment or participation. Officer intervention occurs as part of police patrol duties including "on-view," citizen "flag down," or in response to a call for service.	Police officer and, if present in a co-responder approach, mental health, treatment, social worker, case manager, or peer	In the community, "on view," in response to a call, on patrol	• Civil Citation Network (CCN) • LEAD • Crisis Intervention Team (CIT) • Co-responder

Source: *Adapted from the U.S. Department of Justice, Bureau of Justice Assistance.*

and has been implemented in 161 jurisdictions (D. Meloy, personal communication, April 7, 2020).

When developing deflection initiatives in local communities, law enforcement should select deflection pathways based on specific community problems and challenges that need to be addressed and resources available to address them. Problems may include substance use, mental health issues, sex trafficking, and homelessness. Resources to consider include behavioral health treatment capacity, law enforcement and community leadership, the presence of a case management structure, and the strength of local recovery networks. Communities can maximize deflection program reach by developing multiple pathways as resources allow.

CHALLENGES FOR DEFLECTION PROGRAMS

Numerous issues may challenge current and potential deflection programs, including sparse resources and funding, lack of transportation to treatment and other services, racial inequities in program access and outcomes, and societal stigma attached to drug use. Two main challenges documented in the literature include insufficient treatment capacity and a police culture that relies on arrests for drug-related offenses.

Treatment Capacity

As the number of police deflection programs grows, and as more individuals seek or agree to SUD treatment as a result of police assistance, communities may encounter a new or exacerbated shortage of available SUD treatment. Police deflection programs have identified treatment capacity as a barrier to their success (Barberi & Taxman, 2019; Reichert, 2017; Schiff et al., 2017; Urban, 2017). Limited treatment may lead to waiting lists, which reduces the number following through with treatment, especially in a timely manner (Appel et al., 2004; Chun et al., 2008; Redko et al., 2006).

If waiting periods occur, deflection program team staff can use that time to engage individuals and maintain their motivation for treatment and behavior change. Team staff can discuss harm reduction strategies, which shows promise as a practice (Davis & Beletsky, 2009; Logan & Marlatt, 2010); provide linkages to peer recovery coaches and supports, which generally show promise (Eddie et al., 2019; Samuels et al., 2019); and offer brief motivational interventions, which have been shown to be effective (DiClemente et al., 2017). However, harm reduction, peer recovery supports, and brief motivational interventions have yet to be tested in relation to police and deflection programs. Individuals with opioid use disorder (OUD) can be provided take-home naloxone, which has been proven effective at preventing fatal overdoses (Chimbar & Moleta, 2018), and referred to a health care provider for medications (Volkow et al., 2014). One study found that patients prescribed medication for OUD while on treatment waiting lists had a statistically significant reduction in opioid use compared to those not taking medication (Sigmon et al., 2016).

Police Culture

Police culture has been perceived as an obstacle to the implementation of police deflection (Barberi & Taxman, 2019). In many departments, the police culture approach to drug-related offenses emphasizes the maintenance of order (i.e., the suppression of crime and disorder through invasive law enforcement methods), with a reliance on arrest (Chandler et al., 2009; Terrill et al., 2003), in contrast to police deflection's public health approach (Barberi & Taxman, 2019; Charlier, 2017). Research has shown that a public health and therapeutic approach to addressing SUDs can improve behavioral health outcomes and reduce criminal activity (Chandler et al., 2009).

In order to change police culture, officer training is necessary (Barberi & Taxman, 2019; Branson, 2016; Ekelund & Charlier, 2019; Reichert et al., 2017). In addition to providing information on how deflection programs operate, regular trainings can offer information on the physiology and psychology of SUD and recovery, how to recognize substance misuse, stigma related to SUDs, treatment services and levels of care, Motivational Interviewing and brief interventions, and screening and treatment referrals (Barberi & Taxman, 2019; Branson, 2016; Ekelund & Charlier, 2019; Reichert et al., 2017). While training officers on how to address another behavioral health issue—mental health disorders—has been observed to produce notable benefits (Compton et al., 2008), a 2018 systematic review of Crisis Intervention Team training found mixed results, and there is need for further research (Peterson & Densley, 2018).

RESEARCH ON DEFLECTION

While police deflection programs have rapidly proliferated across the country over the past decade to an estimated 850 known sites, research has not kept pace with the growing field. To date, limited research has focused on describing program participants (Korchmaros, 2019; Schiff et al., 2016; Taxman, 2017) or offering qualitative data (interviews and/or focus groups) to understand police, participant, and community perspectives (Barberi & Taxman, 2019; Formica et al., 2018; Reichert, 2017; Schiff et al., 2017).

One evaluation of a police self-referral deflection program in Lee County, Illinois, found positive feedback on the program from community stakeholders (i.e., probation, courts, local health department, faith-based community, hospitals, city council, community groups, and volunteers), police officers, treatment providers, and clients (Reichert et al., 2017). An evaluation of an adult civil citation program using the officer intervention pathway in

Leon County, Florida, found that participants with greater behavioral health problems and propensity for crime and violence were more likely to fail the program, and that greater behavioral health problems were also associated with a higher probability of postprogram arrest (Kopak & Frost, 2017). Also in Leon County, Florida, an evaluation compared the arrest outcomes for participants in a prearrest adult civil citation program to those of participants in a postbooking diversion program and found the programs had similar postprogram arrest rates (Kopak, 2020).

One deflection program model that has been researched is the LEAD program in King County (Seattle), Washington, which aligns with the officer prevention and officer intervention pathways. The program features services—including case management, SUD treatment, and wraparound support—to individuals postarrest but in lieu of further booking and prosecution (Collins et al., 2015). LEAD clients were found to have statistically significant reductions in recidivism and criminal justice contact compared to a comparison group using a nonrandomized control design (Collins et al., 2015). They also were found to have improved housing and employment outcomes among participants (Clifasefi et al., 2017). However, when LEAD was replicated in Albany, New York, diversions in its first year were few in number, and officer attitudes toward the program were mixed (Worden & McLean, 2018), raising concerns about replicability in communities beyond Seattle.

The efficacy of most police programs, including deflection programs, has yet to be tested using a randomized controlled trial (RCT), the scientific gold standard (Buck & McGee, 2015; Lum, 2009: Lum & Yang, 2005; Shadish et al., 2001; Weisburd, 2003). However, program aspects, regardless of deflection pathway, could be randomized (e.g., how contact is initiated and by whom, how the program is offered and by whom, how referrals are made and by whom, training content). Some pathways (all except self-referral) could randomly test whether active, officer-initiated offers of treatment or services result in better outcomes compared to arrest-as-usual, with the establishment of treatment and control groups (by officer, shifts, beats, precincts/districts, or departments). The self-referral pathway is less conducive to being studied through an RCT approach because it is a referral program, similar to a helpline, in which participants voluntarily request referrals to services. In this model, withholding referrals to create a control group would pose a challenge for police relations and procedural justice. However, this does not mean self-referral pathway programs cannot be evaluated; quasiexperimental designs may be employed, or alternatively, referrals to local social services could be randomized (e.g., some participants referred to treatment provider A and some to treatment provider B). These research approaches could examine outcomes involving police contact, morbidity and mortality, and treatment quality, engagement, and retention.

EVOLUTION OF THE DEFLECTION FIELD

The field of deflection has evolved over the past decade. Figure 1 offers a timeline of milestones in the development of the field, beginning in 2011. As shown, the early years of 2013 to 2015 represent a period of innovation by the end of which all five deflection pathways came into existence, followed by rapid growth in sites and mounting recognition as a new and distinct field of practice from 2016 to the present. Of note are partnerships not involving the police.

In 2016, the Police, Treatment, and Community Collaborative (PTACC) was developed to provide national leadership and vision for the field of deflection and prearrest diversion. Today PTACC, which serves as the field's national voice and knowledge leader, much as the National Association of Drug Court Professionals does for the treatment court community and the International Association of Chiefs of Police (IACP) does for police chiefs, is dedicated to the growth and development of the entire field, across all five pathways and inclusive of nonpolice responses to behavioral health encounters. Currently comprising 42 national and international organizations, PTACC offers deflection guides for understanding the five pathways and suggested core metrics; resources for behavioral health, housing, and recovery; model state deflection laws; policy examples; and webinars. The group addresses the critical topics

Figure 1: Major Development Milestones in the Field of Deflection

2011	First officer prevention program, Law Enforcement Assisted Diversion (LEAD), starts in King County (Seattle), Washington
2013	National convention is held in Chicago exploring how police and treatment can work together to address addiction (includes the Treatment Alternatives for Safe Communities Center for Health and Justice [TASC CHJ]; Office of National Drug Control Policy [ONDCP]; National Institute on Drug Abuse; Substance Abuse and Mental Health Services Administration [SAMHSA] Center for Substance Abuse Treatment; U.S. Department of Justice, Bureau of Justice Assistance [DOJ BJA]; International Association of Chiefs of Police; National Sheriffs' Association; and National Judicial College) First officer intervention program, the Civil Citation Network, is formed in Florida
2014	First naloxone-plus program, Drug Action Response Team (DART), starts in Lucas County, Ohio Term *deflection* is coined to describe these new partnerships between police and treatment First deflection site typology is formulated by TASC CHJ
2015	First self-referral program, Angel, starts in Gloucester, Massachusetts Expanded naloxone-plus program, Quick Response Team (QRT), starts in Coleraine Township, Ohio First active outreach program, Arlington Outreach Initiative, starts in Arlington, Massachusetts First published article uses the term *deflection* to distinguish the work of the emerging field from the longstanding term *diversion*. Diversion is a criminal justice term for policies and practices related to those individuals who have already entered the justice system. In deflection, inclusive of the term *prearrest diversion*, a person does not move into the justice system beyond the initial contact with police. *Prearrest diversion* as a term is any officer intervention pathway to deflection where charges are held in abeyance or a citation with a mandate for treatment or treatment assessment is required. As such, prearrest diversion is a form of deflection.
2016	Police, Treatment, and Community Collaborative (PTACC) is formed Police Assisted Addiction Recovery Initiative is formed as a network of self-referral (Angel) and active outreach (Arlington Outreach Initiative) sites
2017	DOJ BJA incorporates the five deflection pathways in the Comprehensive Addiction and Recovery Act's Comprehensive Opioid Abuse Program (COAP) national solicitation First BJA funding source is established through COAP using the term *first responder diversion* (inclusive of fire services and EMS)
2018	QRT National is formed as the national association for QRT sites PTACC convenes inaugural, fieldwide U.S. conference on deflection and prearrest diversion Illinois passes first comprehensive five-pathway deflection legislation National Association of Counties passes resolution supporting deflection as part of its Justice and Public Safety 2018–2019 platform
2019	ONDCP adds deflection and prearrest diversion to the National Drug Control Strategy National Alliance of Model State Drug Laws releases first "deflection to treatment" model law National Institute of Justice issues first request for proposals for police deflection evaluation First deflection (first responder diversion) mentor sites established by BJA via Opioid, Stimulant, and Substance Abuse Program funding Centers for Disease Control and Prevention and SAMHSA release first site-based funding for deflection with health department as leads in conjunction with law enforcement PTACC adds 40th national partner
2020	National Association of Drug Court Professionals' *Journal for Advancing Justice* calls for first papers on deflection research

of race and equity, children, victims of crime, and core values for the field, and it convenes the only national, fieldwide annual conference to facilitate collaborative learning, sharing, networking, and growth (see ptaccollaborative.org).

The federal government began supporting the field's development in 2017 with national technical assistance and site-based grants provided by the U.S. Department of Justice's Bureau of Justice Assistance (BJA), followed in 2018 by an expansion of site-based grants, the first mentor sites, and expanded technical assistance available to communities that were not federal grantees. Research support was provided through the National Institute for Justice and its police deflection site evaluation research. The Office of National Drug Control Policy included deflection in its 2019 and 2020 National Drug Control Strategy reports, and SAMHSA and the Centers for Disease Control and Prevention have distributed site-based grants. Additionally, BJA is currently undertaking the first national survey of deflection sites.

As increasing numbers of deflection sites came online, deflection-related legislation and public policies have been advanced to facilitate their development and implementation. In 2018, Illinois became the first state to pass comprehensive deflection legislation, the Community–Law Enforcement Partnership for Deflection and Substance Use Disorder Treatment Act (Public Act 100-1025). The act supports all five deflection pathways, provides a funding mechanism for implementation and expansion, and includes performance measurement provisions. The National Alliance for Model State Drug Laws (NAMSDL) created guidance for states seeking to introduce similar comprehensive legislation (NAMSDL et al., 2019). Finally, California, Colorado, Florida, Kentucky, New Jersey, North Carolina, Ohio, Pennsylvania, West Virginia, and Wisconsin have all passed legislation or developed state policies to support deflection pathways (Trautman & Haggerty, 2019).

CONTRIBUTIONS OF THE ARTICLES IN THIS SPECIAL ISSUE

The articles in this special issue explore effective practices for police deflection, as well as lessons learned from established programs. In doing so, they offer new knowledge and a more nuanced understanding of such programs.

In "Engagement in Mental Health Services After CIT: The Effects of Mobile Crisis Team Involvement," Rhonda Smith, Robert Mindrup, Linda Foley, Rita Porter, Frieda Herron, David Patterson, and Raymond Wooten examine Crisis Intervention Teams (CITs), a prearrest diversion program (an officer prevention pathway) designed to train officers to reduce harm when responding to mental health crisis calls and divert individuals from jail to treatment. The authors present findings from a study on how collaboration between CITs and Mobile Crisis Teams (MCTs) affects engagement in mental health services for individuals experiencing mental health crises. MCTs assess and provide services for those in crisis in the least restrictive environment and can assist CIT officers to deescalate situations, make treatment referrals, and provide follow-up services. The authors conclude that when CIT officers used MCT, participants had a significantly higher rate of compliance with follow-up appointments, as well as less time to mental health treatment engagement. The authors further conclude that MCTs are important to the CIT process to divert individuals with mental health disorders from jail detention and improve their outcomes.

In "Law Enforcement Deflection and Prearrest Diversion Programs: A Tale of Two Initiatives," Albert Kopak and Lily Gleicher offer an overview of two law enforcement deflection programs—one in Illinois called the Safe Passage initiative (a self-referral pathway) and one in Florida known as the Civil Citation Network (an officer intervention pathway). Both offer services for individuals with SUDs, aim to reduce justice system involvement, have operated for several years, and are located in states with legislation to support deflection. However, the programs have notable differences, including referral mechanism (or pathway), goals, and target populations. The authors discuss lessons learned from the programs to promote

successful implementation and operations. These include building relationships with program stakeholders, ensuring availability of treatment, and sharing information for evaluation purposes. The authors conclude that additional monitoring and evaluation of deflection programs are needed to assess and enhance deflection programs.

CONCLUSION

While deflection has evolved to serve a variety of purposes, and studies have documented the emerging field, many research questions remain unanswered (IACP, 2018; Neusteter et al., 2018). Questions center around race and equity (racial bias in the application of deflection, transparency, policy, and legislation development); the extent and impact of program operations (e.g., training, staffing, marketing, stakeholders, coordination, collaboration, sustainability, fidelity, net-widening, measurement of risk and needs); officer discretion (who gets offered deflection and why); program staff (e.g., roles, background, training, knowledge, support); treatment issues (e.g., barriers, limits, availability, accessibility, types, medications); participants (e.g., characteristics, needs, levels of support and engagement, substances used); the community (e.g., characteristics, level of support and engagement, relations with police, stigma); impact on children (e.g., foster care, drug endangerment); and outcomes (e.g., criminal justice contact, treatment engagement and retention, substance use, risky behaviors, motivation for change, education, employment, housing). This special issue expands the current literature, and we hope it will engender further study and research-to-practice efforts as deflection sites continue emerging and expanding across the country.

ENDNOTE

1. The term *deflection* was coined in 2014 by the TASC CHJ and first published in a 2015 *Police Chief* article by CHJ Executive Director Jac Charlier ("Want to Reduce Drugs in Your Community? Why Not Deflect Instead of Arrest?"). In contrast to deflection, diversion programs generally involve prosecutors, courts, probation, and/or parole offering postarrest alternative programming or services to individuals in lieu of conviction, traditional sentencing, or violations of supervision conditions.

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AUTHOR BIOGRAPHIES

Jac A. Charlier, MPA, is the executive director and co-founder of the Police, Treatment, and Community Collaborative (PTACC), and the executive director of the Treatment Alternatives for Safe Communities (TASC) Center for Health and Justice. He is an internationally recognized leader in deflection and prearrest diversion for vulnerable populations. Mr. Charlier's work is grounded in collaborative, community-based crime-reduction initiatives at the intersection of the justice and behavioral health systems, while paying special attention to victims of crime, issues of equity, impact on children, and poverty. He received his MPA from the John Glenn School of Public Policy at The Ohio State University.

Jessica Reichert, MS, is research manager of the Center for Justice Research and Evaluation at the Illinois Criminal Justice Information Authority. Her interests include criminology, behavioral health, policing, corrections, and qualitative research methods. Ms. Reichert received her MS in criminal justice from the University of Wisconsin-Milwaukee.

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Correspondence
Please address correspondence concerning this article to:
Jac Charlier, MPA
Tel: 773-266-1420
Email: jcharlier@tasc.org

Jessica Reichert, MS
Email: Jessica.Reichert@illinois.gov

RESEARCH REPORT

Engagement in Mental Health Services After CIT: The Effects of Mobile Crisis Team Involvement

Rhonda G. Smith
University of Tennessee, Knoxville

Robert M. Mindrup
University of Tennessee, Knoxville

Linda T. Foley
Pine Belt Mental Healthcare Resources

Rita L. Porter
Pine Belt Mental Healthcare Resources

Frieda B. Herron
University of Tennessee, Knoxville

David A. Patterson
University of Tennessee, Knoxville

Raymond M. Wooten
Pine Belt Mental Healthcare Resources

Abstract

This article reports on a retrospective study of the effects of a collaboration between two commonly implemented prearrest diversion programs on the engagement in mental health services by individuals who have experienced mental health crises. More than half of all individuals in the United States who report experiencing mental health conditions are untreated. Numerous data report on the barriers to engagement in mental health services, but one study found a critical factor to be the time elapsed between a crisis and the first encounter with a mental health professional. This study is a step toward understanding the impact that collaboration between Crisis Intervention Team (CIT) officers and a Mobile Crisis Team (MCT) has on engagement in mental health services in a small rural county in southern Mississippi. An analysis of 107 health records of CIT contacts examined a group that used MCT after an encounter with law enforcement and another group that did not. The CIT contacts who used MCT had a significantly higher rate of compliance with follow-up appointments, as well as a shorter time span between the CIT encounter and engagement in treatment. These findings are a first step toward understanding how the CIT/MCT relationship can improve engagement in mental health services.

THE PROBLEM

This article reports on a small, retrospective pilot study of engagement in mental health services after an encounter with a prearrest diversion program, Crisis Intervention Team (CIT). In 2017, 46.6 million adults (18%) in the United States reported experiencing a mental health condition, of which 57.4% remained untreated (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). Of these, 11.2 million reported a serious mental health disorder, characterized by serious impairments of functional daily living. Severe functional impairments often lead to crises that result in negative encounters with law enforcement and subsequent incarceration.

These impairments contribute to disparate rates of involvement in the criminal justice system for individuals living with serious mental health disorders. Of the approximately 1,000 individuals fatally shot by law enforcement officers in 2018, 25% were living with serious mental health disorders (Saleh et al., 2018). A 10-year longitudinal study of individuals living with serious mental illness concluded that 28% were arrested during that period (Fisher et al., 2006). Having this many untreated individuals experience criminal justice involvement is a good indicator that mental health practitioners need to improve their ability to engage individuals in services.

Engagement is a factor that predicts how well an individual will respond to specialized care and how actively involved in treatment they become (Roeg et al., 2015). Roeg et al. (2015) also found that the most significant problem in maintaining engagement was the amount of time that passed between a crisis and the first encounter with a professional. Additionally, Bostleman et al. (1994) found that there is a critical window of time between discharge from the inpatient setting and the first appointment for outpatient treatment that is predictive of engagement in continued services.

Numerous studies confirm that many adults living with mental health conditions avoid seeking and becoming engaged in treatment (Kessler, et al., 2005; President's New Freedom Commission on Mental Health, 2005; Sareen et al., 2007; Wang et al., 2005; Wang, Angermeyer, et al., 2007; Wang, Gruber, et al., 2007), even when their conditions are severe and persistent (Kessler et al., 2001). Many factors have been attributed to the failure to obtain treatment, including the stigma associated with mental health conditions (Van Voorhees et al., 2005; Wrigley et al., 2005; Wynaden et al., 2005); accessibility of services, including services for those experiencing homelessness (Sareen et al., 2007); impaired perception of the need for treatment (Edlund et al., 2006; Mojtabai et al., 2002; Sareen et al., 2007); affordability and insurance limitations (Mojtabai, 2005; Oliva & Compton, 2008); and pessimism regarding its effectiveness (Bayer & Peay, 1997). Furthermore, the retention rates of individuals in mental health treatment are poor, ranging from 38% to 50% (Baekeland & Lundwall, 1975; Brandt, 1965; Garfield, 1994; Hatchett et al., 2002; Sparks et al., 2003; Wierzbicki & Pekarik, 1993).

Any of these barriers can inhibit engagement with mental health service providers. Poor engagement may lead to exacerbation of symptoms, emergency department (ED) visits, involuntary hospitalization, loss of job, and damaged familial and social relationships (Tait et al., 2002). Untreated and nonadherent individuals may exhibit symptoms such as feelings of isolation, inability to concentrate or think clearly, thoughts of self-harm, paranoia, hallucinations, and delusional thinking. When these symptoms escalate and remain unchecked, they may result in a crisis. Mental health crises can be acute or chronic (Chivima, 2013). When these crises occur, law enforcement is often called for assistance (Hartford et al., 2004). A large body of literature exists that estimates that between 6% and 10% of law enforcement's calls for service involve a mental health crisis (Borum et al., 1998; Franz & Borum, 2011; Hails & Borum, 2003; Livingston, 2016; Watson et al., 2010) and that 90% of officers report an average of six such calls per month (Cordner, 2006). Without specialized training in mental health, officers often misinterpret the actions of the individual in crisis as criminal in nature (Cochran et al., 2000; Heilbrun et al., 2012; Munetz & Griffin, 2006). Since most individuals in crisis do not respond well to typical police tactics, these encounters lead to disparate rates of arrest

and detention, as well as to injuries to the officer, involved individual, and witnesses to the event (Bronson & Berzofsky, 2017; Engel & Silver, 2001; Franz & Borum, 2011; Teplin & Pruett, 1992; Tyuse, 2012).

A best practice for improving engagement is for service providers to develop a trusting relationship with the individual served that includes a high level of personal interest and caring (Bliss & Ricketts, 2005; Bostleman et al., 1994; Smith et al., 2010). Bradley (2006) explains that engagement is more than just the development of goals in treatment but is a relationship built on trust and rapport. Gillispie et al. (2005) report that high levels of empathy from service providers contribute to service satisfaction of clients. Poremski et al. (2016) conducted interviews with service providers as well as with individuals who frequented EDs for psychiatric mental health care to assess barriers to and facilitators of continuity of care. They found that when programs exist that garner strong working relationships between mental health providers and the people they serve, timely access to aftercare services improves. When the individual served and the case manager had a good working relationship with a mutual goal of recovery, the individual served felt more empowered in their own treatment and was more likely to attend outpatient services for maintenance of care (Poremski et al., 2016).

PREARREST DIVERSION

The cycling of individuals living with mental health conditions from crisis to arrest and detention was labeled the "criminalization of mental illness" by Abramson (1972). Teplin and Pruett (1992) posit that law enforcement officers have become the default first encounter for individuals with mental health crises for two reasons: (1) they are charged with protecting the community from public safety threats, and (2) they are charged with protecting the well-being of vulnerable citizens. Once jailed, few detainees have access to treatment for their condition (Ellis & Alexander, 2017; Lamb, 1998; Lamb & Weinberger, 2001; Lee-Griffin, 2001; Sigurdson, 2000). After release, they are left with a criminal record, increased barriers to services, and repeated crisis events.

Many communities are beginning to recognize the need to develop programs to divert individuals committing low-level offenses away from incarceration and into alternative programs that mutually benefit the community and justice-involved individual. While there are many models of prearrest diversion programs for all behavioral health conditions, our focus is on those designed to reduce the cycle of arrest and detention among individuals living with mental health conditions by diverting them to appropriate service providers (Franz & Borum, 2011). Examples of prearrest diversion programs for individuals involved with substance use are Law Enforcement Assisted Diversion (LEAD) in many cities throughout the United States; Police Assisted Addiction and Recovery Initiative (PAARI) in Gloucester, Massachusetts; and Stop, Triage, Engage, Educate and Rehabilitate (STEER) in Montgomery County, Maryland.

Advocates for individuals with mental illness have designed prearrest jail diversion programs to reduce the cycle of arrest and detention among individuals living with mental health conditions by diverting them to appropriate service providers (Franz & Borum, 2011). In an international literature review of prearrest diversion programs for individuals with mental health conditions, Hartford et al. (2006) found four prevailing models: community service officers; Psychiatric Emergency Response Team (PERT), which has more commonly become known as the co-responder model; Mobile Crisis Team (MCT); and CIT. All models involve training in response to crisis and other incidents involving individuals with mental illness; however, the authors cite the CIT model as having a lower arrest rate and greater incidence of individuals being accepted to a treatment facility. Additionally, the largest number of their survey respondents, nearly 39%, indicated using a CIT program involving MCTs. Based on the available mental health services offered in the geographic location of the study, this paper will focus on the CIT and MCT models.

In mental health prearrest diversion programs, law enforcement officers are trained to recognize the signs and symptoms of mental illness and the resources available for referrals. The officer uses professional discretion in deciding whether to

detain the individual in jail or to divert them to treatment (Cowell et al., 2013; Steadman et al., 1995). As resources for mental health programs have declined, law enforcement has exponentially become the de facto entrance into the treatment system (Lurgio & Swartz, 2000). As a result, over the years, law enforcement's responses to mental health crises have become operationalized, most notably including officer training on mental health conditions and collaboration with mental health service providers (Hartford et al., 2006).

Community Service Officer Model

The community service officer model was established more than 20 years ago in Birmingham, Alabama. Six civilian employees with social services backgrounds participated in six weeks of specialized and field training in how to respond to behavioral health emergencies. The community service officers drive unmarked vehicles and wear uniforms but do not carry firearms. They also provide follow-up social services to domestic and family welfare calls. At least one person is always on call (Steadman et al., 2000).

Psychiatric Emergency Response Team/ Co-Responder Model

Originating in the 1990s in San Diego County, California, PERT paired a mental health professional with first responders (law enforcement, fire, and emergency medical services). It has expanded and evolved into a co-responder model, which typically features a specially trained team with at least one law enforcement officer and one behavioral health professional or peer support specialist responding jointly to situations likely to involve a behavioral health crisis (Puntis et al., 2018; Shapiro et al., 2015). This model is especially helpful in areas (e.g., rural areas) with weak referral mechanisms from law enforcement to the treatment system or those where the behavioral health service system has a diminished capacity to provide services. The co-responder model provides on-the-scene assessments, an immediate behavioral health alternative to jail, and follow-up to involved stakeholders, and it decreases the expenses associated with detainment in jail and hospitalization by providing a community-based treatment alternative.

MCT Model

MCTs act as gatekeepers for inpatient hospitalization when warranted and provide prescreening assessments for many other services that may be available in the community (National Alliance for Mental Illness [NAMI], 2020). The goals of an MCT program are to provide community-based services to stabilize individuals experiencing psychiatric emergencies in the least restrictive environment, to decrease the criminalization of mentally ill individuals, and to reduce the expenditure of law enforcement resources in handling mental health crises (Scott, 2000). At times, an MCT works in tandem with a CIT to handle psychiatric emergencies and provide consultation for crisis calls. An MCT may be called to assist CIT officers who may be unsure of referral resources, for assistance with suicide ideation and attempts, and to help deescalate complex situations. MCTs also respond quickly to individuals in the community experiencing a crisis independently of the CIT. They assess risk and acuity level, use a team response, work to stabilize individuals in crisis to avoid unnecessary hospitalization, and refer individuals to the most appropriate treatment settings and community resources. One advantage of having an MCT in a community setting is its ability to provide follow-up services by telephone or home visits to persons who have previously received crisis intervention services (Scott, 2000). Kim and Kim (2017) found that 44.2% of individuals using an MCT intervention also engaged in mental health services within 30 days at the local community mental health center (CMHC).

Although these services have been offered since the 1970s, a disconnect remains in linking people with mental health disorders, especially the underserved, to the treatment they need. A study investigating the use of mental health services in the United States found that the most underserved populations include the elderly, low-income individuals, members of certain racial or ethnic groups, the uninsured, and clients in rural areas (Wang et al., 2005). It is vital to all individuals with mental illness that linkages to services are improved so that they may lead productive, meaningful lives while remaining stable in their communities. MCTs provide effective linkages to

referral services due to their assessment of the factors that led to the initial crisis.

CIT Model

NAMI led efforts in the 1980s to create a program aimed at improving police interactions during mental health crises; however, their efforts were not fully supported by community leaders (Dupont & Cochran, 2002). Community outrage in response to a 1987 incident involving the shooting death of an individual with schizophrenia in Memphis, Tennessee, led to a task force being formed to investigate the handling of mental health crises by law enforcement. The Memphis Police Department, in conjunction with mental health advocates and professionals, developed a program to help officers assess and manage interactions with mentally ill individuals in crisis (Hanafi et al., 2008). The Memphis model of CIT was created in 1988 to improve client and officer safety, as well as to ensure that an individual in crisis would receive the appropriate treatment rather than be arrested and become a part of the penal system (Cross et al., 2014). This model has been recognized as a best practice for jail diversion techniques for people with mental health conditions (Franz & Borum, 2011). Sociologist Henry Steadman describes the Memphis model of CIT as the "most visible pre-booking jail diversion program in the U.S." (Dupont & Cochran, 2002, p. 59).

The goal of a CIT is to reduce harm to contacts and police officers when responding to mental health crisis calls, as well as to divert individuals from jail to the appropriate treatment center (Compton et al., 2014). An essential element of an effective CIT program is training. The Memphis model offers specialized training to officers by field experts (Watson & Fulambarker, 2012). In this training, officers attend 40 hours of classroom education, including role-play activities and lectures on psychiatric disorders (e.g., psychosis, schizophrenia, addictive disorders, suicide awareness, mental health laws). After classwork is completed, the officers tour local inpatient psychiatric units and emergency service departments that partner with the CIT program to offer treatment to the populations served (Broussard et al., 2010). This collaboration between CIT officers and the mental health services community helps to foster the relationships that will facilitate referrals to treatment for the targeted population. Through this training, CIT officers develop an understanding of how to impact the behavior of an individual with mental illness, and they gain confidence in their ability to deescalate the situation and decrease use of force.

The CIT program promotes collaboration between all aspects of the system of care and is a critical element of services available to individuals who may have contact with law enforcement during a mental health crisis (Arey et al., 2015). Ritter et al. (2011) found that when responding to mental health crisis calls, CIT officers have several options in handling the case. Depending on the situation, they can transport the individual to inpatient treatment via a single point of entry (a dedicated no-refusal crisis center), arrest and transport the individual to jail, deescalate the situation and leave the person on the scene, and/or refer them to outpatient services at a mental health clinic (Ritter et al., 2011). A CIT study by Skeem and Bibeau (2008) examined the resolution of cases handled by CIT officers and found that out of 595 cases reviewed, 74% ended in hospitalization of the client, and of those, 71% were involuntary commitments. Eighteen percent of cases ended with onsite resolution, with the officer's deescalation skills being used to defuse the situation; arrest was used in only 4% of the cases reviewed. Compton et al. (2014) found that CIT training makes a difference in the resolution of mental health crisis cases. Referral to services and transport to inpatient treatment was more likely for trained CIT officers than for non-CIT officers (40% vs. 29%, respectively), and arrest was less likely for trained CIT officers. The available research indicates that CITs are making appropriate referrals to treatment at the time of crisis calls, but there is a gap in the literature about what happens to these individuals after their mental health crisis is over. Failure to continue to provide adequate care after crisis calls are resolved leads to repeat calls for CIT officers and possible arrests, thus creating a cycle of criminalization of mentally ill individuals (Browning et al., 2011).

EVIDENCE TO DATE

Although literature is lacking on follow-up treatment after interactions with CIT officers, research does exist that examines engagement in mental health services after admission to EDs for suicide attempts and other mental health crises (Currier et al., 2010; Heyland & Johnson, 2017; McCullumsmith et al., 2015; Spittal et al., 2017). One-fifth of all ED visits in the United States are associated with a psychiatric crisis, and the type of aftercare one receives after discharge is paramount in preventing repeated ED visits (Boudreaux et al., 2011; Poremski et al., 2016). Olfson et al. (2012) found that more than half of patients who presented to the ED after an incidence of self-harm did not receive follow-up treatment after discharge, while Hunter et al. (2018) reported this number to be upward of 70%. In a study that surveyed EDs in the United States, researchers found that recurrent psychiatric visits were a result of poor referral systems to mental health resources (Boudreaux et al., 2011). EDs have recognized the need for programs to help decrease the frequency of psychiatric crisis visits.

As previously mentioned, MCTs are often used to assist CITs and additionally have been studied to evaluate their efficacy in improving attendance to aftercare appointments following suicidal emergencies in EDs (Currier et al., 2010). MCTs provide mental health care services in patients' homes to decrease unnecessary ED visits when individuals are facing psychiatric crises. Currier et al. (2010) found that 69% of the participants enrolled in MCT services attended the initial follow-up appointment after ED discharge, whereas only 29.6% of the outpatient commitment participants randomized in the study did so. MCT services made a difference in linking participants to outpatient providers; however, this study found no long-term difference in functional improvements in symptoms (Currier, et al., 2010). McCullumsmith et al. (2015) found that follow-up compliance is more likely to occur after an ED visit when the appointment is arranged by hospital staff for the individual served and is scheduled in close proximity to discharge from the ED. Individuals served who were surveyed after discharge from EDs noted that it is important that the hospital set up a follow-up visit with an outpatient provider and provide referrals to peer support groups (McCullumsmith et al., 2015).

Spittal et al. (2017) compared contact with community mental health services at the time individuals were admitted to a hospital for mental health crises. They found that those individuals previously connected to mental health services were more likely to follow up within 30 days of hospital discharge than those who had not previously received mental health treatment. However, only 41% of all individuals discharged from the hospital after being treated for self-harm had face-to-face contact with community mental health services within 30 days of discharge. Researchers further state that the reasons for low levels of follow-up may stem from insufficient integration between inpatient and community mental health services. Communication between facilities may be a key factor in patient scheduling, and discharge plans may not be adequate to encompass such aftercare services.

The aforementioned studies clearly indicate the impact timely follow-up has on treatment engagement and the need to strengthen the linkages between emergency responders or treatment facilities and community resources in order to streamline referrals. A parallel application exists between CIT interventions and ED staff when considering the transfer of care to another resource. Research is needed to explore the paths of engagement in mental health services that CIT contacts follow after the CIT officer transfers the individual to the next level of care.

METHOD

A key component of CIT is linking individuals in mental health crises to sustainable mental health treatment (Cross et al., 2014). Engaging the client quickly and efficiently in mental health services helps decrease the risk of decompensation and recurring hospitalizations and/or additional encounters with law enforcement during a mental health crisis. Given the lack of research on CIT and aftercare engagement with mental health services, this study was designed to examine engagement in

follow-up services for individuals who had contact with a CIT officer in Jones County, a rural county in southern Mississippi, and to investigate what types of mental health services these individuals become engaged in. The results will be important to further measure the effectiveness of CIT's goal of linking individuals with mental illness to the appropriate treatment. Because prior research indicates that client engagement is bolstered when MCTs are used (Kim & Kim, 2017), we hypothesized that engagement would increase when MCTs worked in tandem with CITs compared to CIT contact alone.

Data Collection

CIT officers from every law enforcement agency in Jones County are required to complete a CIT contact report at the time of a crisis call. This CIT contact report collects demographic, descriptive, and outcome data as observed by the CIT officer, along with disposition of the case and referral information. The completed CIT reports are then forwarded to the CMHC within 36 hours to be maintained for statistical purposes and for follow-up by the MCT. The MCT at the local CMHC not only responds to crisis events but also follows up on crisis event referrals from CIT officers and from the diversion center or crisis stabilization unit (CSU). The team uses a wraparound approach to help stabilize mental health symptoms, broker supportive services (e.g., enrollment in insurance, housing, assistance with activities of daily living, health care, employment assistance, transportation), and engagement in mental health services. These services are provided by the MCT until the individual served becomes engaged in regular outpatient services.

This study employed a retrospective chart review of individuals referred to the CMHC, Pine Belt Mental Healthcare Resources (PBMHR), by the CIT in Jones County between June 1, 2016, and May 31, 2018. We reviewed the CIT contact reports within the date parameters requested and developed a list of health records to be reviewed. All individuals included in the retrospective chart review were 18 years of age or older, had contact with a CIT officer during the identified time frame, and had been referred for services in the same region. All charts identified by CIT reports were reviewed regardless of the final disposition of the CIT call (deescalated at scene, referred to outpatient treatment, transported to the local CSU, or arrested and transported to jail).

The electronic health records administrator at PBMHR extracted the data from the electronic health records system for analysis. The requested data included race, gender, primary diagnosis, agency admission and discharge dates, types of program services enrolled, program admission and discharge dates, dates and types of sessions attended, dates of contacts made by staff, and dates of no-show appointments. All requested information was collected in an Excel spreadsheet, stripped of any identifying client information, and given a unique study number. CMHC staff reviewed the CIT contact reports and redacted client identifiers to protect the anonymity of the client. They also assigned cross-matched identifying numbers from the medical record to corresponding CIT contact reports. The reports were subsequently reviewed by the principal investigator, and the date of CIT contact and disposition of the case were recorded in the spreadsheet with chart review information. Trends of repeated calls were also recorded based on duplicate CIT reports for the same individual.

Ethical Considerations

For the purpose of data collection, clients were assigned a unique study number with no link to identifying information. The investigator signed a research and data use agreement with PBMHR agreeing to comply with the agency's confidentiality requirements, including the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR 46 (Protection of Human Subjects), and 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records). The study was reviewed and approved by the PBMHR compliance officer and included a consultation from attorneys who specialize in institutional research. Additionally, the study protocol was approved by the University of Tennessee's Institutional Review Board under a full board review.

Analysis

Frequency analyses of the data were conducted using the SPSS statistical application (SPSS Inc., Version 24, 2016). Basic descriptive statistics categorized the overall sample demographics as well as clinical variable information. We ran a frequency distribution of the types of aftercare services the contacts enrolled in and the disposition of the CIT cases. We used this statistical analysis to compare the frequencies of services offered to and used by clients identified in this study. We conducted chi-square analyses on groups enrolled in MCT services to compare no-show appointments to those not receiving MCT services. Chi-square analysis was also used to measure the amount of time before an individual enrolled in outpatient services after CIT contact, and a separate chi-square analysis was performed to compare the differences in time of enrollment in services for new individuals versus individuals previously served by the CMHC.

RESULTS

We reviewed a total of 107 health records and 146 CIT contact reports. Most of the contacts were White (n = 68, 63.6%) and the remainder were Black (n = 39, 36.4%). Fifty-eight percent (n = 62) of the sample were male. More than half (n = 61, 57%) of the charts reviewed belonged to individuals who had not previously received treatment at the CMHC prior to the date of the initial CIT report. Almost 30 percent (29.9%) of the individuals had a primary diagnosis of schizophrenia or other psychotic disorders, 24.3% had bipolar disorders diagnoses, 18.7% had depressive disorders diagnoses, 11.2% had diagnoses of substance use disorders, and the remaining 9% were diagnosed with attention deficit disorder, adjustment disorder, borderline personality disorder, dementia, generalized anxiety disorder, intermittent explosive disorder, intellectual disability, or posttraumatic stress disorder. Seven and one-half percent (n = 8) of the charts reviewed were missing a primary diagnosis.

Eighty-four individuals (78.5%) had only one CIT contact report, while 23 (21.5%) had two or more. For those with multiple CIT contact reports, the mean days between the first and second reports were 95.83 (SD = 118.80), mean days between the second and third reports were 82.42 (SD = 112.44), and mean days between the third and fourth reports were 108 (SD = 31.09). This indicates that repeated CIT calls occurred an average of every 3 months (95.42 days).

CIT officers documented the disposition of the case at the completion of their contact with the client. The most frequent disposition was transport to the CSU (n = 46, 43%). In instances when the CSU was full or the individual required medical clearance, 15 contacts (14%) were transported to a separate receiving facility in a nearby town. Table 1 displays the disposition of the cases in the remainder of the CIT calls. The columns labeled CIT Call 2, CIT Call 3, and CIT Call 4 indicate repeat CIT contacts as previously described.

Table 1: Dispositions of Crisis Intervention Team (CIT) Calls

Disposition	CIT call 1		CIT call 2		CIT call 3		CIT call 4	
	n	%	*n*	%	*n*	%	*n*	%
Deescalated on scene	13	12.1	6	5.6	0	0	1	0.9
Emergency medical services	5	4.7	1	0.9	0	0	1	0.9
Arrested and jailed	3	2.8	1	0.9	1	0.9	0	0
72-hour emergency hold	19	17.8	6	5.6	4	3.7	2	1.9
Outpatient services	6	5.6	1	0.9	1	0.9	0	0
Diversion site out of county	15	14.0	0	0	2	1.9	0	0
Diversion site in county (crisis stabilization unit)	46	43.0	8	7.5	4	3.7	0	0

Of the 107 charts reviewed, 56 contacts (52.3%) enrolled in outpatient services for the first time after an encounter with a CIT officer, with an additional 17 (16%) having been enrolled in outpatient services previously. Outpatient services included individual counseling, medication evaluation, community support services, psychosocial rehabilitation, assisted outpatient services, MCT services, and group therapy services. Due to the wide variation in the time that elapsed between the date of the CIT contact report and the date of outpatient enrollment, the cases under review were divided into two groups: those who enrolled within 2 weeks of the CIT contact report date and those who enrolled 2 weeks or more after the CIT report date. Twenty-four contacts (42.9%) enrolled in services within 2 weeks of the CIT report date. To examine the differences between contacts who were already enrolled in services with the CMHC and contacts who had not previously been served by the CMHC, we used a chi-square analysis to compare the time that elapsed between the CIT contact report date and enrollment for these two groups. A significant difference was found (chi-square = 6.335, df = 1, p = .018), with 53.8% (n = 21) of the new referrals enrolling within 2 weeks compared to only 17.6% (n = 3) of individuals previously served enrolling within 2 weeks. The researchers acknowledge the small sample size for this portion of the study, which may limit the generalizability of the findings to larger population groups.

We employed descriptive statistics to calculate which outpatient services were used most frequently by individuals after CIT contact (see Table 2). Of the 107 records reviewed, 61 individuals were admitted to inpatient crisis hospitalization (M = 1.24 admissions), 63 attended outpatient individual counseling appointments (M = 5.22 sessions), and 48 received medication evaluation (M = 10.27 evaluations) in the outpatient setting at the CMHC. Eighteen were enrolled in community support services (M = 18.94 times met), eight enrolled in psychosocial rehabilitation (M = 84 days attended), and 19 attended group therapy (M=3.79 sessions). Six individuals were enrolled in the assisted outpatient treatment program (M = 67.50 times met), and 13 received MCT services (M = 5.38 times met).

Disposition of cases was broken down by race and gender, based on demographics collected (see Table 3). Of those admitted to the county's CSU, the majority were White (n = 33, 71.7%) and male 60.9% (n = 28). Individuals who were deescalated on the scene were mostly White (n = 8, 61.5%) and male (n = 8, 61.5%). There was almost an even split of both race and gender for those who were placed on a 72-hour emergency hold (n = 10, 52.6% White and n = 10, 52.6% female). The most notable statistic regarding disposition of cases is that 100% (n = 3) of those arrested and jailed were Black male individuals.

Table 2: Outpatient Services Utilization and Mean Attendance

Service	*n*	*M*	*SD*
Outpatient counseling	63	5.22	5.581
Medication evaluation	48	10.27	12.491
Community support services	18	18.94	20.966
Psychosocial rehabilitation	8	84.00	113.581
Group therapy	19	3.79	2.347
Assisted outpatient treatment	6	67.50	32.359
Mobile Crisis Team	13	5.38	9.412

Table 3: Disposition by Race and Gender

Disposition	Black Total		White Total		Male Total		Female Total	
	n	%	*n*	%	*n*	%	*n*	%
Deescalated on scene	5	38.5	8	61.5	8	61.5	5	38.5
Emergency medical services	2	40	3	60	3	60	2	40
Arrested and jailed	3	100	0	0	3	100	0	0
72-hour emergency hold	9	47.4	10	52.6	9	47.4	10	52.6
Outpatient services	4	66.7	2	33.3	3	50	3	50
Diversion site out of county	3	20	12	80	10	66.7	5	33.3
Diversion site in county (crisis stabilization unit)	13	28.3	33	71.7	28	60.9	18	39.1

We also analyzed use of outpatient services (see Table 4) and found that more White individuals received outpatient counseling (n = 44, 69.8%), medication evaluation (n = 33, 68.7%), psychosocial rehabilitation (n = 5, 62.5%), and group therapy (n = 12, 63.2%). More Black individuals used community support services (n = 10, 55.6%) and MCT services (n = 9, 69.2%). Male individuals used more services than female individuals in every category.

We had hypothesized that individuals who enrolled in MCT services after CIT contact would have a better follow-up rate in outpatient services. Of the 13 MCT clients in this study, all (except for one unknown) were diagnosed with a severe mental illness, and nine (69%) of these had a diagnosis of some type of psychosis. Additionally, seven MCT clients (50%) were involved in a second CIT call, five (36%) had a third call, and three (21%) had a fourth call. This indicates that the individuals enrolled in MCT were indeed complex cases. We used a chi-square analysis to test whether follow-up rates differed between individuals enrolled in MCT and those not enrolled. The results (chi-square = 5.165, df = 1, p = .033) indicated a significant difference, with clients enrolled in MCT services failing to show up for appointments only 30.8% of the time, compared to a 64% no-show rate for those not enrolled in MCT services. As with previous subgroup comparisons, researchers acknowledge the small sample size of individuals enrolled in MCT services. We thus interpreted the results of the subgroup analysis conservatively, and further study will be required to verify their generalizability.

Table 4: Outpatient Services Utilization by Race and Gender

Disposition	Black Total		White Total		Male Total		Female Total	
	n	%	*n*	%	*n*	%	*n*	%
Outpatient counseling	19	30.2	44	69.8	38	60.3	25	39.7
Medication evaluation	15	31.3	33	68.7	30	62.5	18	37.5
Community support services	10	55.6	8	44.4	12	66.7	6	33.3
Psychosocial rehabilitation	3	37.5	5	62.5	6	75	2	25
Group therapy	7	36.8	12	63.2	10	52.6	9	47.4
Assisted outpatient treatment	3	50	3	50	4	66.7	2	33.3
Mobile Crisis Team	9	69.2	4	30.8	9	69.2	4	30.8

Table 5: Appointment Compliance and Mobile Crisis Team (MCT) Enrollment

	Compliance with appointment	Noncompliance with appointment
Not enrolled in MCT	31 (36%)	55 (64%)
Enrolled in MCT	9 (62.2%)	4 (30.8%)

DISCUSSION

Regarding the disposition of CIT cases, this study is congruent with other research (Compton et al., 2014; Teller et al., 2006) that found that an individual in crisis was far more likely to be transported to a diversion center ($n = 61$, 57%) than arrested ($n = 3$, 2.8%), helping to decrease the likelihood of criminalization of the mentally ill. Although this sample size is small and the results cannot be generalized, it cannot be overlooked that the only three individuals arrested and jailed in the current study were Black men, further questioning the disproportionate incarceration of this population in the United States (Garrison, 2011). Because there is a diversion center for emergency drop-off in the county in which this study was conducted, CIT officers had an additional resource to help provide an immediate transfer of care. In areas where a diversion center is not locally available, individuals are arrested or dropped off at EDs.

Since a key component of a CIT is linking individuals in crisis to continued mental health services, this study begins to fill a gap in the literature examining the rates of follow-up services at the CMHC for CIT officer contacts. As reported, of the 107 CIT contacts, 56 (52.3%) subsequently enrolled in outpatient services, with 42.9% of those enrolling within the first 2 weeks following CIT contact. Compared to previous research (Hunter et al., 2018; Olfson et al., 2012; Spittal et al., 2017), this study exhibits a higher percentage of post-CIT client enrollment than the enrollment for referrals by EDs after mental health crises. This result is also congruent with other studies (Bostleman et al., 1994; Roeg et al., 2015) that found that engagement in outpatient services is boosted when follow-up by an MCT is rendered promptly after discharge from the inpatient setting. Since CIT can be accessed on an emergency basis, the amount of time between a crisis and treatment (either at a CSU or through referral to outpatient services) is reduced. In other studies (Boudreaux et al., 2011; Poremski et al., 2016), poor access to care has been blamed on the lack of an efficient referral system and meager relationships between service providers in the community. However, part of CIT's specialized training includes relationship-building between future CIT officers and the mental health professionals they will be referring to in the future (Broussard et al., 2010). During CIT training, team members spend a day touring area resources and diversion facilities to become familiar with the referral and admission process. It is possible that because CIT officers are familiar with local community mental health resources, they are better equipped to make appropriate referrals, therefore increasing the chances that the contact will follow up in a suitable aftercare setting following CIT contact.

Contrary to previous research (Spittal et al., 2017), this study found a significant difference in treatment enrollment between individuals who had never engaged with the CMHC and individuals already being served by the CMHC. While it is not known if this finding is a direct result of the CIT intervention, it is noteworthy. The majority (n = 61, 57%) of individuals encountered by CIT were referred to a CSU for mental health hospitalization, and it is likely that the referral system between the CSU and outpatient services is well integrated (Boudreaux et al., 2011; Poremski et al., 2016). It is important to note that in the region where this study took place, the CSU is administratively associated with the area's CMHC; therefore, as Spittal et al. (2017) cite in their research, communication between facilities for follow-up scheduling is an important factor in providing adequate aftercare services. As reported by McCullumsmith et al. (2015), if future appointments have been arranged by inpatient staff, the individual may be more likely to attend. Further investigation of the referral protocol for the CSU/diversion center is warranted to determine if this is, in fact, the reason for the opposing results in this area.

The purpose of this study was to track the rates of follow-up care after an individual was referred by CIT. We determined through a chart review that outpatient counseling ($n = 63$, $M = 5.22$ sessions) and medication evaluation ($n = 48$, $M = 10.27$ evaluations) were used by the largest number of clients at the CMHC. However, while only eight clients were enrolled in psychosocial rehabilitation (PSR), the mean of the number of days attended was higher ($M = 84$ days, $SD = 113.58$) than for regular outpatient treatment. One reason for the higher attendance rate is the structure of the PSR program. PSR is a daily attendance program and provides a higher level of care than outpatient counseling. Transportation and meals are provided, and individuals enrolled in this program have the option to attend up to 5 days per week. Assisted outpatient treatment also exhibited a high mean of attendance ($M = 67.5$ sessions, $SD = 32.36$), although it was used by only six clients. This service is mandated, usually through involuntary commitment proceedings, to assist clients with compliance after release from mental health hospitalization. Because of the mandated aspect of assisted outpatient treatment, CIT involvement could be considered a referral source for those who require chronic care and supplementary treatment by mental health staff.

To answer the question of follow-up rates among clients who use MCT services, we compared the rates of appointment noncompliance (no-shows) among MCT clients with those for the contacts not enrolled in MCT. Appointment noncompliance is defined as an appointment at the CMHC that was previously scheduled with a mental health professional for which the individual neither called to cancel nor attended the appointment. The significant difference found between the two groups in this study was consistent with Kim and Kim's (2017) research conclusion that individuals are more likely to engage in mental health services if they are also enrolled with MCT, supporting the hypothesis of the current study. One reason for this may be the communication protocol of MCT that involves contacting clients regularly to strengthen compliance (Scott, 2000). For the 13 individuals enrolled in MCT in this study, MCT personnel conducted 173 ($M = 13.31$ communications) phone calls, home visits, or letters reminding clients of mental health appointments, ensuring medication compliance, and/or monitoring the general well-being of the client. Although it was demonstrated that MCT makes a difference in decreasing the number of no-show appointments, it is unclear whether use of MCT services contributes to symptom improvement over the long term (Currier et al., 2010).

STUDY LIMITATIONS

The aim of the current research was to determine the mental health services trajectories of CIT contacts after their encounters with CIT officers. This research included only individuals who had a CIT contact report provided by the officer on the crisis call; it is possible that some officers failed to complete the report, or that CMHC personnel failed to receive the report. Because the study may not have included all CIT calls, it is difficult to generalize the results to all individuals who have been in a mental health crisis. Additionally, this study is limited to a small, rural county, and therefore its results cannot be generalized to other jurisdictions, particularly urban and suburban counties where it may not be as easy to foster interagency relationships.

This study did not track lack of insurance or the ability to pay, as the information was unavailable and is not collected by CIT officers. While this information may be known to the CMHC after the initial intake following referral, obtaining this information from individuals who did not follow up would be challenging. Although the retrospective chart review was effective in collecting some data, a limitation of this type of methodology is the inability to determine the motivation and reasoning for compliance or noncompliance with follow-up treatment. Future studies should employ more probative methods of collecting these types of data through instruments such as SAMHSA's Patient Satisfaction Scale (SAMHSA, 2018) or other mental health engagement tools.

RECOMMENDATIONS FOR FUTURE RESEARCH

Additional research is needed to further study the influence of MCT on treatment engagement of CIT contacts. An experimental design with larger matched samples is needed to validate this small pilot study. Research is also needed to study CIT

referrals and follow-up care in areas where CIT exists but a diversion center is not readily available. An interesting circumstance of the current research was that the diversion center was operated by the local CMHC in the county in which the study took place, and most contacts were diverted there. It is likely that the diversion center made the aftercare referrals to the outpatient setting. It would be advantageous to study the referral relationship between the CSU/diversion center and the outpatient setting to establish whether CIT is a likely variable in predicting long-term compliance and follow-up in the outpatient setting.

Another topic worthy of additional research is the distribution of race and gender within the system of referral from CIT to aftercare treatment. Although this was not the focus of the current research, it is extremely important that this distribution be explored and analyzed further.

CONCLUSION

While additional research is needed to establish the CIT and MCT collaboration as a best practice, the engagement rates in this study are notable and worth further investigation. MCT plays an important role in the CIT process, and it is important to leverage those processes that improve outcomes for individuals living with mental health conditions. Since CIT's inception, numerous individuals in mental health crises have been diverted from the jail setting to treatment. It is important that the practice of making appropriate referrals continues so that the criminalization of mental illness will decrease. Not only does this intervention assist individuals in engaging in mental health services, it may also prevent injury to or the death of law enforcement officers and people who may be experiencing mental health crises.

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AUTHOR BIOGRAPHIES

Rhonda G. Smith, DSW, LCSW, earned a doctorate of social work from the University of Tennessee, Knoxville, where her research interest was in Crisis Intervention Team (CIT) engagement and continued mental health care. She serves on the advisory board for the local CIT program in her community. Dr. Smith has worked in community mental health, in both inpatient and outpatient settings, and is currently a licensed psychotherapist in Laurel, Mississippi. In addition to her clinical practice, she is a lecturer at the University of Tennessee, Knoxville, College of Social Work, and an adjunct online instructor at the University of West Alabama.

Robert M. Mindrup, PsyD, MSSW, is a clinical assistant professor in the College of Social Work at the University of Tennessee, Knoxville. He oversees both the Knoxville and online Bachelor of Science in Social Work (BSSW) programs in his role as director of BSSW programs. His professional interests reside primarily in the areas of psychopathology, evidence-based psychotherapy interventions, integrated health care, and behavioral medicine. In addition to his work at the university, Dr. Mindrup continues to work in integrated health care as a clinical psychologist at a local federally qualified health center.

Linda T. Foley, BS, is the regional CIT coordinator at Pine Belt Mental Healthcare Resources, coordinating CIT programs in 10 counties.

Rita L. Porter, PhD, is a licensed psychologist and the director of adult services at Pine Belt Mental Healthcare Resources. She earned her PhD from the University of Southern Mississippi in counseling psychology.

Frieda B. Herron, MBA, DSW, LCSW, is a clinical assistant professor in the College of Social Work at the University of Tennessee, Knoxville. Her research interest is the study of community-level interventions that have the potential to reduce suicide deaths in rural communities. At the College of Social Work, Dr. Herron teaches clinical leadership courses in the Doctor of Social Work program and clinical practice courses in the Master of Science in Social Work program. She also provides diversity and inclusion training for field practice instructors and students. Dr. Herron is a Licensed Clinical Social Worker in Tennessee with significant experience as a psychotherapist.

David A. Patterson, PhD, MSW, is the Cooper-Herron Endowed Professor of Mental Health Research and Practice in the College of Social Work at the University of Tennessee, Knoxville. He is the founding director of the Doctor of Social Work in clinical practice and leadership program, having served in the position since 2010. Dr. Patterson has been the principle investigator/director of the U.S. Department of Housing and Urban Development and locally funded Knoxville Homeless Management Information System (KnoxHMIS), a community outreach research endeavor of the College of Social Work. He is a UMASS Center for Mindfulness Qualified Teacher and teaches mindfulness-based clinical interventions and practice in a graduate course that integrates the eight-week mindfulness-based stress reduction course into a broader course for psychology and social work students on mindfulness-based interventions. A major focus of his scholarship in recent years has been on homelessness and the application of information technology in service delivery to homeless individuals and families. He is the author of *Personal Computer Applications in the Social Services* (Allyn & Bacon, 2000) and *Data Analysis with Spreadsheets* (Allyn & Bacon, 2006), as well as numerous peer-reviewed journal articles and book chapters.

Raymond M. Wooten, MS, is a programs evaluator at Pine Belt Mental Healthcare Resources. He is a certified mental health therapist and is currently finishing his PhD in research, evaluation, and statistics at the University of Southern Mississippi.

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Correspondence
Please address correspondence concerning this article to:
Rhonda Smith, DSW, LCSW
Tel: 601-580-4267
Email: drrsmith70@gmail.com

PRACTICE COMMENTARY

Law Enforcement Deflection and Prearrest Diversion Programs: A Tale of Two Initiatives

Albert M. Kopak
Western Carolina University

Lily Gleicher
Illinois Criminal Justice Information Authority

Abstract

Law enforcement deflection and diversion programs are rapidly spreading across the United States, largely due to their promising ability to keep people who have substance use and behavioral health needs out of traditional criminal justice processes by connecting them to service providers. Citizen-initiated deflection programs are preventive in nature and encourage people with a substance use disorder to report to a local law enforcement agency to receive an immediate referral to treatment without fear of arrest. Police-led prearrest diversion programs are based on referrals made by a law enforcement officer, usually at the same time that criminal charges are filed, but some of these programs withhold the charges or drop the charges pending successful completion of the treatment program. This paper provides an overview of a deflection initiative in Illinois and a prearrest diversion program in Florida, states that have adopted legislation supporting the expansion of these approaches. These details are used to identify important lessons learned from the planning, implementation, and early-assessment phases of these programs. The early practices in these programs also inform recommendations for necessary research and evaluation work to guide these quickly expanding deflection and diversion initiatives.

INTRODUCTION

The persistence of drug-related crime has recently led many law enforcement leaders to publicly acknowledge that traditional crime-control practices are largely ineffectual in dealing with this problem. This sentiment has been expressed by officers across the country, including former FBI director James Comey, with the widely espoused phrase "We can't arrest our way out of this problem" (Police Executive Research Forum, 2014). This admission came in the midst of the nation's opioid epidemic, which was defined by a 200% increase in overdose deaths between 2000 and 2014 (Rudd et al., 2016). In addition to the significant concerns related to opioid use during this period, research also underscores the role of substance use in a variety of other crimes, including 50% of intimate partner violence (Mason & O'Rinn, 2014) and 40% of acquisitive crime (Pierce et al., 2017), among others. These circumstances have compelled law enforcement agencies to devise new strategies to address the public health issues associated with substance use, overdose fatalities, and drug-related offenses.

A parallel movement emerged during this same period to address the enormous number of low-level offenses being processed through the criminal justice system. Some reports estimate that 10 million misdemeanor cases are prosecuted nationally each year (Boruchowitz et al., 2009). Similar assessments conducted within certain states have shown that misdemeanor arrests account for nearly three-quarters of all statewide arrests (California Department of Justice, 2017; Chauhan et al., 2014). This trend has contributed to the reality that nearly one-third of the U.S. population has been arrested by the age of 23 (Brame et al., 2012), and most conventional criminal justice processes do not address underlying factors that may have contributed to the offense in the first place, including drug use. This point is highlighted by data collected from adult male arrestees booked into metropolitan-area jails indicating that the vast majority (e.g., 63% in Atlanta; 83% in Chicago) tested positive for any one of 10 drugs and that most had at least one prior arrest for a low-level offense (Office of National Drug Control Policy, 2014).

Policing strategies designed to address the opioid epidemic and low-level offenses may seem unrelated to one another at first glance; however, a connection clearly emerges when these issues are examined from a public health perspective. Effective long-term responses to opioid use disorders, in addition to other substance use disorders, must involve connecting individuals to resources that will initiate and sustain long-term recovery from substance use. Similarly, addressing the underlying factors associated with a first-time low-level arrest or repeated low-level offenses and the collateral consequences associated with a lifelong criminal record stand to benefit significantly from a behavioral-health-oriented approach.

The President's Task Force on 21st Century Policing (2015) addressed these common concerns by providing several recommendations to promote effective crime-reduction strategies while enhancing public trust in law enforcement officers. One of the specific suggestions was that police agencies adopt "'least harm' resolutions, such as diversion programs or warnings and citations" (p. 92). The task force formally recognized the role of law enforcement in harm reduction, with an emphasis on the strategic diversion of individuals away from jails and courts and toward services that will provide long-term benefits. As a result, in the past few years, a wide range of prearrest diversion and deflection programs have emerged across the country.

These diversion and deflection programs have been classified according to the ways in which law enforcement officers initially encounter prospective participants, the involvement of criminal charges in the program, and the methods used to connect participants to service providers (Bureau of Justice Assistance, 2019). One group, known as self-referral programs, has been characterized by its prevention approach, in which active drug users are encouraged to report to a local law enforcement agency to receive an immediate referral to substance use treatment without fear of arrest (e.g., Schiff et al., 2017). Citizen-initiated referral programs do not typically involve criminal charges, and these initiatives are also identified as deflection programs due to the immediate linkage to care outside of traditional criminal justice processes. A second

group, known as active outreach programs, is defined by law enforcement officers' identification of individuals who may benefit from substance use treatment services. Following the initial contact by officers, participants are referred to service providers. Similar to the self-referral approach, active outreach programs usually do not involve criminal charges. Officer-initiated referrals may also come as part of an overdose response, and many agencies have implemented a combination of active outreach and overdose response practices (e.g., Formica et al., 2018). The third widely implemented approach can be described as an officer intervention model, in which a referral is made by a law enforcement officer at the same time that criminal charges are filed. Some of these programs withhold the charges, while others provide an option to drop the charges pending successful completion of the treatment program (e.g., Collins et al., 2015; Kopak et al., 2015).

The proliferation of diversion and deflection programs is due, at least in part, to legislation and increasing funding support. At the federal level, the Office of National Drug Control Policy has openly identified these programs for their potential to effectively address substance use disorders, and the Bureau of Justice Assistance has earmarked funds to assist local jurisdictions in their implementation (Office of National Drug Control Policy, 2020; United States Department of Justice, 2020). Two states have paved the way for others by being the first to adopt legislation explicitly designed to expand these initiatives. In 2018, Governor Bruce Rauner of Illinois signed into law SB 3023, which became known as the Community-Law Enforcement Partnership for Deflection and Substance Use Disorder Treatment Act. This approach supports law enforcement in the effort to divert people with substance use and behavioral health needs toward service providers and away from jails. The state of Florida took a similar approach in 2018 with the passage of SB 1392, which endorsed the statewide adoption of prearrest diversion programs. A recent count indicated 18 of 67 counties in Florida are now operating these programs (T. Olk, personal communication, April 21, 2020).

Despite rapidly increasing support, recent legislative actions, and the widespread adoption of these programs, there is a glaring gap in the literature regarding the efficacy of citizen-initiated deflection and police-led diversion programs. This article contributes to the limited knowledge in this area with an overview of two programs from the states that have formally endorsed these initiatives with legislative support. The Safe Passage initiative in Illinois is one of the first citizen-initiated police deflection programs in the country, and the Civil Citation Network in Florida serves as a prime example of a police-led prearrest diversion program. The authors have conducted formal preliminary assessments of the two programs, which have provided some initial results, and rather than provide a systematic review of this early work, the goal of this paper is to identify the key lessons learned from these initiatives to help guide other jurisdictions that are interested in adopting similar programs. We also highlight important considerations for additional research in the larger field of police-involved deflection and diversion. Our aim is to provide leaders and researchers with information to help advance our knowledge of these promising programs.

CITIZEN-INITIATED DEFLECTION AND POLICE-LED DIVERSION: OVERVIEWS OF TWO PROGRAMS

Law enforcement agencies represent a logical access point for people seeking help with substance use disorders because they are the community's first responders when someone calls for assistance. A strong community orientation has driven some agencies to adopt citizen-initiated deflection programs, while others have opted for police-led approaches to provide a behavioral-health-based solution where none previously existed. We identified a citizen-initiated deflection program in Illinois and a police-led diversion program in Florida, the two states with legislation supporting these practices, to highlight the key features of mature programs that have been operating for several years. It is important to note that these two types of programs are characterized by a significant difference. Citizen-initiated deflection programs generally start through voluntary contact, in which a person approaches a law enforcement agency or officer as

an access point to obtain treatment and services for substance use disorder. In contrast, police-led diversion programs function according to a more traditional involuntary encounter with law enforcement (i.e., a complaint that is likely to lead to an arrest). Despite this fundamental difference, both types of programs aim to minimize the formal processing of adults through traditional arrest and prosecution, opting instead for long-term strategies to effectively address the chronic, relapsing nature of substance use disorder.

The Safe Passage Initiative

The Safe Passage initiative was established in 2015 as a citizen-initiated police deflection program based in Lee and Whiteside Counties, two rural jurisdictions in northwestern Illinois. The estimated (as of July 2019) population of Lee County is 34,096; it has a median household income of approximately $58,000, and the majority of residents (92%) identify as White (U.S. Census Bureau, 2020). Its county seat is Dixon. The estimated (as of July 2019) population of Whiteside County is larger at 55,175, and a comparable proportion (95%) of its residents identify as White. It has a similar median household income of $54,000. The two jurisdictions have a combined population of approximately 89,000 in a mostly rural, northwestern area of the state.

Safe Passage was started in the spring of 2015 in response to the region's opioid crisis; the initiative stemmed primarily from citizen concerns about overdose deaths. A community member initially brought to the Dixon police department's attention the Angel Program in Gloucester, Massachusetts, and this program was used as a basis for Safe Passage, which thus became the second such citizen-initiated police deflection initiative in the country. Safe Passage was created to help people with substance use disorders gain access to treatment and services, particularly in an area with few resources and limited transportation to the ones that were available.

Obtaining access to substance use treatment and overdose prevention services in Safe Passage is completely citizen initiated, in that access to the program does not begin with a potential arresting situation or involuntary encounter with law enforcement, but with an individual voluntarily reaching out to a participating police department for help. Community members can walk into a designated police department, call the police department, or request help after an overdose event, making the participating police agencies the centralized location to create a warm handoff to treatment and services. There are six Safe Passage participating agencies: the Dixon Police Department, Lee County Sheriff's Department, Rock Falls Police Department, Sterling Police Department, Fulton Police Department, and Whiteside County Sheriff's Department. When prospective participants enter the law enforcement agency seeking help, they are met by the full-time Safe Passage program coordinator, who conducts triage at the participating police departments, provides peer support and case management, transports participants to service providers, and maintains the reporting system (A. White, personal communication, May 18, 2020).

Following citizen-initiated contact, the Safe Passage program coordinator promptly begins the intake process, typically through meeting the individual at the nearest participating police department. The coordinator works with the individual to complete the intake form while an officer stands by in case a safety issue emerges that requires assistance (A. White, personal communication, May 6, 2020). Eligibility criteria are also established at this point in the process; participants must be over the age of 18 and have fewer than three drug-related convictions, no evidence of violent criminal history, no medical conditions that may require hospitalization, and no outstanding warrants. Because the program coordinator and the respective police departments have good working relationships with the state's attorneys in both counties, these criteria can be somewhat flexible (if, for example, a warrant is preventing someone from receiving treatment, though this also is dependent on the type of offense or warrant). The program coordinator also works with the probation office to assist individuals under community supervision (A. White, personal communication, May 18, 2020).

Pending eligibility clearance, the program coordinator continues the process with a substance

use and behavioral health needs assessment and discusses treatment options according to the levels of care identified by the American Society of Addiction Medicine (Mee-Lee, 2013). The coordinator's goal is to establish a connection with a provider, working through the necessary steps to get an individual into a suitable treatment program (A. White, personal communication, May 6, 2020). The participant also receives basic necessities, such as hygiene products, blanket, pen, paper, and the coordinator's contact card, and is encouraged to call her from the treatment program twice per week (A. White, personal communication, May 6, 2020). Depending on potential charges, arrest history of the individual, and current state of intoxication, the program coordinator, a loved one, or a police officer completes the warm handoff by providing transportation to the service provider.

Connecting community residents with treatment providers also affords the opportunity to deliver aftercare services designed to reduce the likelihood of relapse and maintain a trajectory toward long-term recovery. The Safe Passage initiative has working agreements with 13 treatment and service providers that present a continuum of substance use treatment and care options and work to quickly connect participants to indicated care; however, Safe Passage works most closely with nine of those providers (A. White, personal communication, May 6, 2020).

The Safe Passage initiative has just entered its sixth year of operation. Since its inception, over 400 individuals have participated in the program. An initial assessment demonstrated that a majority of clients were single, unemployed high school graduates; 54% were male; and the clients' average age was 33 years. Forty-two percent indicated they suffered from a mental health disorder (n = 36). All clients misused opioids. All reported using an opioid on the day of intake: 88% used heroin, and of them, 69% used it intravenously. Clients reported using opioids for an average of almost five years. Fifty-eight percent of Safe Passage clients reported receiving prior treatment, and 55% reported previously trying but failing to access treatment. Most clients—83%—had no health insurance at intake. Records indicated that 86% had a criminal history (Reichert et al., 2017).

Civil Citation Network

The Civil Citation Network was established in 2013 in Florida's Second Judicial Circuit, which includes a population of approximately 330,000 residents distributed throughout six counties (Franklin, Gadsden, Jefferson, Leon, Liberty, and Wakulla). According to the National Center for Health Statistics classification scheme, four of the counties are considered rural, without cities of a population of 10,000 or more, and two are considered small metropolitan counties, with a population that does not exceed 250,000 (Ingram & Franco, 2014). The median household income in the area fell just short of $50,000 during the most recent census, and the racial composition consists primarily of White (62%) residents, with Black (32%) and Hispanic (6%) residents representing the largest minority groups. This initiative was designed as an alternative to existing arrest and prosecution practices, with the goals of reducing the impact of a formal record among adults arrested for low-level offenses, decreasing the volume of cases processed through the State Attorney's Offices, and providing services with the aim of addressing behavioral health conditions associated with offending. The program was initiated through a partnership between the City of Tallahassee Police Department, the Leon County Sheriff's Office, the State Attorney's Office for the Second Judicial Circuit, and DISC Village, Inc., the local behavioral health service provider.

This police-led prearrest diversion program provides officers with the option to issue citations to adults rather than making an arrest or issuing a notice to appear in court (NTA). This is a significant yet often overlooked feature of the program because the issuance of the citation does not result in a formally recorded arrest in the state criminal justice history database in the same way that an NTA or a conventional arrest does. Instead, the citation serves as a legally binding referral to DISC Village, where participants are mandated to report to a case manager responsible for monitoring program engagement and completion. The process commences with a comprehensive behavioral health assessment to examine participants' substance use history, mental health needs, and recent behavior; this assessment is used to develop an individualized treatment plan.

Participants work with clinical staff to complete counseling sessions, substance use treatment programming (if applicable), relevant educational modules, community service, restitution (if applicable), and payment of supervision fees. There is a 90-day period available to complete the program requirements.

Returning to the subtle but significant difference between the Civil Citation Network and the issuance of an NTA or arrest-as-usual, in cases involving successful program completion, DISC case managers notify the law enforcement agency, and no arrest is formally recorded. For unsuccessful participants, on the other hand, case managers convey this information to the agency, the State Attorney's Office files an arrest warrant for the original offense, and the participant is prosecuted accordingly. The arrest is entered into the state database and appears on the unsuccessful participant's criminal history.

The program is also supported by the Florida Department of Law Enforcement, which is home to the state's Statistical Analysis Center. This agency is responsible for compiling and managing various criminal justice data, including information related to arrests. One of the research goals of the Civil Citation Network has been to regularly assess subsequent arrest for participants who have received a citation. The Florida Department of Law Enforcement prepares these reports and shares this information as part of the ongoing evaluation process.

Since its inception, over 1,000 participants have entered the program through referrals by police. Approximately half of participants were referred to the program for petit theft; nearly one-third received citations for drug-related offenses (i.e., possession of less than 20 grams of marijuana or possession of paraphernalia); and smaller proportions were referred for low-level offenses such as disorderly conduct or possession of alcohol under 21 years of age. Nine out of 10 participants successfully completed the program, and 87% were not arrested in the three-year period following the inception of the program (Kopak & Frost, 2017).

LESSONS LEARNED FROM DEFLECTION AND DIVERSION PROGRAMS

The Safe Passage initiative and Civil Citation Network may target different populations and have slightly dissimilar goals as citizen-initiated deflection and police-led diversion programs, but they have many shared experiences. These two initiatives have led the way by putting ideas into practice, developing a deep understanding of how to practically adopt procedures to achieve certain goals. Here are a few important lessons learned from these two programs, many of which are applicable to other jurisdictions interested in highly effective practices for deflection and diversion programs.

Lesson 1: Developing Collaborative Relationships With Key Stakeholders

These programs are unique with regard to the high level of collaboration required for successful implementation. To establish Safe Passage, for example, the Dixon police chief spent 3 months working with treatment providers, agency directors, state's attorneys, and other stakeholders to develop organizational agreements to establish a process where law enforcement officials would be able to help those seeking treatment by issuing referrals at the time participants were voluntarily seeking treatment (Reichert et al., 2017). This planning phase included seeking treatment and service providers willing to work with the police department; training police officers on substance use disorders and program operations; working to recruit volunteers to help provide client transportation and assistance with intakes; outlining new policies and procedures related to the Safe Passage initiative, and continuously engaging with community members and organizations (Reichert et al., 2017).

Many of the initial treatment and service resources were initiated through extensive outreach efforts, resulting in the creation of memorandums of understanding. Currently, Safe Passage operates with 13 substance use treatment providers that deliver services to participants residing in Illinois. The program is not limited to Lee County and Whiteside County residents, but individuals residing in Iowa also seek treatment through

the program, as Whiteside County is on the Illinois-Iowa border. This challenges Safe Passage protocols because the program is using only in-state providers, who require participants be Illinois residents. When out-of-state residents inquire about Safe Passage, the program coordinator provides them with information and resources for treatment and services in Iowa (A. White, personal communication, May 7, 2020).

The Safe Passage program was championed by the Dixon police chief in conjunction with the Lee County Sheriff's Department. Though the Dixon police chief is now the Dixon city manager, his replacement has maintained and contributed to the program's continual growth and enhancement. Further, the Lee County sheriff and Rock Falls police chief continue to be program advocates, providing open communication and feedback for program improvement and demonstrating a willingness to continue to learn and a desire for their officers to learn (A. White, personal communication, May 19, 2020). The way these officers trust in the program and program coordinator has provided a model of behavior that has resulted in better working relationships with the program participants and treatment and service providers (A. White, personal communication, May 19, 2020).

Development of the Civil Citation Network was also largely dependent on the establishment of mutually beneficial relationships between law enforcement leaders, the State Attorney's Office, and the director of the local behavioral health provider. Similar to Safe Passage, credit for the successful adoption of the Civil Citation Network is traced directly to a law enforcement leader, in this case an administrative lieutenant who had the ability to develop the necessary agreements with the circuit's chief judge, Court Administrator's Office, Public Defender's Office, local sheriff's office, City Commission, County Board of Commissioners, and local chapter of the NAACP. Having this foundation in place allowed the police department and sheriff's office to develop program eligibility criteria with direct input from the behavioral health provider. This process also involved the development of an evaluation component to consistently monitor program performance so that all participating agencies could have access to current information.

Following the implementation and initial assessment of the Civil Citation Network, key stakeholders garnered legislative support to expand this form of police-led prearrest diversion to all 67 counties in the state of Florida. Not all of them have adopted the program yet, but six of the 20 judicial circuits are currently operating a police-led prearrest program, and the rest are in various stages of implementation.

Much more work needs to be done to evaluate the evidence for Safe Passage and the Civil Citation Network as model programs, but both should be highly regarded for the strengths of the partnerships that have been forged through their development. These partnerships include not only collaborations with behavioral health providers but also collaborations among other justice agencies, including state's attorney's offices and probation departments, and collaborations with public health organizations. Planning and implementation procedures have emphasized the need to identify a "champion" who can lead the charge to implement deflection and diversion programs (Kennedy et al., 2016), and it is abundantly clear that the successful start-up of these two initiatives was rooted in police leadership that was vital in the early stages and remains critical to the sustainability of these programs. Program leadership and collaboration have been identified as core elements in facilitating nonarrest opportunities for law enforcement deflection and diversion programs (Barberi & Taxman, 2019). Agencies interested in developing similar programs should seriously consider who might be best suited to lead a similar charge.

Lesson 2: Ensuring Accessibility and Availability of Services

Citizen-initiated deflection and police-led prearrest diversion programs must consider treatment and service accessibility, availability and capacity of treatment resources, systemic gaps in continuity of care, and the challenges of working with largely uninsured participants. Barberi and Taxman (2019) identify these external obstacles as treatment impediments, many of which require attention early in the development of these programs. With

insufficient availability of residential beds, lack of insurance coverage, or other financial difficulties, for example, wait time to treatment may be extended, collaboration and connection to resources may be compromised, and these types of programs may not operate as intended (Appel et al., 2004; Barberi & Taxman, 2019; McMurphy et al., 2006).

Safe Passage consistently encounters many of these barriers, some of which are related to the program's rural setting. Due to the large distances between police departments and service providers, many participants must be transported at least an hour to access the closest treatment center (Reichert et al., 2017). These partners, including treatment and service providers, are fully supportive in treatment and recovery for a widely dispersed population that can be difficult to work with due to the chronic, relapsing nature of substance use disorders.

Working agreements with regard to these types of citizen-initiated police deflection programs help individuals more easily access treatment and services, as cross-system collaboration can reduce the wait time (with general treatment placement within 24 hours, though often more quickly) for engaging with providers. Reducing wait times for access to services also capitalizes on the intrinsic motivation of individuals voluntarily seeking treatment through the Safe Passage initiative (A. White, personal communication, May 19, 2020).

Obtaining insurance and funding for uninsured populations can also be difficult when setting up a citizen-initiated police deflection program. Safe Passage has been able to secure competitive grant funds and private donations to help support program development and operation (Reichert et al., 2017; A. White, personal communication, May 6–7, 2020). Some treatment providers or program coordinators may also work with uninsured individuals upon intake to enroll them in insurance to help support the individual through treatment and recovery. Most initiatives will have to develop a locally oriented funding system that works best for the agencies and providers in a particular jurisdiction.

Accessibility should also be interpreted according to the sociodemographic diversity of prospective program participants. This is especially the case for some programs that were explicitly developed to address racial disparities in arrests for drug-relates offenses (see, for example, Beckett et al., 2005). Many initial assessments of citizen-initiated deflection programs have shown that the majority of participants identify as male and White, are unemployed, and have a median age in the late 20s or early 30s (Gleicher & Reichert, 2020; Reichert et al., 2017).

There are many challenges associated with making a determination of whether equal access is provided to deflection programs. First, many programs are still in their infancy and have limited numbers of participants. Second, citizen-initiated programs are located in certain jurisdictions with unique population demographics, making it difficult to fully understand who receives treatment and who does not according to potential program biases. Although more work is required to understand whether these programs are accessible by diverse populations, programs should strongly consider strategies to maximize program participation in all segments of the community, especially racial or ethnic minority group members who may be skeptical about seeking help from law enforcement officers (Barberi & Taxman, 2019). Both citizen-initiated deflection and police-led diversion programs can be significantly undermined in the absence of trust or legitimacy among community members, and these factors should be seriously considered throughout the planning, implementation, and evaluation processes.

Lesson 3: The Importance of Evaluation Based on a Variety of Data

Many law enforcement leaders and behavioral health providers cringe at the mention of the word, but data are critical to understanding the individual- and community-level impact of deflection and diversion programs over time. Data-collection practices do not need to be onerous, so long as key information is being recorded by all of the program's stakeholders in an efficient manner. One of the best ways to implement and maintain such a system is to involve a data analyst in the process. Some agencies may be fortunate enough to have an analyst on staff; others may consider approaching

other state entities or local universities to develop a partnership. These behavioral-health-oriented deflection and diversion programs occupy a unique position by providing much-needed services to populations who stand to benefit the most, but they are also challenged by the need to connect criminal justice information with behavioral health data to accurately monitor program performance and impact. Safe Passage and the Civil Citation Network draw on the work of external researchers who have access to different data sources and the capacity to link them, but the programs can also maintain the confidentiality of participants when reporting to criminal justice officials and service providers. In this approach, law enforcement agencies are restricted from accessing individual-level intervention program data, and the researchers provide aggregate information through interim reports that directly inform program practices.

Citizen-initiated programs focused on connecting people to treatment providers might be most interested in the number of successful referrals provided, indicators of treatment engagement, retention or duration of services provided, connection to aftercare services and recovery support, and how these relate to criminal justice activity. In Illinois, measures specified in the Community-Law Enforcement Partnership for Deflection and Substance Use Disorder Treatment Act related to police deflection and diversion programs include demographic information, number of law enforcement encounters that result in a treatment referral, time from law enforcement encounter to treatment engagement, and rate of treatment engagement at 30 days from the point of initial contact. Additional performance measures include, but are not limited to, the number of memorandums of understanding with treatment and service providers; number of awareness campaigns or public information initiatives to promote awareness of the program in the community; number of protocols put in place to support the program; number of police officers, civilian staff, and 911 dispatchers trained in substance use disorders and the deflection program; number of program coordinators; and number of referrals made to each level of treatment, including referrals to providers for medications for opioid use disorder.

Police-led programs may also be interested in identifying associations between individual needs at the time of referral, participation measures such as program completion, and subsequent criminal justice contact. Data collected from the Civil Citation Network, for example, have shown that participants with greater behavioral health needs were more likely to be arrested after being referred to the program and that a significantly smaller proportion (9% versus 59%) of participants who successfully completed the intervention were subsequently arrested compared to those who failed to complete the program (Kopak, 2019).

As previously mentioned, a citation through the Civil Citation Network serves as a legally binding mandate for the participant to report to the service provider. Data show that a very small proportion, just 2%, of participants failed to report (Kopak, 2020). This high rate of compliance should encourage officers to continue to exercise this prearrest diversion option when eligibility criteria are present. If this number were significantly higher and programmatic changes were not implemented to increase the reporting rate, officers could easily become discouraged by the low levels of program engagement among people who receive citations. After learning that prospective participants are not reporting to the program, for example, many officers might quickly to revert to the use of traditional arrest procedures. Nonreporting participants may also present greater behavioral-health-related risks for offending, and failure to engage with the treatment provider represents a lost opportunity to deliver services.

These analyses were the result of fairly comprehensive and organized data-collection procedures, but they are far from perfect. Working extensively with the information collected from these programs has revealed gaps that, if they were filled, would contribute a significant amount of knowledge about their impact. The behavioral health intervention provided within the framework of the Civil Citation Network, for instance, is based on an individualized treatment plan developed according to the results of a needs assessment conducted at

the time of program initiation. Participants are then required to complete the plan, but no follow-up behavioral health information is collected at the time of discharge from the program. Thus, changes in behavioral health are not measured and cannot be used to determine the level of response to the program material or to identify end-of-program risk for further contact with the criminal justice system.

Program administrators and policy makers tend to be most interested in how deflection and diversion initiatives influence recidivism, and there are many lessons to be learned about how this information is collected and analyzed. Law enforcement leaders want to know the degree to which officers spend their time addressing high utilizers (i.e., individuals charged with repeat offenses); state's attorneys require information on the number of arrests, charges, or court cases among participants; and policy makers want to know whether a program is effectively meeting goals, with recidivism reduction being among the most often cited (Rempel et al., 2018). One way to meet this objective is to establish a partnership with the state's Statistical Analysis Center (Justice Research and Statistics Association, 2020) to query arrest records to determine who comes into contact with law enforcement following program participation. Programs might also consider the collection of self-reported postprogram substance use and criminal activity to generate a more comprehensive portrayal of long-term recovery and desistance from crime that can be overlooked by relying solely on official records.

Citizen-initiated deflection and police-led prearrest diversion programs should consider collecting a wide variety of information from all participating stakeholders to conduct comprehensive evaluations. These efforts should focus on the data that can be used to track program performance, especially as they relate to achieving certain goals. Interested programs might consider the collection of key measures specifically designed to demonstrate the various ways deflection and diversion programs can impact individuals, police agencies, and the community (Police, Treatment, and Community Collaborative, 2020).

Lesson 4: Sharing Information for Research and Evaluation Purposes

The primary strength of deflection and diversion programs is embedded in their behavioral health approach to substance use and other behavioral health needs that contribute to crime, but this also introduces one of the most profound challenges of working with information collected by law enforcement agencies and service providers. While most law enforcement data (e.g., arrest and booking information) are public record or can be reasonably requested for research and evaluation purposes, information collected from treatment providers is slightly more difficult to obtain and work with because it is subject to protection under the Health Insurance Portability and Accountability Act (HIPAA); Title 42 of the Code of Federal Regulations Part 2 (42 CFR Part 2), regarding substance use treatment patients in facilities that receive federal funding; and other state-level protections.

Some treatment providers will invoke these protection mandates as if they are ironclad and completely prohibit the disclosure of information, but there are several situations permitting data sharing. HIPAA includes explicit references to providing disclosures for public health activities, judicial proceedings, criminal justice agencies, court-ordered examinations, and correctional facilities, as well as through business agreements (Substance Abuse and Mental Health Services Administration, 2014). Similarly, 42 CFR Part 2 permits disclosures for public health research, reports of abuse, crimes that take place on the premises of service delivery, the criminal justice system if treatment is a court-mandated activity, and other systems with consent or a Qualified Service Organization Agreement (Substance Abuse and Mental Health Services Administration, 2014).

In addition to the permissions built into these regulations, service providers may obtain consent waivers directly from program participants at the point of treatment initiation. Some providers have this option built into their service provision agreements as part of the routine intake process. Others may adopt this protocol to facilitate research and evaluation objectives following the implementation of a deflection or diversion program.

Another option available to researchers who enter into an agreement with a program is to obtain approval from an institutional review board or privacy board to share protected information, with or without the individual's authorization. Regulations for permitting disclosure of identifiable protected health information for research must meet the following criteria: (a) the use of protected health information has no more than minimal privacy risk; (b) there is no practical way to conduct the research without the waiver of authorization; and (c) there is no practical way the research can be conducted without the use of the personal health information (United States Department of Health and Human Services, 2018).

Navigating the process to ensure that a comprehensive set of law enforcement and behavioral health data is available for the research and evaluation of deflection and diversion programs is vital to ensuring these programs meet their stated goals. The Safe Passage program coordinator has established a data-sharing protocol, beginning with the collection of intake information. The program currently provides aggregate-level treatment data, including how many individuals were referred to each type of treatment, demographic background information, substance use history, criminal history, and any identified or diagnosed mental health or physical disorder.

An example from the Civil Citation Network can also help illustrate one way to navigate the process for sharing information between law enforcement agencies and treatment providers. At the time of the program's inception, an administrative officer at the police agency leading its implementation was responsible for compiling the original citation information for all participants. Offense type, severity, official charges, and demographic background factors were recorded in a secure data file. Meanwhile, the service provider archived behavioral health information pertaining to substance use, mental health, and offending risk, which was also stored in a secure fashion to follow mandated requirements for patient privacy protection. These two sources of information were linked by the program's analyst, who was able to complete the process while maintaining the confidentiality of participants by not sharing individuals' behavioral health information with law enforcement and vice versa. Although it may be somewhat challenging to establish the processes required to confidentially share and merge behavioral health information with offense data, the procedures are fairly easy to replicate at regular time intervals. These practices are also integral to developing a comprehensive portrait of the impact of deflection and diversion programs, making them essential to the evaluation process.

Many citizen-initiated deflection programs are still figuring out the most efficient data-sharing methods that allow them to meet their research and evaluation goals. The same is true for police-led programs, and each jurisdiction must determine the approach that works best for the involved agencies. Jurisdictions looking to develop information-sharing procedures should consider these examples but also review other materials to establish their practices (e.g., Petrila & Fader-Towe, 2010).

RESEARCH RECOMMENDATIONS

One of the primary objectives of this paper is to provide overviews of a citizen-initiated deflection program and a police-led diversion program along with helpful information that can be used for jurisdictions interested in using this knowledge to start, expand, or evaluate similar initiatives. Safe Passage and the Civil Citation Network have been involved in a wide variety of research, which offers an informed perspective to guide additional work in this area. Currently, research on deflection and diversion programs remains in its infancy and should be assessed accordingly. Although the programs are generally endorsed for their promise to reduce persistent offending by addressing substance use and behavioral health needs that contribute to crime, the conclusive evidence to support this outcome is currently not available. However, a brief overview of the preliminary work conducted with these programs can inform recommendations for other programs as they determine how to proceed with their evaluations and contribute to the evidence to identify best practices.

The research, evaluation, and information on citizen-initiated police deflection programs are especially limited as they relate to program participation and criminal justice or other quality-of-life outcomes. More information is also needed regarding aftercare services and processes, including access to and continuation of substance use disorder treatment and services (i.e., outpatient care), housing, social and human services, and other recovery-support services that an individual may need to be successful in their recovery. Individuals may run into post-treatment barriers regarding housing (and stability in housing), employment, and connection to aftercare services, particularly without transition services after their discharge from a residential facility (Laudet & Humphries, 2013; Manuel et al., 2017; Rog et al., 2014). Initial results from the Angel Program (on which Safe Passage is based) demonstrate a high (95%) direct-referral-to-treatment rate for participants who approached law enforcement officers seeking help with opioid use disorder, which is higher than emergency-department-based initiatives (Schiff et al., 2017), but little is known about what happens after a referral takes place and a person is deflected. Initial results from the Stop, Triage, Engage, Educate and Rehabilitate (STEER) program in Maryland show that half (51%) of participants who initiated treatment through the deflection method remained actively engaged after 30 days (Addiction Policy Forum, 2017). Additionally, the Tucson Police Department deflection program in Arizona has documented positive reactions from program participants, including gratitude for assistance and encouragement from officers (Korchmaros, 2019). These results are promising, but much more work needs to be done to develop a better understanding of how these programs can benefit participants, families, and communities.

Many of these initiatives were also developed in response to the opioid epidemic, but overdoses tend to involve polysubstance use. Programs that focus heavily on any single substance may discourage prospective participants who may benefit from services related to drugs not explicitly identified by name, for example. More educational and community awareness surrounding all types of substance use disorders is needed. In addition, programs can benefit from the continuous training of police officers, providers, and partners to identify individuals seeking help for a variety of substance use disorders (Gleicher & Reichert, 2020).

Related to the issue of citizen-initiated referrals is the glaring lack of information about who may or may not approach law enforcement officers for help regarding substance use disorder. Research has demonstrated that people who use drugs sense the stigma associated with this behavior, especially among police (Barberi & Taxman, 2019). Likewise, police often view diversion programs as being too soft on drug users, many of whom are viewed by officers as individuals who repeatedly offend and require punishment rather than treatment (Worden & McLean, 2018). One area for further inquiry is to assess the impact of a neutral program coordinator, who can be helpful in building trust within communities, serving as a liaison between the police and treatment providers, and managing the repository of relevant data collected about the program. Researchers might examine a program that has a coordinator and compare it to a program that does not have a coordinator to determine how these programs are perceived by prospective participants. The impact of a program coordinator may also be examined with regard to program consistency and stability, as having someone in this position gives the law enforcement agencies and treatment providers an individual point of contact for the program.

The paltry work conducted with citizen-initiated programs has been limited to the earliest stages of the deflection process: initial contact and referral. Continuity of care and aftercare for individuals leaving residential or inpatient settings and reentering the community has not yet been examined. Some treatment providers involved in citizen-initiated deflection are equipped to deliver these aftercare and continuity services. However, many individuals who come back to their community may not be connected to such services (for instance, if they have been receiving inpatient or residential treatment somewhere farther away, perhaps due to treatment capacity issues or a lack of the appropriate level of care near the community in which they reside). While there are outpatient

and intensive outpatient programs available in some communities, these may not provide for the holistic needs of individuals in recovery. To identify the impact of aftercare services, evaluations need to be conducted to examine various social domains and recovery trajectories among participants enrolled in aftercare services relative to those who are not. It is assumed that those provided with aftercare services fare better in terms of remission from substance use disorder and criminal justice contact, but the evidence from citizen-initiated programs is not yet available.

Future research conducted with citizen-initiated programs could also explore the risk-need-responsivity (RNR) model and whether it has application to police deflection and diversion programs (Bonta & Andrews, 2007). However, this would only be relevant for individuals in police-led programs specifically designed for populations with high criminogenic risk and corresponding needs. Minimal consideration for risk and protective factors related to continued substance use or misuse, risk for relapse, quality of life, and barriers to recovery are germane for the types of police deflection and diversion programs described here. Programs under the auspices of court or community correctional agencies will benefit from the stronger guidance of the RNR model (which was created to assess and rehabilitate individuals in the justice system), particularly regarding needs directly associated with risk for reoffending. In many cases, substance use is but one risk factor or need embedded in a much broader approach (Bonta & Andrews, 2016).

Several key findings have emerged from the preliminary evaluation work conducted in partnership with the Civil Citation Network to identify important areas for future work regarding police-led prearrest diversion programs. The initial examinations of the program provided two key findings. First, program completers were significantly less likely to be arrested in the three years following completion compared to participants who did not complete the program (Kopak & Frost, 2017). There are many potential explanations underlying this observation, one possibility being that participants who completed the program received the full intervention, while those who did not complete the program were not exposed to the same dose of potentially behavior-changing treatment. Subsequent analyses of behavioral health needs demonstrated that participants who presented more protracted behavioral health needs were more likely to fail to complete the program (Kopak, 2019). It is possible that a feature of the treatment protocol did not match the needs of this group, prompting premature separation from the program. Programs providing behavioral health interventions should establish a method to follow up with unsuccessful participants to learn more about the reasons for this outcome. This information can be used to enhance treatment retention with the goal of maximizing the likelihood of completion.

The second key set of findings derived from these preliminary assessments identified certain demographic background characteristics associated with increased risk for postprogram arrest. Specifically, younger male participants presented the greatest likelihood of police contact following referral to the program. From the behavioral health perspective, additional methods may be required to enhance the effectiveness of the intervention for this high-risk group. Similar to the prior recommendation, collecting information about these engagement techniques from this subset of participants can help guide future practices.

Another area of work focused on police-led diversion programs has identified the important role of officer discretion in the issuance of referrals to the program. Records from the Civil Citation Network indicate that certain officers frequently issue program referrals while others do not. While this information has not been analyzed formally to identify the relationships between discretionary referral practices among officers, other work with police-led diversion programs has examined this trend among officers and has generated some interesting results. One study conducted with officers in the Law Enforcement Assisted Diversion (LEAD) program, for example, found that officers who held favorable views of the program were more likely to divert eligible participants than officers who did not share the same views (Worden & McLean, 2018). This result converged with other examinations of law enforcement views of prearrest

diversion programs, citing officer skepticism about the program and length of time as an officer as primary obstacles to widespread implementation (Barberi & Taxman, 2019; Rouhani et al., 2019). These results, in combination with the anecdotal review of referral data from the Civil Citation Network, strongly suggest that police-led diversion programs should collect information about officers' views of the program, referral rates, and the use of alternatives to diversion for potentially eligible participants. This can help inform law enforcement administrators about diversion practices as they evolve, but it can also be shared with officers to demonstrate impact over time.

Many police-led prearrest diversion programs are focused on limiting subsequent criminal justice contact and reducing recidivism. Early evaluations of the LEAD program, which started as a police-led prearrest diversion program in Seattle, have focused heavily on these metrics, producing mixed results. Initial results indicated lower odds of subsequent arrest six months after program entry among participants relative to a comparison group that was prosecuted as usual, but these differences disappeared over time (Collins et al., 2017). It is possible that police-led programs work well in the short term to help stabilize participants and initiate the recovery process, but they should be examined more closely to help understand how to extend this impact further by promoting sustained remission from substance use disorder.

Putting this work into context, our current knowledge of citizen-initiated deflection programs and police-led prearrest diversion programs provides basic descriptive information highlighting high referral rates, the importance of officer discretion, and dubious findings related to their ability to reduce recidivism. Little is known about anything that takes place between referral and further police contact or rearrest. There is a significant amount of work to be done with regard to the extent to which these programs expedite and establish firm connections with treatment providers compared to alternative practices, how they increase or enhance the recovery process among people with substance use disorder, and how they improve law enforcement practices, especially with regard to policing drug-related crime. These programs are touted for their potential to enhance police–community dynamics, to address substance use disorders as a leading cause of certain types of persistent offending, and to redirect people away from jails and the courts and toward treatment providers, but there currently is no strong evidence indicating that they have accomplished these goals.

One of the primary functions of police-led prearrest diversion programs for low-level offenses is to eliminate the stigma associated with an official arrest record. Research has not yet been conducted to determine the magnitude of this intended effect, which could enhance employability, educational attainment, and stability in many other social domains as well. Research in this area also lacks longitudinal studies and more rigorous process and outcome evaluations, including those with more substantial follow-up times, comparison and control groups, and assessment of potential long-term impacts. This is likely due to the early stages of implementation of many of these types of programs. If future process and outcome evaluations indicate efficacy, cost–benefit analyses should be conducted, identifying possible disparities in potential cost to taxpayers between program types. Only by pursuing additional work in these areas will there be a deeper understanding of the potential impact of these programs and how to maximize their intended effects.

CONCLUSION

Judge Janet Holmgren of the 17th Circuit Court in Illinois recently noted, "The overrepresentation of people with behavioral health disorders in the criminal justice system is a problem that cannot be ignored and should not be tolerated" (Council of State Governments, 2020). Citizen-initiated deflection and police-led diversion programs have been dubbed the "wave of the future" for their promising ability to address these needs, improve community dynamics, reduce crime, and prevent people from being processed through the courts (Hoisington, 2018). The number of programs continues to grow steadily, especially as states such as Illinois and Florida legislate them into practice. Federal support for these programs also continues to increase, which will certainly contribute to

wider adoption as funding is directly allocated to deflection and diversion initiatives.

Despite the widespread support and endorsement of these programs, little is known about how well they function. Citizen-led deflection programs, for instance, are designed according to a voluntary participation model, and evaluation work has not been conducted to determine the extent to which these programs grant treatment access to people with substance use disorders, whether the programs are utilized by the majority of people in need, the degree to which these programs meet the stated goals of reducing (short- and long-term) recidivism, whether they increase the efficiency of law enforcement agencies, or whether they can be effectively adapted to a wide range of communities (e.g., rural, urban, racially diverse). Police-led prearrest diversion programs are currently in a similar position as they have been drawing a significant amount of attention for their potential to address substance use and behavioral health needs, reduce criminal justice involvement, and enhance public safety before their effectiveness is fully understood (Roberts, 2018).

The intention of reviewing these lessons learned from Safe Passage and the Civil Citation Network is to inform law enforcement administrators, behavioral health advisers, and community leaders about some of the important considerations to take into account when starting or refining deflection and diversion initiatives. Monitoring program performance will be one of the keys to measuring and sustaining effectiveness, but this can only occur through a collaborative relationship involving full participation from all stakeholders. In the absence of a well-planned strategy designed to continually assess and enhance these programs, they will easily become a passing trend that falls out of style just as quickly as it arrived.

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AUTHOR BIOGRAPHIES

Albert M. Kopak, PhD, is an associate professor in the Department of Criminology and Criminal Justice at Western Carolina University. His research informs practices that are designed to minimize the long-term impact of criminal justice system involvement on someone's life, while taking the opportunity to address substance use, mental health, and other factors contributing to law enforcement contact. This work has generated many peer-reviewed publications, reports, and the implementation of reformative practices in several communities.

Lily Gleicher, PhD, is a research analyst at the Illinois Criminal Justice Information Authority. Her interests include data-driven practices, implementation of best practices, criminal justice policy, behavioral health, corrections, correctional policy, and research methodology. She received her PhD from the University of Cincinnati in 2018 with a concentration in corrections and criminal justice systems.

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Correspondence
Please address correspondence concerning this article to:
Albert M. Kopak, PhD
Department of Criminology & Criminal Justice
Western Carolina University
1 University Drive, Belk 410
Cullowhee, NC 28723
Email: amkopak@wcu.edu

GUEST EDITOR NOTE

Introduction: Emerging Best Practices in Community Supervision to Address Behavioral Health Challenges

Sarah K. Jalbert
Institute for Community Health

At this moment in time, community supervision officers are confronting unprecedented obstacles to doing their work, whether due to the impact of the COVID-19 pandemic on traditional supervision practices, challenges to the legitimacy of the justice system due to institutional racism, or the more mundane but significant pressure on the state and municipal budgets that fund the majority of supervision activities. These pressures are set against a long-standing backdrop of limited research into and evaluation of best practices in supervision, as well as concern among policymakers that community supervision does not meet the needs of clients and communities.

This issue of the *Journal for Advancing Justice* is devoted to identifying ways to limit the use of incarceration by implementing effective practices in the community. Incarceration is a blunt approach that harms individuals, families, and communities. Community supervision has the ability to mitigate some of this harm by using flexible, responsive tools to address factors such as serious mental illness, substance use disorders, and trauma that make people vulnerable to incarceration. But these tools should be used sparingly. We know from the literature that low-risk clients do worse under supervision, and that concentrating resources on people with high needs produces better outcomes. To continue to reduce the use of corrections, agencies need to know which tools to use, for whom, and when.

How can we support supervision leaders and practitioners as they try to confront these challenges? My answer as an evaluator is usually "more evaluation." But evaluation is useful only when its findings can be applied broadly and support meaningful change. Supervision agencies vary so much in their mission, scope, and approaches that application of evaluation findings is difficult. Adding to the challenge is the potential for role and mission conflict within organizations. For instance, research into and evaluations of community supervision outcomes frequently define success as reduced recidivism without increased returns to prison for technical violations. To achieve reduced recidivism without increased use of incarceration, the available evidence supports the use of risk-need-responsivity (RNR) supervision, a constellation of practices that use assessment to identify risks and needs that can be managed by officers using a balance of surveillance and treatment. RNR supervision, while not a panacea, reflects decades of effort to identify the ideal balance of treatment and surveillance practices to keep communities safe while limiting the use of incarceration.

Two articles in this special issue present important research and commentary on implementing effective practices for people under community supervision. In "An Exploratory Analysis of the Relationship Between Various Community Supervision Field Contact Activities and Recidivism," Walter Campbell, Holly Swan, and I report on an exploratory analysis of the components of supervision field contacts, one of the most resource-intensive components of supervision. In probation and parole, field contacts are a core component of most agencies' supervision practice and account for significant probation and parole resources. Our study proposes several theoretical pathways that might underlie field contact effectiveness, measures activities that occur during field contacts in two agencies, and then tests the relationships between these activities and recidivism in the two agencies.

Several activities were significantly associated with recidivism, though in some cases the direction of the relationship differed by jurisdiction, and even within jurisdictions our findings were nuanced. In Ohio, the use of case planning and evidence-based practices (EBPs) is associated with a significant reduction in recidivism as well as increased time to recidivism. In Minnesota, when supervision officers came into contact with family members, recidivism dropped; however, when officers were in contact with neighbors, recidivism rose. Importantly, our findings varied by race and ethnicity (though we had sufficient sample to test this in only one site). For Black and Hispanic clients, EBPs and family contacts were not effective in reducing recidivism, suggesting that these practices may not be culturally responsive and require modification. Furthermore, non-White clients were less likely to receive these rehabilitative services than White clients, a finding that should be explored in future research. We speculate that field contacts may encourage officers to build rapport with clients, better target interventions, and enhance clients' perceptions of officer legitimacy. While these findings were exploratory and not causal, we believe they will help the field formulate important research questions that can be tested rigorously and translated to improved community supervision practices.

In "Finding the Balance: The Case for Motivational Interviewing to Improve Probation and Parole," Michael Clark describes the research supporting the use of RNR as a model for supervision. He highlights the demonstrated harm of using overly punitive, zero-tolerance supervision practices and suggests that harm can also come from an overly tolerant method of supervision. Motivational Interviewing (MI) in the context of RNR can provide numerous benefits: it can help agencies implement EBPs and staff navigate the dual role of the supervision officer, it can help overcome the deficiencies in RNR supervision when applied with reluctant clients, and it is nonadversarial, brief, culturally responsive, and learnable. Clark suggests that MI used in conjunction with RNR supervision can improve outcomes, but only in an agency that values the balance between rehabilitation and surveillance. When agencies do not adhere to a balanced model, supervisees are returned to incarceration more frequently.

As the push to reform the justice system and drastically reduce the use of incarceration continues, community supervision will play a critically important role in maintaining public safety while addressing the significant racial equity issues embedded in the justice system. No single approach or intervention will work universally to improve outcomes for this vast and diverse population. Evaluations must be large enough and sufficiently funded to support critical explorations of how different populations fare under different types of supervision practices. Research into and evaluation of community supervision must also include the voices of the people subject to supervision, giving these clients an opportunity to provide insight on their experiences, successes, and setbacks. Hearing from supervision clients can also help reframe our definitions of success, allowing the field to develop practices that affirm the strengths and possibilities of individuals supervised in the community.

RESEARCH REPORT

An Exploratory Analysis of the Relationship Between Various Community Supervision Field Contact Activities and Recidivism

Walter Campbell
Abt Associates

Holly Swan
Abt Associates

Sarah K. Jalbert
Institute for Community Health

Abstract

Field contacts are a core component of community supervision, yet the activities they comprise vary widely by supervisee, officer, department, and agency. To date, very few studies have investigated the use of field contacts, and only one study has explored the impact on recidivism of specific activities conducted during a contact. The current study addresses this knowledge gap through an investigation of the effect of various field contact activities on recidivism across four different agencies in Ohio and Minnesota. Using survival and multilevel logistic regression models that incorporate supervisee and officer contact characteristics, we find that an officer's frequent use of unscheduled contacts is linked to reductions in recidivism across sites. Within Ohio, we also find that the use of evidence-based practices and case planning during a field contact are linked to reductions in recidivism. Within Minnesota, we find that collateral contacts and contacts involving additional officers are also linked to recidivism rates. These nuanced findings provide initial insight into some of the activities that may make field contacts an effective community supervision practice; additionally, the findings suggest the theoretical underpinnings for this work.

Field contacts are a core component of community supervision used by a majority of community supervision agencies across the United States (W. L. Campbell et al., 2017). They account for a substantial proportion of community supervision agency resources and were included in the original conception of probation and parole (Finn & Kuck, 2003; Petersilia, 2003). Further, they often vary within the risk-need-responsivity (RNR) model of community supervision, changing as risks and needs change (C. A. Campbell et al., 2018; Latessa et al., 2010; Lovins et al., 2018; Taxman et al., 2006). Prominent criminological theories suggest various ways that field contacts could improve outcomes (by addressing criminogenic needs and reducing stressors or deterring criminal behavior) or worsen outcomes (via excessive surveillance accompanied by excessive use of revocation).

Despite their centrality to community supervision, field contacts are understudied. Beyond the basic understanding that they involve in-person contact with a supervisee outside of the office setting, there is little research on the activities that make up field contacts, the goals and purposes of field contacts, and whether they are effective in reducing recidivism or noncompliance with conditions of supervision. This lack of research is in spite of a vast body of knowledge on other tactics used in community supervision, such as intensive or enhanced supervision (Chamberlain et al., 2017; DeVall et al., 2017; Hyatt & Ostermann, 2017; Lane et al., 2007; Mann et al., 2003; Shannon et al., 2015).

The current study addresses these gaps in our understanding of community supervision with data from four agencies in two states. Our team used checklists filled out by probation and postincarceration supervision officers after each field contact over a 2-month window to document where field contacts occur, what instances prompt additional contacts, how often field contacts are unscheduled, what activities occur during a contact, whether more than one individual is involved in a contact, and what the outcomes of a contact are. We examine the connection between certain features of field contacts and the probability of recidivism and time to recidivism for supervisees. This research explores the aspects of field contacts that may be linked to effectiveness in reducing recidivism and increasing public safety.

CURRENT UNDERSTANDING OF FIELD WORK

Increasingly, research is being conducted on the effectiveness of strategies deployed by corrections agencies or programs to address criminogenic issues, such as Motivational Interviewing and cognitive behavioral therapy. Yet very little research has focused on certain core components of community supervision, such as the mode of service delivery (i.e., office, field, phone) (Bonta & Andrews, 2007). The paucity of research on these core practices of community supervision has consequences for agencies that expend resources on them, and on supervisees who may be harmed by unintended consequences of ineffective practices.

Field contacts are one aspect of community supervision among a host of underevaluated core activities. They are commonly used across agencies, are often built into agency supervision standards, and have the potential to increase work-related stress and safety concerns among officers. Agencies invest heavily in officer time and resources to ensure field work is conducted, without knowing whether these investments result in improved agency outcomes, or what aspects of field work are contributing to success. In fact, among the few studies that include field work as a distinct practice, most fail to note what activities are conducted in the field. Only one study to date (Meredith et. al, 2020) has investigated how aspects of a field contact are linked to success. This knowledge gap leaves the field with a very limited understanding of whether field contacts work and which of their aspects, if any, make them effective. Understanding and replicating the effectiveness of field contacts requires researchers to learn more about the implementation of field work by asking simple yet parsimonious research questions: Are field contacts scheduled or unscheduled? On average, what actions are taken during a contact? Who goes on these contacts? And what do these contacts result in? Answers to these questions would provide a clearer definition of field contacts and insight into the theory that explains why field contacts may be effective in reducing recidivism.

THEORETICAL UNDERPINNINGS OF FIELD WORK

Field work is multifaceted, and it could provide multiple theoretical pathways to reducing recidivism. For instance, field contacts may reduce recidivism via deterrence—officers can more readily detect whether their supervisees are violating conditions of their supervision or engaging in new criminal activity, and they can also quickly intervene with sanctions to prevent future criminal conduct (Alarid & Rangel, 2018), consistent with arguments that deterrence can be enhanced by swiftness, certainty, and severity (Nagin & Pogarsky, 2006b).

The use of field work may also increase supervisees' perception that officers will discover criminal activity (whether or not they actually do so), thereby reducing noncompliance or criminal behaviors, consistent with perceptual deterrence (Stafford & Warr, 1993). Most research suggests that increases in the perceived certainty of sanctions are far more likely to result in behavioral changes than are increases in the perceived or actual severity or celerity (swiftness) of sanctions (Howe & Brandau, 1988; Nagin, 1998; Nagin & Pogarsky, 2006a, 2006b; Yu, 1994). However, the use of field contacts may also increase the perceived celerity of punishment, as supervisees may assume that absent field contacts, their behavior might go undetected until their next office visit or scheduled drug test. If supervisees know they could be sanctioned sooner because their officer may witness illegal activity sooner, this could also result in a deterrent effect.

Surveillance-based deterrent interventions in community supervision have a history of producing unintended consequences and mixed results when implemented in the field. For instance, efforts in the late 1980s through early 1990s to supervise otherwise prison-bound individuals in the community via surveillance-focused early intensive supervision programs were shown to increase returns to prison due to technical violations rather than new criminal activity (Petersilia & Turner, 1993). These results spurred jurisdictions to de-emphasize surveillance in favor of therapeutically informed risk- and needs-based correctional treatment, which has shown promise in various settings (Andrews et al., 2006; Gaes et al., 1999). More recent experiments with deterrence-based swift, certain, and fair sanctions for individuals at risk of violating conditions of probation have failed to reproduce their initial promise, showing no improvement in outcomes over probation as usual (Lattimore et al., 2016). These results suggest that the deterrence aspect of field work may not be producing the results that supervision agencies intend.

Alternatively, field contacts may influence recidivism by enabling officers to more readily identify their supervisees' social and behavioral needs, whether financial, familial, psychological, or otherwise, and provide the necessary supports and resources in a timely fashion (Ahlin et al., 2013; Patten et al., 2016). Robert Agnew's general strain theory posits that stressors are among the primary causes of crime and that reducing the likelihood of offending requires reducing the scope of stressors or improving coping strategies (Agnew, 1992, 2001, 2007; Agnew & White, 1992). Field work might uniquely enable officers to identify supervisees' stressors by presenting officers with a clear picture of aspects of their clients' lives that cannot be observed during office, phone, or virtual contacts. Recent research highlights that this may likely be the case, finding that when officers focus on both the rules of supervision and the needs of supervisees during a field contact, reductions in recidivism are more pronounced (Meredith et al., 2020).

Interacting in settings where the supervisee feels comfortable (such as their own home) also allows officers to develop rapport, a necessary step for successfully implementing needs-based correctional treatment (Blasko et al., 2015). Field work with a correctional, rehabilitative focus allows officers to build rapport with their supervisees through a common understanding of a supervisee's challenges, and this understanding can be enhanced by meeting with the supervisee and their family in their own environment. Higher levels of rapport and stronger officer-supervisee relationships have been linked to reductions in recidivism, with evidence suggesting that when parolees have a positive relationship with their officer, they are less likely to recidivate, and that

this relationship also mediated the benefits of other services, such as therapy (Blasko et al., 2015; Chamberlain et al., 2017). In addition to the effect that rapport has on client receptivity to services, it may also result in reductions in recidivism via improved perceptions of the criminal justice system and its actors, and thus changes in feelings of legitimacy toward supervising officers. Improved levels of visibility and contact between the public and the criminal justice system have been shown to improve officer legitimacy (Hawdon et al., 2003), and improvements in legitimacy are linked to reductions in offending (Tyler, 2003).

With rapport established, officers engaged in field work may additionally be able to identify supervisees' previously unknown criminogenic needs. Research has found, for example, that family conflict and gang membership are among the strongest predictors of recidivism (Caudill, 2009; Cottle et al., 2001; Mulder et al., 2010; Pizarro et al., 2014), but supervisees may have strong incentives not to disclose such situations during an office contact. In the field, officers may be able to observe family functioning and potential barriers to success and thereby have an additional chance to quickly intervene using evidence-based practices (EBPs) such as Motivational Interviewing or referrals to outside treatment. While these resources can be provided later in an office meeting, field contacts allow officers to provide them immediately, and thus to address emergent issues before they result in more serious harm. Essentially, field work allows officers to use all of the well-validated EBPs that are core to an RNR model as soon as they notice an issue (Basanta et al., 2018; Bonta & Andrews, 2007).

Field contacts draw on principles from various theories of crime prevention and desistance, but the practice is relatively undefined in the research literature and variously implemented across agencies. Furthermore, despite the disproportionate share of community supervision resources devoted to field contacts, there has been little research on the effectiveness of the practice. The current study seeks to illuminate the pathways to field contact success by exploring what aspects of a field contact are associated with reductions in recidivism.

METHOD

In our analyses, our goal was to better understand the relationship between actions taken during a field contact and supervisee outcomes. To do so, we assessed the following characteristics of field contacts that are identified in the literature as likely to be linked to reductions in recidivism: unscheduled contacts, family contact, neighbor contact, the use of EBPs and case planning, and additional officers on a contact.

Unscheduled contacts may operate through a deterrent effect because supervisees do not know when they will occur. Such contacts can serve as a means of obtaining more honest assessments of supervisees' current conditions because they do not allow advance notice and thus do not allow supervisees the chance to alter home conditions. Family and neighbor contacts should also allow officers to obtain a better understanding of a supervisee's conditions as they allow officers to (a) verify information they obtained through the supervisee, (b) obtain new information the supervisee was hesitant to share, (c) meet the individuals most closely involved in that supervisee's life, and (d) establish rapport with those individuals. The use of EBPs and case planning on a contact signals that officers are prepared to respond immediately to issues that come up during the contact, rather than at a later time during a scheduled office contact. Finally, the presence of additional officers should allow the primary officer to focus on the interaction during a contact because their fellow officer can monitor safety issues and provide a second set of eyes and ears on the information being obtained. For these reasons, we hypothesized that the use of unscheduled contacts, contacts with family members and neighbors, contacts that involve EBPs and case planning, and contacts that involve additional officers would all be linked to reductions in likelihood of recidivism and prolonging of time to recidivism. Further, we hypothesized that regular use of these practices by officers would be linked to reductions in likelihood of recidivism and prolonging of time to recidivism for those officers' supervisees. Finally, as gender, racial, and ethnic disparities are a significant problem for the criminal justice field (e.g., Brunson & Miller, 2006; Gelman et al., 2007; Mauer, 2006; Tillyer et al., 2015), we

explored variation by gender, race, and ethnicity. While we could not make clear predictions about how field contact utilization and supervisee outcomes would vary by gender, race, and ethnicity, we predicted that significant variation would exist in the ways that field contacts are conducted and in outcomes by site.

To test the relationship between each of these components and recidivism, we used mixed-effects logit models with clustering by officer, and parametric survival models with a log-normal distribution and shared frailty by officers. The effect of each component is assessed at the supervisee level and the officer level to distinguish between the effects of, for example, an individual client receiving an unscheduled contact and an officer who frequently uses unscheduled contacts to supervise clients.

Sample

We analyzed data collected from four supervision agencies within two states: Ohio and Minnesota. We obtained data from two sources: a checklist designed by the study team that all officers filled out after every visit for a 2-month window and administrative data linked to these checklists.

Sites

In Ohio, we worked with the Adult Parole Authority of the Ohio Department of Rehabilitation and Correction (APA). The APA is responsible for the supervision of individuals following their release from an Ohio prison. Postrelease community supervision in Ohio involves supervising either parolees or individuals on postrelease control, a byproduct of truth-in-sentencing legislation. Thus, the APA is the single agency that supervises all adults postrelease within the entire state of Ohio.

In Minnesota, we worked with three agencies. Minnesota community supervision is divided into three broad categories: Department of Corrections (DOC) counties, County Probation Officer (CPO) counties, and Community Corrections Act (CCA) counties. In DOC counties, also known as contract counties, the DOC provides supervision services for adults with felony convictions, adults with misdemeanor convictions, and juveniles. In CPO counties, the county is responsible for supervising juveniles as well as adults with misdemeanor convictions, and the DOC is responsible for supervising adults with felony convictions. Finally, in CCA counties, the counties are responsible for all forms of supervision, receiving funding from both state and county tax dollars.

The county-based variation in supervision structure in Minnesota made obtaining data from the entire state impractical for this study, so instead we obtained data from all adult supervisees in two CCA counties (Ramsey and Anoka) and one DOC county (Benton), and from all felony supervisees in one CPO county (Chisago). These counties are geographically diverse. Ramsey County contains St. Paul, the state's second-largest city. Anoka County is contiguous with Minneapolis, the state's largest city, but more northern portions of Anoka are suburban and rural. Chisago and Benton are both rural counties approximately an hour away from the Twin Cities. The counties we partnered with also oversee diverse supervision and offense types, with adults serving supervision sentences for felonies, gross misdemeanors, misdemeanors, and petty misdemeanors, as well as adults on postincarceration supervised release and adults on probation.

In both sites, the use of field contacts was determined by departmental policy. Within each agency, the number of field contacts was consistent within each supervision level, yet actions taken during a field visit were allowed to vary as needed.

Checklist Data

In each state, officers completed a one-page checklist after each actual or attempted field contact with their supervisees over a 2-month period. The checklist asked about a variety of topics, including the following: who receives field contacts, and how often; where field contacts occur; why field contacts occur; how field contacts occur; what occurs during a field contact; and what additional actions, if any, the field contact resulted in. The specific categories and language on the checklist were adapted to each participating site, yet there was substantial overlap in questioning and categories. The results presented here reflect a synthesis of the categories across sites.

The checklists were distributed as hard copies that officers filled out soon after each attempted or actual field contact and mailed to the study team on a weekly basis. In both sites, this occurred over a 2-month window, the exact dates of which varied by site, with the Ohio checklists collected during the summer of 2016 and the Minnesota checklists collected during the spring of 2018. Copies of these checklists are provided in Appendix A.

Administrative Data

In order to investigate the outcomes of the activities described in the checklist data, we merged them with administrative data provided by each participating agency. These data were transformed to create consistent terms of supervision. In Ohio, these terms represent a single case supervised by the APA. In Minnesota counties, these terms may represent multiple cases supervised by the same agency, as an individual can be on supervision for multiple cases simultaneously. Supervision, though, does not change when a new case is added; supervision is risk-and-needs-based, not case-based. As we were only concerned with supervision terms that overlapped the 2-month checklist window, each individual has only one supervision term represented in this sample, and thus each observation represents a supervisee.

One difficulty arose in the classification of initial supervision levels. While Ohio uses a single set of risk-assessment tools (the Ohio Risk Assessment System) and has statewide classification and supervision standards, Minnesota uses a diverse array of risk-assessment tools, including the Level of Service/Case Management Inventory, the Minnesota Screening Tool Assessing Recidivism Risk, and the Level of Service Inventory–Revised to determine initial supervision level. In addition to diversity in the tools used to determine supervision level, there is also diversity in the names applied to each level (e.g., enhanced vs. high, traditional vs. medium) in Minnesota. Despite this variation, the levels of field contacts are similar across differently named categories in each county, and thus they were combined into a new variable and coded as "low," "moderate," or "high/very high" to coincide with those supervision levels found in Ohio.

Some cases within each state did not merge into administrative data (1,457 out of 4,773 in Ohio; 194 out of 834 in Minnesota). Failed merges occurred for a number of reasons, including illegibility or typos in the identifications listed on the checklist forms. As the forms contained no other personally identifying information for data-security reasons, if the identification was misspelled or illegible, nothing could be done to attempt to match it to administrative data. In addition, a number of cases were missing in Ohio because they were probation or community control cases. While the APA is primarily responsible for supervision of clients on postincarceration release, in some of the smaller or more rural counties in Ohio, it also assists in the supervision of probation and community control cases. A number of checklists filled out by Ohio officers were for such cases, but data on these individuals were not a part of the administrative data maintained by the APA for this project, so only individuals on postincarceration release were retained.[1]

We retained all cases in which (a) the supervisee had not been on supervision for longer than 3 years at the start of the checklist period; (b) information on the officer responsible for the case was not missing; and (c) an individual was not on a specialized form of supervision, such as the Intensive Supervised Release program in Minnesota. Evidence suggests that if recidivism occurs, it is likely to occur within the first few years of supervision (Luallen et al., 2018; Rhodes et al., 2014), and thus those individuals who have been supervised longer than 3 years are unlikely to recidivate regardless of the types of field contacts that they receive. We retained only those cases with officer information because understanding officer activities is a goal of this study. Finally, we excluded cases with specialized supervision types, as they often receive qualitatively distinct supervision.[2] These inclusion and exclusion criteria left us with a final sample of 2,724 supervisees in Ohio and 640 supervisees in Minnesota.

Due to their different start dates and the project's end date, supervisees in each state were followed for different lengths of time after the end of the 2-month checklist window. Supervisees in Ohio were followed for 18 months, and those in Minnesota were followed for 3 months.

Checklist Measures

The checklists were designed for officers to record information about a variety of aspects of field contacts, but for the purposes of this study, we focused on the five variables most closely aligned with the theoretical underpinnings of field work: unscheduled contacts, family contact, neighbor contact, the use of EBPs and case planning, and the presence of additional officers on a contact. For each of the selected activities, we measured both the effect of a supervisee receiving such a contact and the effect of an officer using these types of contacts often. For the latter, we created a dichotomous indicator of whether an officer used that activity (e.g., went on the visit unscheduled, used EBPs or case planning) on 50% or more of their field contacts during the checklist window. All measures were developed in collaboration with sites. EBPs and case planning represent a broad array of approaches intended to capture a rehabilitative approach to field work. Through personal communication with the sites, we determined that EBPs represented the use of tactics such as Motivational Interviewing, Carey Guides, and problem-solving techniques, while case planning involved identifying and addressing dynamic risk factors.

Tables 1 and 2 show the rates of activities for supervisees in each state (Table 1) and officers in each state (Table 2). Rates of most activities vary significantly across the two states, as assessed with a two-sample test of the equality of proportions,

Table 1. Supervisee Contact Characteristics by State During a 2-Month Window

	OH[a] (%)	MN[b] (%)
Unscheduled contact**	57.31	49.06
Family contact***	26.84	16.41
Neighbor contact	7.38	7.97
Evidence-based practices or case planning***	34.84	24.22
Additional supervision officers***	32.34	74.69

Note. Not mutually exclusive.
[a] $n = 2{,}724$. [b] $n = 640$.
$^{\dagger}p < .10$. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

Table 2. Officer Frequent Contact Activities by State During a 2-Month Window

	OH[a] (%)	MN[b] (%)
Unscheduled contact**	71.72	53.15
Family contact***	56.90	9.91
Neighbor contact*	9.00	1.80
Evidence-based practices or case planning*	33.10	21.61
Additional supervision officers***	32.07	69.37

Note. Not mutually exclusive.
[a] $n = 290$. [b] $n = 111$.
$^{\dagger}p < .10$. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

performed using the *prtesti* command in Stata 14.1. In addition, we examine differences in the use of activities during field contacts by gender and by race/ethnicity[3] using chi-square tests. Race and ethnicity are measured differently in each site. In Ohio, there are two categories: (a) White, non-Hispanic and (b) non-White or Hispanic. In Minnesota, there are three categories: (a) Black, non-Hispanic; (b) White, non-Hispanic; and (c) Hispanic or other race.

We find that in Ohio no activities vary by gender, but additional officers on a contact are more likely for non-White or Hispanic supervisees than for White, non-Hispanic supervisees (35.60% vs. 29.27%; $p < .001$), and EBPs and case planning are less common for non-White or Hispanic supervisees than for White, non-Hispanic supervisees (32.09% vs. 37.49%; $p < .01$). In Minnesota, additional officers on a contact are more common for female supervisees (84.62% vs. 72.16%; $p < .01$) and less common for White, non-Hispanic supervisees (65.42% vs. 77.66% for Black supervisees and 80.79% for Hispanic or other race supervisees; $p < .01$), and EBPs and case planning are more common for White supervisees (37.95% vs. 19.29% for Black supervisees and 15.72% for Hispanic or other race supervisees; $p < .001$).

To better understand the source of these differences, we explored variation in demographics and activities by supervision level. In Ohio, supervision levels do not differ by race or ethnicity at a statistically significant level ($p = .399$), but

they do differ by gender, with male supervisees more likely to be on moderate or high/very high supervision ($p < .001$). In Minnesota, supervision levels do not differ by race and ethnicity or by gender at a statistically significant level, but both approach significance, with male supervisees more likely to be on either low or high supervision and less likely to be on moderate supervision ($p = .063$) and Black, non-Hispanic and Hispanic or other race supervisees more likely to be on moderate or high supervision ($p = .068$). These differences, though, do not align with differences in activities by supervision level. The use of EBPs and additional officers only vary at a statistically significant level in Ohio, where supervision level does not vary by race or ethnicity (both activities are more common as supervision level increases; $p < .001$). In Ohio, unscheduled contacts are also more common at higher supervision levels ($p < .001$). In Minnesota, family contacts ($p < .05$) and neighbor contacts ($p < .05$) are more common at higher supervision levels. These findings suggest that while activities vary by supervision level, the racial or ethnic and gender disparities in activities are not a product of differing activities by supervision level.

Outcome Measures

For the outcomes analysis, recidivism is measured differently within each state as a result of different data availability. Ohio's recidivism measure captures recidivistic events that result in either new incarceration or new sentences to community supervision. This measure spans 18 months after the checklist period, and 26.8% of Ohio supervisees in our sample recidivated during this time frame according to this measure.

In Minnesota, recidivism is measured as reincarceration in either a local jail or a state prison. Thus, while the measure of recidivism in Minnesota involves a more inclusive definition of incarceration—both jail and prison—it does not include new supervision sentences. This measure spans 3 months after the checklist period, a shorter follow-up period than Ohio, and the rate of recidivism within our sample is 4.1%. This low rate is likely because of the shorter follow-up time period and because the Minnesota measure of recidivism does not capture new supervision sentences.

In both states, recidivism may be the product of a new criminal offense, a technical violation, or a combination of the two. We were unable to distinguish these within the data, and thus these measures of recidivism do not necessarily indicate new criminal events.[4] The follow-up time periods within each state reflect the longest possible follow-up period within the study timeline. Differences in how recidivism is defined in each state could not be bridged, as neither state collected recidivism data in a fashion that resembled the other state.

Control Measures

To isolate the effect of the checklist measures in the outcomes analysis, we accounted for a number of demographic, criminal history, and supervision-related variables linked to recidivism. The specific variables vary by state due to data availability. Table 3 lists these variables and the state(s) they were available in. In both states, we accounted for supervisee gender, race/ethnicity, and age. Gender disparities exist at various levels of criminal justice processing (Tillyer et al., 2015), as do racial and ethnic disparities (Brunson & Miller, 2006; Brunson & Weitzer, 2008; Gelman et al., 2007; Massoglia et al., 2013; Mauer, 2006). Research on age and offending suggests a bell-shaped age–crime curve in which offending peaks in the teens and declines steadily beginning in the early twenties, implying a clear link between age and likelihood of offending (Fabio et al., 2011; Kurlychek et al., 2012; Loeber & Farrington, 2014; Loeber et al., 2012). To normalize the age distribution, we took the natural log of age and included that variable in the regression models.

In terms of criminal history covariates, we were able to account for offense type in both states; for sentence length, sex offender status, and number of prior prison sentences in Ohio; and for offense level and case type in Minnesota. Accounting for criminal history is vital in accurately identifying effects of checklist activity on recidivism because past offending is one of the strongest predictors of future offending (Blokland & Nieuwbeerta, 2010; Bushway et al., 2011; Kurlychek et al., 2012).

We were also able to account for supervision level, annual number of successful field contacts, annual number of office contacts, and annual number

Table 3. Presence of Control Variables Used in Multivariate Models Across States

Variables	States
Male	Both
Race/ethnicity	Both; different operationalizations
Age at start of supervision	Both
Sentence length	Ohio
Offense type	Both, different operationalizations
Sex offender status	Ohio
Prior prison sentences	Ohio
Supervision level	Both
Offense level	Minnesota
Case type	Minnesota
Annual number of successful field contacts	Both
Annual number of office contacts	Both
Annual number of collateral contacts	Ohio
Annual number of unsuccessful field contacts	Ohio
Annual number of phone contacts	Both
Annual number of other contacts	Minnesota

of phone contacts in both states; annual number of collateral (e.g., family, neighbor) contacts and annual number of unsuccessful field contacts in Ohio; and the annual number of other contacts (including collateral contacts, unsuccessful field contacts, and missed office contacts) in Minnesota. Supervision level captures two phenomena likely linked to recidivism. First, it captures the overall risk of recidivism associated with a supervisee based on an assessment that accounts for their past criminal activity as well as for various other risk factors, such as substance use issues, peer networks, and social supports (Duwe, 2013; Latessa et al., 2010; Lovins et al., 2018). Second, supervision standards in both states are largely determined by supervision level and thus indirectly account for these other components of supervision that cannot be directly measured. Other forms of officer contact (e.g., office, collateral, phone, missed contact) are likely to vary alongside various field contact activities and are also likely linked to recidivism. Thus, variables that document office, phone, and other contact types indicate how reachable an individual is, whether an officer is making greater or fewer attempts at contact than recommended by policy, and what other services a supervisee might be receiving outside of those they receive on field contacts.

Table 4 provides descriptive statistics for these variables across the two states, highlighting differences in the supervision populations and in the operationalization of variables. While supervisees are more likely to be male in both states, the proportion is greater in Ohio. Race/ethnicity is operationalized slightly differently in each state depending on data availability, and the racial/ethnic makeup of the supervisee population varies slightly across the two states, with Minnesota supervisees less likely to be White (non-Hispanic) than Ohio supervisees. Offense types also vary by state, with Ohio supervisees more likely to have committed a violent offense, a finding that is likely a result of the APA's focus on postprison supervisees. Supervision levels also differ across sites, with Minnesota supervisees less likely to be on moderate supervision than Ohio supervisees. Finally, while officers in both states are conducting similar numbers of field and phone contacts, officers in Minnesota are conducting more office contacts than officers in Ohio.

Analytic Strategy

Research often models recidivism as either a dichotomous event or a time-dependent event (DeVall et al., 2017; Dooley et al., 2014; Hyatt &

Table 4. Control Variables Used in OH and MN Multivariate Models

	OH[a] Mean (*SD*)	MN[b] Mean (*SD*)
Male	93.91%	79.69%
Race/ethnicity		
Black, non-Hispanic	—	30.78%
White, non-Hispanic	50.92%	33.44%
Hispanic or other race	—	35.78%
Non-White or Hispanic	49.08%	—
Age at start of supervision (years)	36.67 (11.43)	36.23 (11.29)
Sentence length (months)	55.98 (73.22)	—
Offense type[c]		
Violent	54.11%	24.84%
Sex offense	—	12.66%
Property	17.80%	23.13%
Drugs	11.97%	24.69%
Public order	16.12%	—
Sex offender status[d]		
Prior sex offender	5.69%	—
Current sex offender	23.79%	—
Prior prison sentences[e]		
One prior	22.83%	—
More than one prior	32.75%	—
Supervision level[f]		
Moderate	48.24%	20.33%
Very high or high	39.02%	68.91%
Offense level[g]		
Felony	—	82.66%
Gross misdemeanor	—	16.25%
Case type[h]		
Postprison supervised release	—	31.25%
Annual number of successful field contacts	4.27 (4.05)	5.75 (8.67)
Annual number of office contacts	5.67 (5.17)	11.56 (7.41)
Annual number of collateral contacts	5.80 (7.60)	—
Annual number of unsuccessful field contacts	10.38 (9.94)	—
Annual number of phone contacts	4.34 (3.89)	5.04 (10.96)
Annual number of other contacts	—	15.60 (15.04)

[a] n = 2,724. [b] n = 640. [c] Mutually exclusive in OH; not mutually exclusive in MN. [d] Reference category: not a sex offender. [e] Reference category: no prior prison sentences. [f] Reference category: low or monitored time. [g] Reference category: misdemeanor offenses. [h] Reference category: probation cases.

Ostermann, 2017), but for our outcomes analysis, we use both, mirroring an approach to measuring recidivism that has been used by others (Alarid & Rangel, 2018; Rhodes & Jalbert, 2013). Using both methods permits an understanding of both the overall probability of recidivism and the time to recidivism. In addition, both methods provide useful information for community supervision agencies, which are concerned with both whether and when an individual will recidivate. Finally, using both methods allows for easier comparison of our findings with other current and future research in the field, regardless of which method is used.

To assess recidivism as a dichotomous event, we use a mixed-effects logistic regression model. Random effects are clustered by officer, with misspecification-robust standard errors. As an offset variable, we include the logged time on supervision to capture the amount of potential exposure to recidivism each individual experienced. This model was run using the *melogit* command in Stata 14.1. To assess recidivism as a time-dependent event, we used a log-normal parametric survival model with a shared frailty for the officer responsible for a supervisee. This model is analogous to a mixed-effects model with clustering by officer for time-dependent variables. Log-normal models were used as Akaike information criterion and Bayesian information criterion statistics, and Kaplan–Meier graphs of survival time demonstrated that the log-normal distribution best fit the patterns of recidivism. This model was run using the *streg* command with the *distribution(lognormal)* option in Stata 14.1. Due to differences in how sites operationalize our control and dependent variables, we assessed findings across the two sites separately. These differences also suggest that we cannot make direct comparisons between sites but instead must view these findings as highlighting all possible relationships between field contact practices and recidivism across the two sites.

RESULTS

We assessed how the varied components of a field contact are linked to supervisee outcomes by regressing recidivism on these activities, holding demographic, criminal history, and supervision-related covariates constant. The results of these analyses are displayed in Table 5. For simplicity of presentation, only the output for the aspects of field contacts are displayed (full models are available in Table B1 of Appendix B). Time ratios above 1.00 indicate that a variable prolongs the time to recidivism, while those below 1.00 indicate that it shortens the time to recidivism. Similarly, odds ratios above 1.00 indicate that a variable increases the odds of recidivism, and odds ratios below 1.00 indicate that it reduces the odds of recidivism.

Findings differ across states, likely as a result of the different outcome measures and varied ways in which field contacts are conducted. However, some strong patterns emerge across and within states. Within Ohio, the use of any EBPs or case planning is associated with reductions in the overall odds of recidivism and increases in the time to recidivism (specifically, the use of any EBPs or case planning increases the time to recidivism by 20%). This finding is illustrated in Figure 1, which graphs the survival curves for supervisees who received any EBPs or case planning during field contacts and supervisees who did not.

Within Minnesota, the frequent use of neighbor and family contacts by officers has an impact on the overall odds of recidivism but in divergent directions: when officers frequently make contact with family members, recidivism among their supervisees is lower, but when officers frequently make contact with neighbors, recidivism among their supervisees is higher.

Figure 1. Time to Recidivism by Supervisee Receipt of Evidence-Based Practices (EBPs) or Case Planning

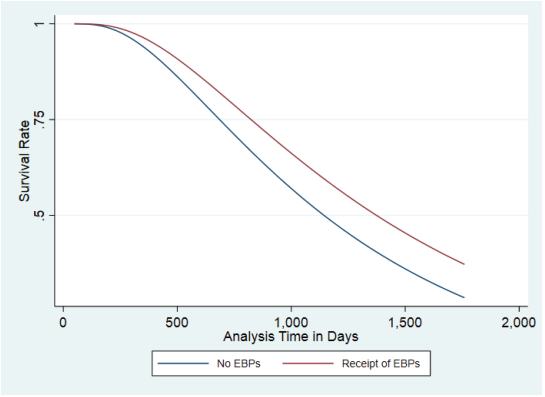


Table 5. Regressions of Recidivism on Contact Type, Personnel, and Activities During Field Contacts

	OH—New supervision or prison sentence[a]		MN—New return to jail or prison[b]	
	Mixed-effects logit model odds ratio, coefficients (*SE*)	**Log-normal parametric survival model with shared frailty time ratios (*SE*)**	**Mixed-effects logit models odds ratio, coefficients (*SE*)**	**Log-normal parametric survival model with shared frailty time ratios (*SE*)**
Client variables				
Any unscheduled contacts	0.86, -0.15 (0.13)	1.06 (0.05)	6.69, 1.90 (0.59)**	0.37 (0.14)*
Any family contacts	1.19, 0.17 (0.16)	0.94 (0.05)	0.81, -0.21 (0.90)	0.99 (0.41)
Any neighbor contacts	1.36, 0.31 (0.22)	0.88 (0.07)	0.90, -0.11 (1.06)	1.26 (0.65)
Any evidence-based practices (EBPs) or case planning	0.63, -0.46 (0.19)*	1.20 (0.07)**	2.16, 0.77 (0.67)	0.71 (0.26)
Any contacts with additional supervision officers	1.04, 0.04 (0.20)	1.00 (0.06)	5.99, 1.79 (0.66)**	0.38 (0.22)†
Officer variables				
Frequent unscheduled contacts	0.65, -0.43 (0.23)†	1.13 (0.07)†	0.07, -2.69 (0.71)***	4.22 (1.88)**
Frequent family contacts	0.78, -0.25 (0.19)	1.09 (0.06)	0.10, -2.34 (1.19)*	4.45 (3.91)†
Frequent neighbor contacts	1.03, 0.03 (0.31)	1.02 (0.11)	13.33, 2.59 (0.96)**	0.25 (0.19)†
Frequent EBPs or case planning	1.01, 0.01 (0.21)	1.02 (0.07)	0.45, -0.80 (0.76)	2.41 (1.38)
Frequent contacts with additional supervision officers	1.02, 0.02 (0.20)	1.01 (0.07)	0.17, -1.76 (0.78)*	1.41 (0.64)

[a] $n = 2{,}724$. [b] $n = 640$.
†$p < .10$, *$p < .05$, **$p < .01$, ***$p < .001$.

The presence of additional officers on a field contact had a mixed effect on recidivism in Minnesota. When measured as a supervisee-level variable, the presence of additional officers was linked to an increased odds of recidivism, but when measured as an officer-level variable it was linked to a decreased odds of recidivism.

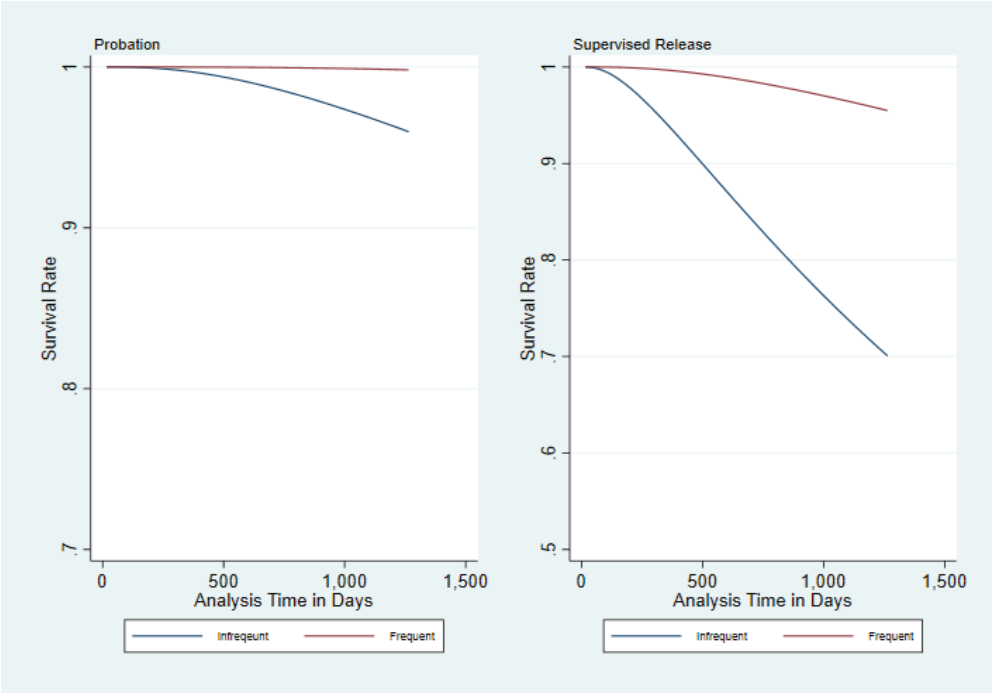
The impact of unscheduled contacts also varied by the level of measurement. Within Minnesota, supervisees who received an unscheduled contact were more likely to recidivate and recidivated more quickly. Yet at an officer level, unscheduled contacts are linked to reductions in recidivism and prolonged time to recidivism. This relationship is illustrated by the survival curves in Figure 2, which graph time to recidivism for those on probation and those on postprison supervised release according to whether they had an officer who frequently conducted unscheduled contacts. When officers frequently conduct unscheduled contacts, supervisees' time to recidivism is dramatically prolonged.

Finally, we attempted to explore differences in field contact activities and outcomes by gender and by race/ethnicity, but due to small sample sizes for female supervisees in both states and for all racial/ethnic groups in Minnesota, we were only able to estimate reliable coefficients for race/ethnicity in Ohio. To do so, we split the sample by race/ethnicity and reran the models. We found the impact of EBPs only remains significant for the sample of White, non-Hispanic supervisees. We also found that for White supervisees, contact with a family member is associated with a 36% reduction in the odds of recidivism ($p < .05$), but that this is not the case for non-White or Hispanic supervisees. Also, while unscheduled contacts are associated with a 47% reduction in the odds of recidivism for non-White or Hispanic supervisees ($p < .05$), this is not true for White supervisees.

CONCLUSION

Despite it being a staple of community supervision practices, little is known about field contacts, and particularly whether the components of a field contact contribute to success in supervision (Meredith et al., 2020). To build knowledge of this important aspect of community supervision, we conducted this study to assess whether certain

Figure 2. Time to Recidivism by an Officer's Use of Unscheduled Contacts



elements of a field contact are linked to recidivism. We found that, to varying degrees and in different ways, family contact, neighbor contact, the use of any EBPs or case planning, unscheduled contacts, and the presence of additional officers on a contact were all linked to recidivism within at least one of the two states included in our study. The directions of these relationships provide some insight into how field contacts may be linked to recidivism. Field contacts may reduce recidivism by increasing the perceived certainty and swiftness of punishment and thereby producing a deterrent effect (Stafford & Warr, 1993). They may also impact recidivism by allowing officers to better deliver correctional treatment targeted to supervisees' criminogenic needs (Agnew, 2007; Blasko et al., 2015; Chamberlain et al., 2017; Meredith et al., 2020). Field contacts may also be linked to reduced recidivism by improving rapport between officers and supervisees, which allows officers to act more effectively on the issues they observe, and which may also increase feelings of legitimacy among supervisees (Blasko et al., 2015; Tyler, 2003).

The effect of the two types of collateral contact varies, with neighbor contacts associated with increased recidivism and family contact associated with decreased recidivism. While contact with neighbors may provide officers with additional information on their supervisees, contacts with neighbors are rare in both states and may only be productive when neighbors are sufficiently motivated to talk to officers or when the information is negative enough to potentially necessitate a revocation. Conversely, family contact is more frequent and may occur regardless of how a supervisee is doing. Such contacts likely provide officers with an even clearer understanding of how their supervisee is doing, allowing them to more fully address the stressors and issues faced by that supervisee. Further, they allow officers to build a relationship with the people most actively involved in their supervisee's life, and thus family contacts are likely to improve rapport between the officer and supervisee, enhancing the delivery of services and feelings of legitimacy. The findings for collateral contacts are intriguing but not definitive; more research is needed to investigate the differential outcomes for collateral contacts.

The effectiveness of using any EBPs or case planning during field contacts suggests the importance of responding to stressors as soon as possible. If an officer notices an issue on a field contact, they can either respond to it immediately by adjusting the case plan or using some form of EBP, or they can make a note to address it at a later office contact. The findings in this study suggest that the former may be more beneficial: addressing stressors sooner lessens their impact and reduces the possibility of recidivism occurring during the time between the field contact on which the stressor is identified and the office contact during which it is scheduled to be addressed.

At the supervisee level, unscheduled contacts and the presence of additional officers are both linked to increased recidivism. Both aspects of a contact provide officers a greater opportunity to witness new offending and noncompliant behavior. Unscheduled contacts catch supervisees unprepared; thus, when an officer stops by, supervisees may be currently engaging in illegal or noncompliant activity or may be unable to hide signs of past illegal or noncompliant activity. Similarly, the presence of additional officers may increase the ability of officers to more easily witness behavior that could lead to a revocation, with one officer paying attention to safety so that the other can pay better attention to the supervisee. It is also possible that when officers bring another officer on a contact, they expect a revocation is likely; perhaps they are bringing assistance because they think things are going poorly with that particular supervisee. Further, these findings may be driven by a lack of use of rehabilitative practices during both types of contacts. The use of any EBPs or case planning is less common on unscheduled contacts than on scheduled contacts (15.29% vs. 32.82%; $p < .001$) and on contacts where additional officers are present (18.83% vs. 40.12%; $p < .001$). This finding suggests that unscheduled contacts and contacts involving additional officers are both more likely to be used with a surveillance approach to supervision.

Conversely, both of these types of contact—unscheduled contacts and contacts involving multiple officers—are linked to reductions in recidivism when they are used frequently by officers. If a supervisee has an officer who often conducts unscheduled field contacts, the

supervisee may perceive a greater certainty of punishment as, in any moment, they cannot know whether their officer will stop by and find them engaging in problematic activity. In addition, officers who often use unscheduled contacts likely obtain more useful information about the stressors faced by their supervisees because their supervisee cannot prepare for the contact, and thus the true nature of their living condition is readily visible to the officer. Similarly, officers who regularly conduct field work in teams may be more likely to notice stressors because there are two officers present, and thus what one fails to notice the other might witness, leading to better information about that supervisee and thus a more appropriate case plan. Officers who regularly conduct contacts with other officers may also be able to pay more attention to their supervisees because they do not need to worry about safety issues and thus may develop better rapport with their supervisees.

In general, these findings highlight some of the actions taken by officers during field contacts that are linked to reductions in recidivism. This study provides insight into how officers can improve supervisee outcomes through field contacts, and it also highlights aspects of field contacts that warrant further investigation in future studies.

Finally, while we were unable to explore variation by gender and race/ethnicity in all our findings, where we did, we observed differences. Most notably, we find that non-White or Hispanic supervisees are less likely to receive any EBPs or case planning in both states. In Ohio, they do not receive a statistically significant benefit from the use of these tactics, while their White, non-Hispanic counterparts do. We are unable to explore the reasons for these differences within our data, and they may be due to myriad factors that are by no means limited to practices of community supervision officers. Regardless of their cause, they point to a problem with community supervision as currently practiced. Variation in officer practices by race/ethnicity lead to disparate outcomes by race/ethnicity, and this can result in continued criminal justice contact for non-White or Hispanic supervisees that is not experienced by White, non-Hispanic supervisees.

LIMITATIONS

The study has some limitations that the reader should consider. First, we rely on limited and varied measures of recidivism due to differences in data availability at both sites. The study timeline and varied priorities in measuring recidivism in both states limited our ability to capture similar measures of recidivism across the two states. Results should be interpreted with this limitation in mind. Future research should test whether these findings are maintained with more complete measures of recidivism that also account for factors like arrests and convictions and that encompass longer time periods. Second, we make the assumption that a 2-month window provides us with a general understanding of the supervision received across a sentence. While our conversations with representatives from both states lead us to believe that this is a reasonable assumption, future studies would benefit from a longer time series of checklist data. Third, while our checklist measures provide suggestions of the mechanisms underlying the impact of field contacts, we do not directly test these mechanisms. Directs tests of, for example, the link between unscheduled contacts and perceived deterrence would provide an even clearer understanding of field contacts. Fourth, we use a broad measure of EBPs and case planning. Future research should investigate the impact of specific EBPs and case-planning approaches used in the field. Fifth, the findings of this study suggest that both deterrent and rehabilitative approaches to supervision may result in reductions in recidivism. We were unable to test this directly. A more direct comparison of these two approaches and their benefits would greatly improve our understanding of field work in community supervision. Further, better understanding agency orientation will also provide insight into when and how recidivism occurs, as agency orientation is likely linked to revocation policy. Sixth, field contact training varies by agency (W. L. Campbell et al., 2017), and this may have impacted the results, especially with respect to variation across the states in our study. Assessing training was not within the scope of this study, but future research should investigate the impact of variations in field contact training on supervision outcomes. Seventh, the focus of this study is on field work, but mode of contact

likely impacts the effectiveness of practices used during that contact. For example, EBPs may be differentially effective when used on a field, office, telephone, or virtual contact. While exploring this relationship was not within the scope of our study, we encourage future researchers to explore the relationship between different modes of contact and supervisee outcomes. Eighth, few studies to date have investigated the overall impact of field contacts on supervisee outcomes. We rely on these studies in assuming that field contacts are generally linked to reductions in recidivism, but this assumption needs to be more thoroughly explored in future research. Ninth, our assessment of racial and ethnic differences in supervision is limited by the categories of race and ethnicity collected by each site. As race and ethnicity are important topics within criminal justice, going forward, agencies should attempt to collect the most detailed information that they can.

Finally, this study is an exploratory one that examines a variety of outcomes, but it is not an experimental or quasiexperimental causal test of effectiveness. Our goal was to highlight correlations that can guide future research. While we believe that we have accounted for some of the potential sources of endogeneity by controlling for various supervision activities (e.g., other types of contacts, missed field contacts, supervision level, officer), absent a strong quasiexperimental or experimental design, these findings should not be used to make any causal claims. As experimental research can be difficult, expensive, and time-consuming and identifying the opportunity for a quasiexperimental design is often challenging, we believe that highlighting these correlational relationships is an important first step toward a better understanding what works in community supervision. Exploratory research can identify significant relationships between intervention characteristics and outcomes that a more rigorous design would not, so testing our preliminary findings using a quasiexperimental or experimental design is an important next step. We hope that, alongside the work of Meredith and colleagues (2020), this study provides future guidance about the aspects of field contacts that should be tested using more rigorous methods and thus functions as a useful starting point for a stronger understanding of this core correctional practice.

ENDNOTES

1. While these merge issues did not appear to be systematic, to better understand their impact, we used a probit model with sample selection to test the robustness of our findings. This process involved using checklist variables for both those supervisees that merged and those that did not to model the selection process, and then rerunning the outcome models with this selection accounted for. This analysis was run using the *heckprobit* command in Stata 14.1. With the exception of the results for supervisee receipt of EBPs and case planning in Minnesota and officer use of unscheduled contacts in Ohio, the results did not substantively differ from those presented in this paper (same sign and indication of statistical significance). In the models presented in this paper, supervisee receipt of EBPs and case planning does not have a significant impact on recidivism in Minnesota and officer frequent use of unscheduled visits has an effect that approaches significance, but in the probit model for sample selection, the effect of both is statistically significant ($p < .05$). Otherwise, none of the findings in this paper seem to be sensitive to selection issues associated with a failure to merge all checklists to administrative records. Because the probit model for sample selection does not allow for an accounting of clustering by higher-level variables, we did not use it in the main analysis, as we believed it was more important to appropriately account for variations in supervision across officers.

2. Specifically, the groups excluded were those individuals being supervised under Intensive Supervised Release (ISR), the Challenge Incarceration Program (CIP), and the Conditional Release Program (CRP) in Minnesota. These three types of supervision serve distinct populations. ISR is designed for especially high-risk supervisees, while CIP and CRP are designed for lower-risk supervisees. In both cases, supervision requirements vary significantly from requirements for the general population. For example, while other high-risk supervisees in Ramsey County are supposed to receive a field contact every 6 months, ISR supervisees receive four a week. These contacts also vary in their intention, with the primary purpose

being to confirm that no violations of supervision are occurring. In addition, supervisees must let their supervising officer know where they will be at all times.

3. The authors treat race and ethnicity as a single variable for this study due to data limitations. The study sites did not consistently distinguish between these variables, thus restricting the authors' ability to do so. The categories used in this study reflect the categories recorded by the study sites, not those chosen by the authors. The authors believe that this may mask important distinctions, as race and ethnicity are not the same concepts, and research suggests they may matter in different ways throughout the criminal justice system.

4. Interviews and focus groups with officers and supervisors in both states suggest that officers are unlikely to seek a revocation solely for technical violations unless those violations are particularly numerous or egregious.

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Appendix A. Checklist Forms

OHIO DEPARTMENT OF REHABILITATION AND CORRECTION – FIELD CONTACT CHECKLIST

Client CCIS #		Date of Contact:	
Total Drive Miles:		Start Time:	
Total Drive Time:		End Time:	

CONTACT MADE: ☐Yes ☐No

IF NO, REASON:
☐Client/Offender Not Present at Site
☐Safety Concern(s)
☐Accessibility (ex: *impassible roads*)

Collateral Contact Made: ☐Yes

Offender Type [check all that apply]:	**Contact Location** [check all that apply]:	**Location Type** [check all that apply]:
☐PRC/IPP/RR	☐ Residence	☐House (free-standing)
☐Sex Offender	☐ Place of Employment	☐Duplex or multi-family house
☐Parole	☐ Treatment Center	☐Apartment
☐ICOTS (compact)	☐ Other:_____	☐Shelter
☐Community Control		☐Halfway House
☐JUR/JUR80		☐Community Service Provider
☐Transitional Control (TRC)	☐ Multiple Attempts; Total: _____	☐Public Place: _____
☐Treatment Transfer	☐ Multiple Locations; Total: _____	☐Other:_____
☐Treatment in Lieu		
☐Other:_____		

Confirmation of offender's residence ☐Yes ☐No

IF NO, REASON:
☐N/A (ex: *employment contact*)
☐Client/Offender Did Not Report Move
☐Other:_____

CONTACT TYPE [check all that apply]:
☐Scheduled Visit
☐Unscheduled Visit
☐Placement Investigation (Offender not present)
☐VAL Investigation
☐Regular Visit As Determined by ORAS Level
OR
Additional Visit Due To:
☐Missed Office Visit
☐Positive Drug Test
☐Law Enforcement Call/Incident
☐Community Call
☐Other: _____

☐Additional APA Staff; Total:_____
☐ Other Law Enforcement Escort; Total:_____
List of Other LE Agencies:
_____
_____
_____
_____
_____
_____
_____
_____
_____

ACTIVITIES [check all that apply]:
☐Visual Confirmation of Location
☐Search
☐Arrest
☐Contact with Family Member
☐Contact with Community Member/Neighbor
☐Assessment/Reassessment
☐Other EBP's
☐Case Planning
☐Drug Test
☐Other:_____

ACTIONS [check all that apply]:
Visit Resulted In:
☐Office Visit Required
☐Reassessment
☐No actions

For Abt Associates Use Only
Date Entered into Database: _____
Entered By: _____

HOME AND FIELD CONTACT CHECKLIST - MINNESOTA

Agency Name:
- ☐ Benton DOC
- ☐ Chisago DOC
- ☐ Chisago CPO
- ☐ Anoka CCA
- ☐ Ramsey CCA

Client's CSTS ID Number: _____

Date of Contact: _____

Time of day:
- ☐ Morning (before noon)
- ☐ Afternoon (noon-4pm)
- ☐ Evening (4pm-8pm)
- ☐ Night (after 8pm)

Client Contact Made:
☐Yes
☐No

If no client contact made, reason:
☐Client Not Present at Site
☐Safety Concern(s)
☐Accessibility (ex: *impassible roads*)
☐Client moved
☐Other:_____

Client Type [check all that apply]**:**
☐ISR
☐CIP/CRP
☐Supervised Release
☐Probation
☐Other:_____

Supervision Level:
☐High
☐Medium
☐Low
☐ISR/CIP/CRP

Contact Location:
☐Client's Residence
☐Place of Employment
☐Non-residential Treatment Program
☐School/College
☐Public Place (ex: shopping center, street corner)
☐Other:_____

If contact was at client's residence, residence type:
☐Single family house
☐Duplex or multi-family house
☐Apartment
☐Shelter
☐Hotel/Motel
☐DOC leased/ATTIC
☐Halfway House
☐Residential Treatment Program
☐Other:_____

Reason for Contact:
Routine Contact As Determined by Contact Standard:
- ☐Scheduled Contact
- ☐Unscheduled Contact

OR
Contact Due To [check all that apply]**:**
- ☐Missed Office Visit
- ☐Positive Drug Test
- ☐Law Enforcement Call/Incident
- ☐Community Call
- ☐EM/EHM Compliance
- ☐Placement Verification
- ☐Other: :_____

Additional Personnel [check all that apply]**:**
☐Conducted with a partner (team of 2)
☐Conducted as a team of 3 or more
☐Conducted with a law enforcement escort
Number of law enforcement escorts:_____

Activities [check all that apply]**:**
☐Visual Confirmation of Location
☐Search
☐Arrest
☐Contact with Family Member
☐Contact with Community Member/Neighbor
☐Assessment/Reassessment
☐Other EBP's
☐Case Planning
☐Drug Test
☐Other:_____

Resulting Actions [check all that apply]**:**
☐Office Visit Required
☐Reassessment
☐Violation/Restructure
☐No actions

Appendix B. Full Model Output

Table B1. Effect of Contact Type, Personnel, and Activities on Recidivism

	OH—New supervision or prison sentence[a]		MN—New return to jail or prison[b]	
	Mixed-effects logit model coefficients (*SE*)	Log-normal parametric survival model with shared frailty time ratios (*SE*)	Mixed-effects logit models coefficients (*SE*)	Log-normal parametric survival model with shared frailty time ratio (*SE*)
Client variables				
Any unscheduled contacts	-0.15 (0.13)	1.06 (0.05)	1.90 (0.59)**	0.37 (0.14)*
Any family contacts	0.17 (0.16)	0.94 (0.05)	-0.21 (0.90)	0.99 (0.41)
Any neighbor contacts	0.31 (0.22)	0.88 (0.07)	-0.11 (1.06)	1.26 (0.65)
Any evidence-based practices (EBPs) or case planning	-0.46 (0.19)*	1.20 (0.07)**	0.77 (0.67)	0.71 (0.26)
Any contacts with additional supervision officers	0.04 (0.20)	1.00 (0.06)	1.79 (0.66)**	0.38 (0.22)†
Male	1.06 (0.33)**	0.70 (0.07)**	0.10 (0.69)	0.96 (0.37)
Race/ethnicity				
Black, non-Hispanic	—	—	—	—
White, non-Hispanic	—	—	0.19 (0.65)	0.95 (0.34)
Hispanic or other race	—	—	-0.22 (0.75)	1.01 (0.38)
Non-White or Hispanic	0.21 (0.13)	0.93 (0.04)	—	—
Logged age at start of supervision (years)	-1.24 (0.25)***	1.56 (0.15)***	-0.36 (0.85)	1.29 (0.66)
Sentence length (months)	0.00 (0.00)	1.00 (0.00)	—	—
Offense type[c]				
Violent	—	—	-0.26 (1.03)	1.04 (0.39)
Sex offense	—	—	-2.26 (1.18)†	4.85 (4.08)†
Property	0.12 (0.19)	0.90 (0.05)†	-0.37 (0.92)	1.12 (0.42)
Drugs	0.21 (0.18)	0.91 (0.06)	-0.21 (0.82)	1.11 (0.44)
Public order	0.02 (0.18)	0.98 (0.06)	—	—
Sex offender status[d]				
Prior sex offender	-0.43 (0.30)	1.22 (0.12)*	—	—
Current sex offender	-0.52 (0.18)**	1.36 (0.09)***	—	—
Prior prison sentences[e]				
One prior	0.20 (0.16)	0.93 (0.05)	—	—
More than one prior	0.43 (0.18)*	0.82 (0.05)**	—	—
Supervision level[f]				
Moderate	0.17 (0.20)	1.00 (0.07)	0.94 (1.58)	0.75 (0.54)
Very high or high	0.26 (0.21)	0.93 (0.07)	2.69 (1.78)	0.23 (0.15)*
Offense level[g]				
Felony	—	—	-1.44 (0.96)	3.27 (1.78)*
Gross misdemeanor	—	—	0.25 (0.64)	1.12 (0.58)

	OH—New supervision or prison sentence[a]		MN—New return to jail or prison[b]	
	Mixed-effects logit model coefficients (*SE*)	Log-normal parametric survival model with shared frailty time ratios (*SE*)	Mixed-effects logit models coefficients (*SE*)	Log-normal parametric survival model with shared frailty time ratio (*SE*)
Case type[h]				
Postprison supervised release	—	—	2.28 (0.80)**	0.22 (0.09)***
Annual number of successful field contacts	0.03 (0.02)	0.98 (0.01)*	-0.13 (0.06)*	1.07 (0.04)†
Annual number of office contacts	0.07 (0.01)***	0.97 (0.00)***	-0.04 (0.03)	1.04 (0.03)
Annual number of collateral contacts	0.07 (0.01)***	0.98 (0.00)***	—	—
Annual number of unsuccessful field contacts	0.11 (0.01)***	0.97 (0.00)***	—	—
Annual number of phone contacts	0.04 (0.02)*	0.99 (0.01)*	0.05 (0.02)*	0.98 (0.02)
Annual number of other contacts	—	—	0.03 (0.01)*	0.98 (0.01)**
Agent variables				
Frequent unscheduled contacts	-0.43 (0.23)†	1.13 (0.07)†	-2.69 (0.71)***	4.22 (1.88)**
Frequent family contacts	-0.25 (0.19)	1.09 (0.06)	-2.34 (1.19)*	4.45 (3.91)†
Frequent neighbor contacts	0.03 (0.31)	1.02 (0.11)	2.59 (0.96)**	0.25 (0.19)†
Frequent EBPs or case planning	0.01 (0.21)	1.02 (0.07)	-0.80 (0.76)	2.41 (1.38)
Frequent contacts with additional supervision officers	0.02 (0.20)	1.01 (0.07)	-1.76 (0.78)*	1.41 (0.64)

[a] $n = 2{,}724$. [b] $n = 640$. [c] Mutually exclusive in OH, reference category: violent crime; not mutually exclusive in MN. [d] Reference category: not a sex offender. [e] Reference category: no prior prison sentences. [f] Reference category: low or monitored time. [g] Reference category: misdemeanor offenses. [h] Reference category: probation cases.
†$p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$.

AUTHOR BIOGRAPHIES

Walter Campbell, PhD, is a criminal justice researcher. His research interests include issues in community supervision and reentry, geographic patterns of crime, issues in policing, and quantitative program evaluation.

Holly Swan, PhD, is a sociologist and implementation scientist with expertise in criminal justice, behavioral health, health services research, and mixed methods research and evaluation. She has led and supported the design and execution of numerous research and evaluation projects and has led the development and administration of quantitative and qualitative data collection instruments for several studies.

Sarah K. Jalbert, MA, MS, is a researcher and evaluator whose research focuses on justice and behavioral health issues. She is executive director of the Institute for Community Health.

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Correspondence
Please address correspondence concerning this article to:
Walter Campbell, PhD
Tel: 617-520-2347
Email: Walter_Campbell@abtassoc.com

PRACTICE COMMENTARY

Finding the Balance: The Case for Motivational Interviewing to Improve Probation and Parole

Michael D. Clark
Center for Strength-Based Strategies

Keywords: Community corrections, Motivational Interviewing, risk-need-responsivity, probation officer, parole officer, hybrid, dual role, synthetic officer, working alliance

Abstract

Newly published findings report that 45% of all state prison admissions in the United States are due to violations of probation or parole—by way of new offenses or technical violations. Community corrections has become a paradox, not only failing in its mission to divert and remediate, but making matters worse. This commentary focuses on the direct practice of probation and parole officers, as they exert much influence on decisions to punish. It identifies groups that willfully contribute to this "prison pipeline." One group includes those who supervise with mindsets of "zero tolerance" and "incarcerate first"—those with seemingly little flexibility in remanding parolees back to prison. The author compares research into the failure of coercive force with new research on the hybrid or synthetic officer, characterized by blending the dual roles of "control" with "working alliance." This type of practice includes officer traits of being firm, fair, caring, and motivating, all attributes predictive of success. Outcome research is merged into an initial continuum of practice. The author suggests empowering risk-need-responsivity approaches with Motivational Interviewing, ending with a discussion of the benefits that caused Motivational Interviewing to be deemed a good fit for community corrections.

THE PIPELINE PARADOX

Probation and parole (P&P) recently experienced a wake-up call from a 2019 report released by the Council of State Governments Justice Center. This report determined that 45% of state prison admissions in the United States are due to violations of probation or parole—by way of new offenses or technical violations (Council of State Governments Justice Center, 2019). New offenses aside, it is particularly disconcerting that a high number of these state prison admissions are for technical supervision violations such as failure to report or not completing community service work as directed. Skeem and Manchak (2008) report on these troubling results:

> One might argue that detecting and sanctioning technical violations is an index of the surveillance model's success in preventing crime [citation omitted]. However, there was no evidence that violating probationers on technical offenses prevented new arrests or otherwise protected public safety. (pp. 230–231)

When technical violations of court orders are met with incarceration, the economic consequences are severe. Keannealy et al. (2012) determined that the cost of housing a single inmate is more than 20 times higher than supervising that individual via community corrections. Community corrections has become a paradox; not only are we failing in our mission to divert and remediate, but we are making matters worse. Community corrections has become a pipeline to prison.

WHO TO FOCUS ON—AND WHAT TO FOCUS ON?

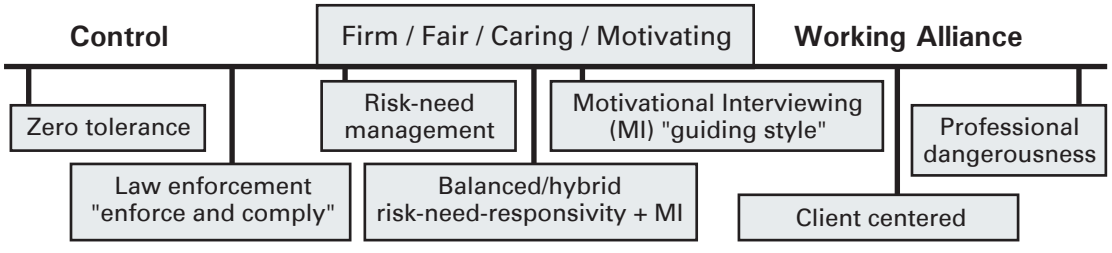
Once a justice-involved individual is diverted to the community, *who* makes the decision to incarcerate? Initial attention may be directed toward the judge or prosecutor. However, many who truly understand the P&P supervision process will correctly acknowledge the considerable impact of the supervising officer's recommendations. Multiple studies note that supervising officers wield a powerful influence in decision-making and are critical contributors to punishment decisions (Kerbs et al., 2009; Rodriguez & Webb, 2007; Rudes & Portillo, 2012).

Working to establish compliance and then moving to influence behavior change is a complex business. To begin lowering prison admissions, what to focus on could be methods of practice—those techniques and strategies extended to individuals under court jurisdiction. Focusing on the supervising officer's influence toward revocations, this article seeks to examine suggestions for improving the direct practice of P&P officers. This commentary ends with a suggestion to employ Motivational Interviewing (MI) in community corrections work and examines several benefits of this approach to help reduce violations and revocations.

THE SYNTHETIC OFFICER: MOVING TOWARD THE MIDDLE OF "BOTH/AND"

Our field seems handicapped by a dualism; punishment or rehabilitation, law enforcement or social work, hard or soft. These "either/or" dichotomies have grown stale, while research points to the inclusiveness of "both/and." Figure 1 merges outcome research to place the range of P&P practice on a continuum. To embrace outcome research is to concentrate on the blocked-off center area of this continuum. The middle ground seems to represent a Goldilocks principle of "just the right amount" of both control and working alliance.

Figure 1. Continuum of Probation and Parole Practice



In the middle of the continuum in Figure 1 is the risk-need-responsivity (RNR) framework that is complemented and empowered by MI. When it was introduced, RNR brought renewed optimism to the field. After decades in which the P&P field was adrift, this method demonstrated reduced recidivism in an accessible and practical way, providing much-needed empirically grounded and scientifically confirmed outcomes. RNR operates through three core principles:

- **Risk principle:** Risk assessment tools are used to determine a person's level of risk so that the dosage or intensity of treatment can be set accordingly. (It determines who should be assigned to a continuum or intensity of services.)

- **Need principle:** Treatment goals should be focused on criminogenic needs, or individual situations functionally related to criminal behavior. (It determines what issues are to be targeted or worked on.) What individuals "need" to work on are causal issues that have been shown to influence reoffending.

- **Responsivity principle:** This principle suggests that we base programs and services on what will effect change for the individual in front of you. (It determines how to design and deliver services that will sync to the individual, including relationships, motivations, and styles of learning.) This includes the role of the officer-supervisee relationship in increasing engagement and motivation.

However, RNR is not a perfect solution. The most often-cited critiques are that the RNR model can be more about programs than people, and that it lacks clear guidance for day-to-day implementation of the RNR principles across diverse programs and target groups (Polaschek, 2012). Further work on the principle of responsivity documents that one must retain a focus on the person to apply any empirically based model effectively (Lowenkamp et al., 2012). Even the best approaches will fail if the individual is disinterested and does not want to participate. Start with client engagement or forget starting at all.

Effective officers establish a working alliance via warm, high-quality officer-supervisee relationships, and these relationships occupy the middle of this continuum. This blend of control and connection has been found to be predictive of success in supervision (Lovins et al., 2018). Descriptions from research are plentiful:

- The "synthetic" officer: surveillance and rehabilitation to establish a "working alliance" (Klockars, 1972; Polaschek, 2016; Skeem & Manchak, 2008; Viglione, 2017)

- Warm but restrictive relationships (Bonta & Andrews, 2016)

- Firm, fair, and caring—respectful, valuing of personal autonomy (Kennealy et al., 2012)

- A "hybrid" or "synthetic" approach to probation, combining a strong emphasis on both social work and law enforcement (Grattet et al., 2018)

- Motivational communication strategies and MI (Viglione et al., 2017)

- Open, warm, enthusiastic communication and mutual respect (Dowden & Andrews, 2004)

- Blending care with control through a "dual relationship" (Skeem et al., 2007)

The Goldilocks principle also involves extremes to be avoided from both ends of the spectrum shown in Figure 1. Move to the left end (zero tolerance—law enforcement) and the officer is too distant and punitive. At the opposite end (client-centered—professional dangerousness), the officer is too close, believing there is no need for firmness where troubling (or repeated) violations are ignored.

AVOIDING THE EXTREME OF "TOO TOUGH"

Researchers have found that a fringe portion of community corrections staff seek to incarcerate. Lowenkamp et al. (2012) make reference to line staff who "hope for a negative outcome" (p. 11).

Although these authors believe this attitude is consigned to "isolated cases," many believe the actual numbers are enough to place this group on the practice spectrum. For instance, Skeem and Manchak (2008) cite the common P&P adage "trail 'em, nail 'em, and jail 'em." This phrase is so well known across the community corrections field that these authors affix this adage not just to a few outliers, but as a type of "supervision model" (p. 230).

As it relates to technical violations, it is important to consider this rigid approach not as an artifact or remnant from the "get tough" era of 40 years ago, but very much in the present tense. Consider a recent publication in which Kras et al. (2019) speak of those "seeking to incarcerate" as a distinct group: "Justice workers committed to primarily punitive approaches such as 'zero-tolerance' or 'incarceration first' may encourage their own desired outcomes, regardless of the agency goals, even if their own aims are ineffective or potentially detrimental to clients and public safety" (p. 476). It would seem our first order of business could be to move this fringe group from a mindset of "force over" to one of "power with" (Hawkins, 2002)—all to moderate the "zero tolerance" stance as a way of doing business.

Current research tells us that there is a failure of using force for preventing revocations:

- When supervising parolees, officers who emphasized law enforcement were three times as likely to revoke community supervision (Kennealy et al., 2012).
- When community supervision workers tried to use sanctions to shape behavior, failure rates rose (Clear & Frost, 2014).
- Supervision strategies rooted in punitive, deterrence-oriented principles have a poor record of reducing recidivism (Lovins et al., 2018).
- Research demonstrates that programs based on deterrence, incapacitation, and increased control do not reduce future criminal activity (MacKenzie, 2013).
- Research has shown that a punitive, fear-based treatment approach focused on avoiding "bad" behaviors has not been very successful (Wormith et al., 2007).

When problems do occur (and they will), they can be addressed by using "intelligent flexibility" (Gunnison & Helfgott, 2013), rather than pulling the plug upon first breach. This flexibility speaks to the responsivity principle and to officers individualizing their response(s) to match the person in front of them. Strategies for line staff, to be used during stressful situations when breaks or noncompliance occur, are important for reducing violations and revocations. Such strategies can be used to stop violations and revocations before they start, or to negotiate in more effective ways when consequences become necessary.

AVOIDING THE EXTREME OF "TOO SOFT"

What occupies the other end of this spectrum is what I have referred to as "professional dangerousness" (M. D. Clark, 2005). This issue involves a failure to bring forth violations that should be reported. It occurs with staff who have become too client centered and who may ignore the need for firmness and control. This happens in a fairly predictable way: Hard work is extended to gain the supervisee's trust and engagement, and staff may hold too tightly to this hard-won rapport. An officer may fret that reporting violations will set back or weaken this working alliance. At this extreme, an officer might find themselves saying to a supervisee, "I won't report this to my supervisor (or judge or prosecutor) *this* time, but don't do it again." Here the officer has swung too far to the opposite extreme and is not directive enough. The hope and belief that the officer can build an alliance and work together with a supervisee is not the same as ignoring violations. Believing that supervisees are worth doing business with is not the same as adopting the easiest way of doing business with them.

Agencies can help P&P officers avoid practices that are too distant and tough, or too close and yielding, by adopting evidence-based practices (EBPs). These practices include skill sets that can better equip

the supervising officer to ward off violations and revocations. Iarussi and Powers (2018) note that MI is one such EBP that appears to be a "natural fit" (p. 28) for delivering P&P services.

PROBATION AND PAROLE—THE BEST HYBRID USES MOTIVATIONAL INTERVIEWING

McNeill (2009) notes that "the legitimacy of the officer—on which his or her influence for good depends—is hard-won, easily lost and hard to recover" (p. 8). There is a wealth of literature on what officers should do but far less on how to do it. RNR and the ability to build quality relationships have been improved with the mindset and skills of MI. This is a true strength of MI—helping P&P staff with methods for direct practice.

As an experienced MI practitioner and trainer, this author moves to suggest several benefits of the MI approach for community corrections. These include:

1. MI can align P&P with evidence-based practices and is well placed in community corrections.
2. MI is complementary to RNR approaches and teaches staff how to negotiate the dual roles of surveillance/law enforcement and alliance/behavior change.
3. MI can stand the heat. It has effective methods for reluctant or resistant probationers and parolees
4. MI can influence positive behavior change through nonadversarial methods.
5. MI is suited for busy caseloads. It can make an impact in brief interventions—even single sessions or within compressed time frames.
6. MI crosses cultures well.
7. MI is learnable and has options for safe and responsible procedures for the pandemic era, with its need for physical distancing.

Benefit 1: MI Can Align P&P With Evidence-Based Practices and Is Well Placed in Community Corrections.

With more than 1,200 controlled clinical trials across many different fields (Miller, 2020), MI has been designated as an EBP (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). An empirical study of MI suggests that certain types of brief interactions are as beneficial as more lengthy interventions, and that certain kinds of direct practice work by staff could more effectively elicit change (Miller & Rollnick, 2013). MI started as an alternative to working with problem drinkers—particularly those individuals who may have been perceived as being resistant or in denial (Miller, 1983). It has been advanced as a way of communicating with people to help them find their own reasons for change (Miller & Rollnick, 1991, 2002, 2013). MI is especially suitable when P&P goals and supervisee goals do not match. It avoids advice-giving, confrontation, and coercion in favor of engagement, relationship-building, and amplifying the supervisee's ideas for compliance and change (Stinson & Clark, 2017).

Specifically for criminal justice settings, early evaluations of MI with supervisee work in New Zealand showed a positive impact on recidivism rates (Anstiss et al., 2011) and effectiveness with high-risk individuals (Austin et al., 2011). Several studies have found MI to be an effective practice suitable for use in community corrections (McMurran, 2009; Taxman, 2002; Viglione et al., 2017). A recent study of MI in a community corrections setting found that the relational skills of MI were important predictors of treatment initiation (Spohr et al., 2016). We know that intervening at the human service level is crucial for effectively addressing the problem of criminality (Bonta et al., 2008). In other words, an approach like MI that emphasizes specific interactions to build a working alliance between a supervisee and P&P staff has proven successful through decades of research (Bogue et al., 2008).

Benefit 2: MI Is Complementary to RNR Approaches and Teaches Staff How to Negotiate the Dual Roles of Surveillance/Law Enforcement and Alliance/Behavior Change.

Why does MI fit in the middle of this continuum? Of the many reasons, two are important to review. First, MI fits as a base for RNR programming. Research has found that when MI is added to another EBP, *both become more effective*—and the effect is sustained over a longer period of time (Miller, 2018). Combining MI with an RNR approach is more effective for two reasons. One, with MI in place, supervisees are more responsive to participation, and two, they are more likely to complete what is intended by the tandem evidence-based treatment. MI has been studied as a prelude to treatment, but those in corrections view it as a "base" approach (i.e., a way of being) to be used throughout programming with supervisees. Use MI as a stand-alone practice or as an adjunct to existing treatment approaches already in place.

The second reason that MI fits is that it offers methods for negotiating the blending of control with a working alliance. These critical skills emerge from the MI community—informing supervising officers how to carry out the dual roles of surveillance/enforcement and engagement/assisting behavior change. The methods and strategies are available and within reach for P&P staff who seek to negotiate control and alliance. Consider the titles of various subsections in a recent publication that focuses on the application of MI to community corrections (Stinson & Clark, 2017):

- Addressing Violations and Sanctions
- Explaining the Dual Role
- When Goals Don't Match—Clarifying Your Role
- Adherence to Core Correctional Practices
- Muscle vs. Meekness
- Understanding Control vs. Influence
- "Power With" vs. "Force Over" to Facilitate Change

This list represents a deep dive into negotiating this dual role. Administrators and researchers alike have found that MI can transform mechanical and depersonalized supervision models and add important core counseling skills, realizing all the while that supervisee engagement is a critical first step (Stinson & Clark, 2017). As a result, the most widely accepted RNR programs within the last decade—Effective Practices in Community Supervision (EPICS), Staff Training Aimed at Reducing Rearrest (STARR), and the Carey Guides—have all recommended and/or taught MI as an important component to better facilitate a climate of behavior change. (For EPICS, see University of Cincinnati Correctional Institute, n.d.; for STARR, see Robinson et al., 2011; see also Gleicher et al., 2013. For the Carey Guides, see Carey & Carter, 2019.) Note that the Carey Guides include MI and refer to it as "*a communication style that provides the groundwork for the professional alliance* [emphasis added] that is so critical to helping offenders address skill deficits and implement risk reduction strategies" (Cary & Carter, 2019, p. 5).

Benefit 3: MI Can Stand the Heat. It Has Effective Methods for Reluctant or Resistant Probationers and Parolees.

It might be helpful for community corrections departments to know that MI was originally developed for those more resistant, angry, or reluctant to change (Stinson & Clark, 2017). MI has been found to be a particularly effective approach for working with people who are angry and defensive *at first contact* (Miller & Rollnick, 2013). Research is clear about the impact of first impressions (Bar et al., 2006; Yu et al., 2014). From the first greeting and handshake, relationships can begin collaboratively rather than gearing up for a boxing match. In a past interview, one probationer noted, "I thought she [the supervision officer] was playing me, because some try to act interested but they're not. She's real. She cares. Never had one like her."

Posttraumatic stress disorder (PTSD) can add heat to an officer's interactions. Studies have shown that people with a higher reactance level have a better response to MI than to more directive styles (Miller & Rollnick, 2013). A person with elevated reactance can be oversensitive, touchy, or even volatile. Consider that individuals entering community corrections caseloads might suffer from PTSD and the elevated reactance levels so prevalent in this condition. Research from the

field of trauma-informed work states, "MI enables service providers to carry out the intentions and goals of trauma-informed practice" (Motivational Interviewing and Intimate Partner Violence Workgroup, 2010, p. 101).

Now add the complexity of dual diagnosis, meaning that a new supervisee may enter a P&P department with both mental health and substance use disorders. Results from a 2018 study indicated that MI was associated with increased self-efficacy and treatment completion of dually diagnosed clients (Moore et al., 2018). A department chief told me of a parolee who had tested positive for illicit drugs following a random drug screen during an office visit. When confronted, he admitted to a recent relapse. Before being transported to detention, he begged to talk to the agency chief. The chief agreed to a quick visit and told me of his surprise that, rather than the expected plea to "give me a break," the parolee had wanted to "apologize" for "messing up your new program." When the chief replied that he wasn't sure what "new program" he was referring to, this person said, "You know, the way your officers talk to us now, respect us. I don't want ruin this and I'm sorry 'cause I think I probably have." This administrator realized this person was referring to the department's recent implementation of MI. He noted that the visit left him "stunned" that someone being processed for a parole violation would apologize for "letting people down," something that had never happened before in his 35 years of service.

Benefit 4: MI Can Influence Positive Behavior Change Through Nonadversarial Methods.

MI has a directional aspect, whereby clients are intentionally guided toward what the supervising officer (or court or judge) regards as appropriate goals (Stinson & Clark, 2017; Miller & Rollnick, 2013). The directional aspect of MI is not immediately apparent. Those who give it only superficial consideration may see it as only a warm, "hug-a-thug" counseling approach. The counterpoint to this assertion is straightforward—progress and change do not have sides. Direct confrontation has little relationship with actual behavior change, and in most instances, it damages the relationship and leaves one less able to influence change. The MI alternative of negotiating ambivalence, evoking change talk, and increasing the readiness to change—the directional aspect of MI—is neither soft nor easy, as it requires more skills, patience, and strength from the staff member.

The less tolerant law enforcement view might rely too heavily on giving advice, yet such reliance often leads nowhere. Do you want to be right, or do you want to be effective? Success may depend on your ability to do something other than give advice. "Getting right to it" with advice and directions generally lengthens the process (Stinson & Clark, 2017).

What MI conveys to community corrections is that there is a limit to coercion. Disrespectful treatment is not a sanction, it is simply disrespect. Research is clear that approaches that favor confrontation or pressured compliance fail to produce lasting and meaningful change (Walters et. al., 2007). There are staff who avoid the extreme of "zero tolerance" yet remain consistently wedded to harsh law enforcement tactics. These muscle officers are asked to consider new research that found that torture (O'Mara, 2018) and aggressive interrogation methods (Alison et al., 2014) have not been as successful as interventions that involve more of a working alliance. MI has recently been applied to counterterrorism policing (M. D. Clark, 2019) as well as used to improve interrogation techniques with detainees (Surmon-Böhr et al., 2020). Ramping up coercion and abuse is paradoxical—the more you push, the more they push back.

This directional quality is one important reason that MI has been described as a "natural fit" for delivering P&P services (Iarussi & Powers, 2018)—it steers the supervisee using a nonadversarial approach. Staff members who learn the mechanics of MI turn to a "guiding style" (motivation plus influence) and are in a much better position to blend "care with control" (Skeem et al., 2007). This is MI's strong suit—building an all-important working alliance to enable a directional, nonadversarial approach.

Benefit 5: MI Is Suited for Busy Caseloads. It Can Make an Impact in Brief Interventions—Even Single Sessions or Within Compressed Time Frames.

MI has been designated an EBP for increasing both engagement and retention in treatment (SAMHSA, 2010). This type of engagement is as rapid as it is durable. MI has been called an "effective tool" for use within compressed time frames (Forman & Moyers, 2019). Multiple randomized clinical trials have shown reliable outcomes when MI is used in just a single session (Diskin & Hodgins, 2009; McCambridge & Strang, 2004). Another multisite effectiveness study found that participants who received a single session of MI had significantly better retention in outpatient substance use treatment at 28 days when compared with controls (Carroll et al., 2001).

Many trainees ask, "But I have a large caseload—can I 'do' MI in five minutes?" I answer this question with a rebound, "Can you ruin motivation in five minutes?" Of course you can. Little time to intervene means little room for error. Training in MI can improve the likelihood that short interactions will prove helpful. You can confront and work through the ensuing tangle of arguments or excuses, or you can use a guiding style to move more efficiently to productive conversations. Miller and Rollnick (2013) were the first to posit this idea:

> Perhaps the underlying question is whether it is possible to make a difference with a few minutes of MI. Not only is it possible, but if you have only a few minutes to discuss behavior change, MI is likely to be more effective than finger-wagging warnings. (p. 343)

MI has spread quickly across probation, parole, and corrections. One reason for this is that MI has helped staff to "raise the odds" by increasing the readiness to change in compressed time frames (Stinson & Clark, 2017). Despite this spread, many P&P staff are still not trained to have a working knowledge of motivation (and how to increase it) and the process by which human behavior changes (and how to influence it). Has this lack of training influenced the rise in revocations? Departments that are working to correct the pipeline to prison can ill afford to ignore these training deficits. I was impressed with an officer who, even with an overly large caseload, had come back voluntarily for more training. "You're so busy," I noted, "and yet you're back?" He answered, "With the caseload numbers I'm trying to juggle, how can I not use MI?"

Benefit 6: MI Crosses Cultures Well.

Some treatments do not cross cultures well—yet MI does. The great benefit from its use with people of color is that the effect size of MI is *doubled* when used with these clients. This was determined by 11 controlled clinical trials examining the cross-cultural applications of MI (Miller, 2020). A finding from one meta-analysis is significant. Hettema et al. (2005) published a meta-analysis of 72 studies, 37 of which looked at racial and ethnic composition. These researchers found that the effects of MI were significantly larger for people of color.

Why does MI work better cross-culturally—especially when one would hope for no difference between differing ethnic or cultural groups? William Miller, co-originator of this approach, offered a thought-provoking explanation:

> MI seems to be particularly useful with people who are least respected. It is for people who are the most marginalized and who are the most despised and rejected members of our society. If you're a minority member, you may not be familiar with being treated respectfully. (Miller, 2018)

This was made clear to me by a probationer of color who said, "I saw a sign once that said, 'Nothing about me, without me.' I thought—yeah, sure, what a lot of bullshit. But this is one report-in place that really tries to make that happen."

Benefit 7: MI Is Learnable and Has Options for Safe and Responsible Procedures for the Pandemic Era, With Its Need for Physical Distancing.

A helpful research finding is that one's ability to learn MI is not contingent on experience, education, or professional field. You do not need years of seniority or advanced degrees (Miller et

al., 2013). MI is now being taught and practiced in more than 50 languages and literally spans the globe. Here in the United States, it has been taught in varying degrees to courts, prisons, drug courts, and community corrections groups in all 50 states (M. D. Clark, 2020a). A considerable number of corrections departments across multiple states have implemented MI to the point of using training-of-trainers sessions to enable in-house sustainability.

MI also has well-established fidelity measures to determine whether it is being used correctly by officers in the field (competency) and to what quality and extent (proficiency). Miller and Rollnick (2013) found that even when trainees could not reach competency levels, their training often was enough to cause them to stop using several of the worst relationship-fracturing responses. Thus, indirect benefits are realized even when competency levels prove elusive (p. 381).

The 2020 pandemic has sent training environments into flux and seemingly stalled learning initiatives. Many management teams easily embrace technology and Internet-based learning options, while others have been reluctant and seem to trust only on-site classroom training (M. D. Clark, 2020b). Consider that empirical comparisons of classroom and distance learning often find that both modalities enjoy similar rates of learning and both can be equally motivating (e.g., Bernard et al., 2004; R. E. Clark et al., 2006). Anyone can readily recall an in-person (on-site) training that was painfully boring or held little value. The same can be said for Internet-based distance education. If there are differences in learning outcomes, the discrepancies can be traced to engagement with the audience and accuracy of the content—not the medium used to deliver the instruction. In simple terms, it's not the medium that carries the message, it's the way the message is crafted (R. C. Clark & Mayer, 2007; R. E. Clark, 1994, 1999; Mayer, 2005).

MI is well suited to respond to the changes in training media by offering options for safe and responsible Internet-based training. The MI field has extensive on-demand web courses, in which the coursework is followed with the use of skill-building resources to convene small groups via web-conferencing tools. The web courses allow learning transfer, and small group meetings enable skill-building. Webinars and web coaching are readily available for sustainability and continued skill-building.

CONCLUDING THOUGHTS

It was no accident that MI arose in the field of criminology after several decades of muscle and punishment that had only made things worse. This left supervision programs overwhelmed by roadblocks that many now realize were self-imposed (Bogue et al., 2004; McMurran, 2002). There are over a thousand research studies demonstrating that positive relationships are one of the strongest and most consistent predictors of outcomes across human service approaches (Orlinsky et al., 2004). Holding fast to the idea that supervision work is any different is simply being resistant to change oneself. Thankfully, new correctional research is starting to investigate the working alliance between officer and supervisee. The benefits already attributed to MI are cause for optimism (Polaschek, 2016).

One point of confluence is offered: "No matter what population you work with, the mechanisms that propel behavior change remain the same. This is the reason that motivational interviewing has such broad applicability to such seemingly different groups" (Stinson & Clark, 2017, p. 241). MI seems to take hold in systems that have relied too heavily on the "killer Ds" of degrading, directing, demanding, and domination.

For cynics to say that MI cannot work within P&P—after it has been shown to improve techniques for interrogating terrorists labeled "high-value detainees" (M. D. Clark, 2019)—is simply resisting change MI can offer the know-how and techniques for P&P to deliver services with a nonadversarial, nonpunitive approach. This approach demonstrates that the working alliance does not have to be abandoned when the road gets rough. MI, which has been a leader in developing and delivering this noncoercive approach across several decades, reminds us all that while you may not be responsible for the supervisee's starting point, you have considerable influence over what happens next.

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AUTHOR BIOGRAPHY

Michael D. Clark, MSW, has served as a probation officer and magistrate in Lansing, Michigan. He is a member of the Motivational Interviewing Network of Trainers (MINT) and is the director of the Center for Strength-Based Strategies, a technical assistance group that offers training in Motivational Interviewing to the corrections, addictions, and mental health disciplines. Mr. Clark has recently served as a contractual consultant to the United Nations Office on Drugs and Crime in Vienna, Austria, and is coauthor of the book *Motivational Interviewing with Offenders: Engagement, Rehabilitation, and Reentry*, published in 2017 by Guilford Press.

Conflict of Interest Attestation
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Correspondence
Please address correspondence concerning this article to:
Michael D. Clark, MSW
Email: mike.clark.mi@gmail.com


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