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UNDERSTANDING AND PREVENTING FREQUENT JAIL CONTACT

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Introduction

Efforts to reduce jail populations that increased following policies and practices such as deinstitutionalization, the "war on drugs," and broken windows policing have seen success in the past two decades. Yet, jails still see just over 10 million annual bookings (Zeng, 2021). Most of these bookings represent a person's lone jail contact for the year. However, some people experience repeated, sometimes frequently repeated, jail contact in a year. People with frequent jail contact may constitute up to one-half of a jail's annual bookings (MacDonald et al., 2015). This group of people, who experience multiple jail bookings in a short period, represents a unique group within the larger population of people who have contact with jails specifically and the criminal legal system broadly. People with repeated contact with jails are described as trapped in a revolving door of system involvement that often reaches beyond just the legal system and into emergency, housing, behavioral health, and other systems (Eswaran et al., 2022; Kanzaria et al., 2019). This involvement is costly to both people and their local communities. While there have been some successful responses, many local jurisdictions struggle to meet the needs of people with frequent jail contact (Gilbreath et al., 2020).

A wide range of terms and phrases are used to refer to people with frequent jail contact, including hot spotters (MacDonald et al., 2015), frequent users (Gilchrist-Scott & Fontaine, 2012), frequent utilizers (Gilbreath et al., 2020), frequent systems utilizers (Harding & Roman, 2017), and familiar faces (SAS Institute, 2017; National Association of Counties, 2022). Throughout this chapter, we use person-first language and refer to this population as "people with frequent jail contact." We use this term to refer to people with frequent jail contact over short periods (e.g., months to a few years) rather than people who experience repeated contact over long periods (e.g., lifetime).

In this chapter, we review the existing literature on people with frequent jail contact and offer recommendations for research and practice. We first discuss variations in ways people with frequent jail contact are identified. Next, we describe the prevalence, characteristics, and needs of this population. We focus specifically on people of color and people with behavioral health conditions, who are overrepresented among those with frequent jail contact (Chan et al., 2020; MacDonald et al., 2015). Then, we discuss unmet needs experienced by this

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population, the lack of coordination between systems, the racial disparities in who is served by systems, and how these structural factors contribute to frequent cycling through the jail. We also describe existing interventions to reduce frequent jail contact. We conclude with five recommendations for future research and practice to best identify people with frequent jail contact, further specify the causes and consequences of frequent jail contact, develop and test interventions, and address racial disparities in frequent jail contact.

Identifying People with Frequent Jail Contact

Currently, there is no consensus on what amount of jail contact should be labeled as frequent or what other criteria should be considered when identifying people as having frequent contact. Instead, local jurisdictions and researchers have each developed their own definitions. In general, there are four categories of criteria used to identify people with frequent jail contact (see Figure 18.1): 1) the specific type of jail and other criminal-legal system contacts counted, 2) the number of contacts considered frequent; 3) the window of time in which repeat contact occurs, and 4) inclusion of contact with other systems.

Type of Jail and Other Criminal Legal-Contact

One criterion used to define frequent contact is the specific type of jail or other criminal-legal system contacts that are considered. Contact is most often measured as jail bookings, with each booking or each arrest representing a separate instance of contact (Fishman et al., 2017; Gilchrist-Scott & Fontaine, 2012; Milgram et al., 2018). Some studies measure contact by the number of days spent in jail custody or on community supervision (Somers et al., 2015). Finally, some studies incorporate other forms of criminal-legal system contact (e.g., convictions, sentencing, and time on supervision by a probation department) into their definitions of frequent contact (Augustine & White, 2020).

Number of Contacts and Length of Time

The number of contacts and the length of time over which contacts occur are also criteria used to define frequent jail contact. For example, using nationally available public health data,

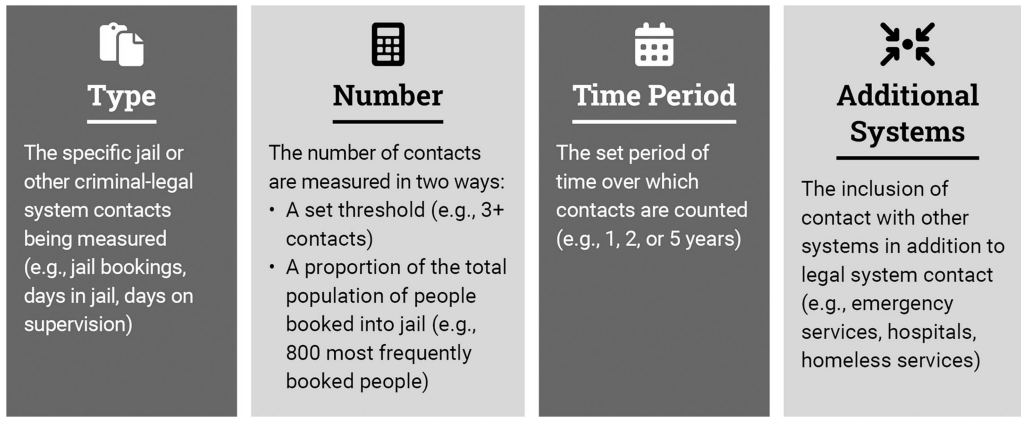


Figure 18.1 Criteria Used to Define Frequent Jail Contact.

Prison Policy Initiative considered frequent jail contact to be three or more arrests in 12 months (Jones & Sawyer, 2019). Alternatively, a study of an intervention aimed at reducing people's jail contact by providing housing and wraparound services considered frequent jail contact to be four or more jail admissions over 5 years (Listwan et al., 2018). Of the studies we reviewed, the most common number of contacts was three or more (Fishman et al., 2017; Gilbreath et al., 2020; Jones & Sawyer, 2019), and generally, a 1-year period was the most common length of time in which to consider contacts (Augustine & White, 2020; Fishman et al., 2017; Gilbreath et al., 2020; Jones & Sawyer, 2019). Other studies use 18 months (The Long Beach Justice Lab, 2019) and 24 months (Schwindt, 2018).

Rather than using a raw number of contacts, other studies have used a top percentage or percentile of the total population of people with jail contact within a jurisdiction to determine frequent jail contact. For example, in a study of people in Camden, NJ, researchers considered people with frequent jail contact to be those who fell in the top 5% (defined by the number of arrests and emergency department visits) over 5 years (Milgram et al., 2018). Similarly, MacDonald and colleagues (2015) rank-ordered all people booked into jail in New York City based on the number of times they were booked during a 5-year period. The 800 most frequently booked people were considered the frequent jail contact group.

Contact with Additional Systems

The fourth criterion of frequent jail contact definitions is contact with additional systems. People with frequent jail contact often have frequent contact with other systems, including emergency departments (Augustine & White, 2020; Jones & Sawyer, 2019; Milgram et al., 2018), hospitals (Milgram et al., 2018; Somers et al., 2015), emergency medical or ambulance services (Augustine & White, 2020; Desmarais et al., 2017; SAS Institute, 2017), substance use and mental health services (Augustine & White, 2020; Gilchrist-Scott & Fontaine, 2012; MacDonald et al., 2015), homeless shelters (Augustine & White, 2020; MacDonald, 2015), Medicaid (MacDonald et al., 2015), and financial assistance programs (Somers et al., 2015). In these studies, frequent jail contact includes contact across several systems. For example, a study of an intervention in Washington, D.C. considered people to have frequent contact if they had three or more jail bookings and three or more stays in a shelter in the past 3 years, as well as a serious and persistent mental health diagnosis listed on their Department of Corrections record (Gilchrist-Scott & Fontaine, 2012). Other studies used more complicated strategies. For example, Augustine and White (2020) developed a utilization score to rate the intensity of system utilization for the people in their sample. This score combined information within the criminal legal system (e.g., jail bookings, convictions, sentences, and probation supervision) and across systems (e.g., criminal legal, behavioral health, human services) to rate overall system utilization.

Implications

The wide range of criteria used across studies makes it difficult to identify people with frequent jail contact as a consistent subgroup of the total population of people who have contact with jails. Few studies explicitly state the reasoning behind their chosen criteria for identifying people with frequent jail contact; however, these decisions often appear to be informed by more practical issues, such as statistical power and related research design considerations (Gilbreath et al., 2020). To demonstrate, Milgram and colleagues (2018) noted that their decision to include the top 5% rather than another proportion was partly because 5%

provided a sample large enough to identify meaningful profiles of people. Similarly, the type of legal or other system contact examined may reflect data availability, access, and linkage constraints. The periods over which repeated jail contact is considered may be driven by the time allotted for data collection or the years for which data are available. The perspectives and experiences of the various partners and collaborators involved in the research process also will influence the criteria. Overall, the operational definition of frequent jail contact generally appears to be based more on experience and practical considerations rather than on evidence from theory or empirical data. Thus, the current understanding of "people with frequent jail contact" reflects an amorphous group – or, more accurately, groups – of people. Given the current state of the research and the practical considerations involved, our recommended approach for defining people with frequent jail contact is to let jurisdictions establish criteria based on their goals and the information they have available. Then, researchers and jurisdictions must be consistent and transparent in the application and reporting of the criteria used to define this population.

Describing People with Frequent Jail Contact

Estimating the prevalence and needs of people with frequent jail contact is foundational to developing policies and interventions designed to end system contact and improve outcomes among this population. The definitional issues discussed above notwithstanding, a review of the existing research reveals patterns regarding the size, demographic characteristics, needs, and service utilization among this population. We summarize the findings of empirical investigations across these three areas in the following sections.

Size of Population

Nationally, people with frequent jail contact are estimated to account for approximately 9% of all jail admissions. This is likely a conservative estimate, as the dataset used to develop this estimate did not include people in jail, prison, or homeless shelters at the time of data collection (Jones & Sawyer, 2019). In New York City, those with frequent jail contact made up 0.3% of all incarcerated people but accounted for about 3.5% of all jail admissions in 6 years (MacDonald et al., 2015). A study of mental health jail diversion programs in Miami-Dade County, Florida, found that people with frequent jail contact make up 5% of all people served by the programs but nearly one-quarter of all program referrals (Desmarais et al., 2016). Finally, a study conducted in Sonoma County, California, found that people with frequent multi-system contact represented 1% of the population of people using public systems but accounted for an average of 28% of behavioral health costs, 52% of nights in housing or shelters for people experiencing homelessness, and 26% of all jail contacts in 4 years (Augustine & White, 2020). Taken together, these estimates suggest that people with frequent jail contact represent 5% or less of the total population in each study and underscore that they have disproportionate rates of system contact.

Demographic Characteristics

Consistent with the broader population of people involved in the criminal legal system (Fernandes & Crutchfield, 2018), studies show that Black men make up a significant proportion of people with frequent jail contact. For instance, a study in New York City found that people with frequent jail contact were more likely to identify as Black than a randomly

selected control group of people in jail without frequent contact (MacDonald et al., 2015). Other studies found that Black people made up 30–50% (Ford, 2005; Jones & Sawyer, 2019; SAS Institute, 2017; Schwindt et al., 2018) or even as much as 75–95% of people with frequent jail contact (Gilchrist-Scott & Fontaine, 2012). Information regarding other races and ethnicities is less common. Still, when reported, studies find that 1% of people with frequent jail contact are Asian, 2% are American Indian, 15–55% are Hispanic, and 14–66% are white (Augustine & White, 2020; Desmarais et al., 2017; Jones & Sawyer, 2019; Listwan et al., 2018; MacDonald et al., 2015). Findings regarding gender are consistent; most samples of people with frequent jail contact are comprised primarily of men (75–88%) with smaller percentages of women (9–14%; Desmarais et al., 2016; Listwan et al., 2018; MacDonald, 2015; Schwindt et al., 2018).

There are mixed findings concerning age across studies and jurisdictions. In New York City, for example, people with frequent jail contact were significantly older than a sample with non-frequent contact (MacDonald et al., 2015). Conversely, in Sonoma County, CA, people with frequent jail contact were younger than those with non-frequent jail contact (Augustine & White, 2020), and in Mecklenburg County, NC, people with and without frequent jail contact were about the same age (Listwan et al., 2018). In one study from Wake County, NC, researchers found the age distribution of people with frequent jail contact was bimodal, peaking in the 26–35 range and the 46–55 range (SAS Institute, 2017[1]. Overall, the average ages of people with frequent jail contact range from 35 to 50 (Augustine & White, 2020; Desmarais et al., 2016; Ford, 2005; Gilchrist-Scott & Fontaine, 2012; MacDonald et al., 2015).

Needs

People with frequent jail contact often have specific housing and behavioral health needs. The link between homelessness and legal system involvement has been demonstrated frequently in research (Jacobs & Gottlieb, 2020; Pattillo et al., 2022; Robinson, 2019), with evidence suggesting that it is not uncommon for people to cycle between experiences of being homeless and being in jail (Gilchrist-Scott & Fontaine, 2012). This link between homelessness and jail contact may be salient for people with frequent jail contact. Studies have reported high rates of homelessness among people with frequent jail contact (Ford, 2005; Harding & Roman, 2017). One study of a pilot intervention program found that people with frequent jail contact may spend anywhere from about 80 to about 200 days in a homeless shelter each year between jail stays (Fontaine et al., 2011). This population may also experience high rates of street homelessness, with one study finding that one-third of their sample reported living on the street before their most recent jail contact (Harding & Roman, 2017). Moreover, people with frequent jail contact experience higher rates of homelessness than people without frequent jail contact. For example, 52% of people with frequent jail contact in New York City jails in 2013 had a mention of homelessness in their jail medical charts compared to about 15% of people with non-frequent jail contact (Macdonald et al., 2015).

People with frequent jail contact also experience elevated rates of mental health and substance use concerns (Arnold Ventures, 2020; Jones & Sawyer, 2019). Studies have found that one in five to nearly one-half of people with frequent jail contact have a mental health condition (Ford, 2005; Jones & Sawyer, 2019; Macdonald et al., 2015) and that people with frequent jail contact have higher rates of mental health conditions than people who do not have frequent jail contact (Desmarais et al., 2017; Macdonald et al., 2015). People with frequent jail contact also are more likely to report substance use than those without frequent jail contact (Ford, 2005; Macdonald et al., 2015). As many as 88–99% of some samples report drug or alcohol use

(Ford, 2005; Macdonald et al., 2015), and as many as half have been identified as having a diagnosed substance use disorder (Jones & Sawyer, 2019). In a study in rural North Carolina, people who met the criteria for moderate-to-severe opioid or amphetamine use disorders were more likely to be readmitted to jail multiple times in 12 months than people who did not meet the criteria for these substance use disorders (Kopak et al., 2019). There are many reasons that substance use can lead to system involvement (e.g., risk-taking, disinhibition, drug-seeking behavior), including the fact that the use of many substances is illegal and criminalized across much of the United States (Glasheen et al., 2012; Park et al., 2020).

Co-occurring mental health conditions and substance use may be even more common among people with frequent jail contact than either condition alone (Harding & Roman, 2017; Somers et al., 2015). Indeed, people who meet the criteria for multiple substance use disorders and multiple mental health conditions are nearly three times more likely to be readmitted to jail multiple times compared to people who do not meet the criteria for similar combinations (Kopak et al., 2019). Studies that consider rates of mental health conditions and substance use (or substance use disorders) do not always examine whether a proportion of their sample has both. Studies that examine the overlap find high rates of co-morbidity (Augustine & White, 2020; Gilchrist-Scott & Fontaine, 2012) – sometimes, as much as 82% of a study sample has co-morbid mental health and substance use disorders (Somers et al., 2015). There is also evidence that people with frequent jail contact are more likely to be identified as having potential mental health and substance use problems compared to the overall population of jail bookings (Desmarais et al., 2017).

Service Utilization

Given their high rates of housing and behavioral health needs, people with frequent jail contact often experience frequent contact with other systems, including hospitals, homeless services, and behavioral healthcare services (SAS Institute, 2017). To demonstrate, an analysis of participants in jail diversion programs operated by the 11th Judicial District Criminal Mental Health Project in Miami-Dade County, Florida, found that over 5 years, 97 people accounted for nearly 2,200 arrests, 27,000 days in jail, and 13,000 days in crisis units, state hospitals, and emergency rooms (Desmarais et al., 2016). Comprising just 5% of all people in the program, these individuals accounted for nearly one-quarter of all program referrals. Another study from Sonoma County, California, found that people with frequent multi-system contact spent an average of 34 days in jail, 160 days on probation, 66 days in a shelter or housing program, 2 days in inpatient substance use disorder treatment, and 5 days in a hospital each year (Augustine & White, 2020). Studies also suggest that there are different combinations and frequencies of system contact. Some people may primarily experience frequent jail contact, while others may primarily experience frequent homeless shelter contact (Augustine & White, 2020; Gilchrist-Scott & Fontaine, 2012; Harding & Roman, 2017; Milgram et al., 2018).

Altogether, demographic characteristics, needs, and service utilization patterns distinguish people with frequent jail contact from those without in meaningful ways. By understanding this population's specific and often co-occurring housing and behavioral health needs, jurisdictions can better identify the underlying reasons for frequent jail contact.

Examining Causes of Frequent Jail Contact

Frequent jail contact is a complex problem with causes across a range of individual, contextual, and societal factors. We focus here on unmet needs, the lack of coordination across

systems with which this population interacts, and racial/ethnic disparities in system contact as drivers of frequent jail contact.

Unmet Needs

Unmet housing and behavioral health needs are primary drivers of frequent jail contact (Ramezani et al., 2022). For example, people experiencing homelessness or unstable housing may engage in behaviors that have been criminalized, such as sleeping or preparing food in public spaces (Robinson, 2019). Research shows that experiencing homelessness immediately upon release from jail or anytime in the first year after release increases people's chances of being rearrested (Jacobs & Gottlieb 2020). Further, experiencing homelessness can result in engagement in low-level crimes (e.g., trespassing, petty theft) as a means of survival, resulting in rearrest. These low-level "nuisance" charges are common among people with frequent jail contact (Chan et al., 2020; Fishman et al., 2017; Jones & Sawyer, 2019; Macdonald et al., 2015).

People with mental health and substance use-related needs are at increased risk for jail contact due to the criminalization of symptoms of mental health conditions and substance use and the overlap that can occur between behavioral health conditions, homelessness, and engagement in illegal or risk-taking behaviors (Munetz et al., 2001; Reddy et al., 2014; Swartz et al., 1998; Teplin, 1984; Van Dorn et al., 2013; Van Dorn et al., 2017). Once people are in jail, they may lose access to any medication or treatment they receive. Lost access can bring about deterioration of their mental health that is further exacerbated by the conditions of detainment (Lim et al., 2015; McCauley et al., 2018; Scheyett et al., 2009). Upon release, re-engagement with medication and treatment may be challenging due to loss of employment and benefits, missed appointments, difficulty finding a provider, and provider stigma related to legal system involvement (Hu et al., 2020). Accordingly, people may be forced to navigate reentry into the community with unmanaged behavioral health needs.

Lack of Coordination across Systems

The systems that people with frequent jail contact cycle through do not always share information (Schwindt et al., 2018). This lack of communication hampers efforts to coordinate care and services across systems and can result in people losing access to the care they received in one system when they move into another (Substance Abuse and Mental Health Services Administration (SAMHSA), 2019a; The Equitas Project, 2022). For one example, when a person is taken to jail, they may lose access to their bed in a shelter facility because staff may not be made aware that they are in jail and may allocate their bed to someone else (Jashnani et al., 2017). As another example, people receiving psychiatric medication through a community service provider may find that their access to that medication is delayed or prevented entirely when they are booked into jail. There are several reasons for this potential lapse or loss of medication. For example, communication between jails and community-based providers may be limited or non-existent, and as a result, jails may be unable to confirm the prescription with a community provider. Jails may lack the resources, including medical staff, necessary to administer new assessments and prescribe new medications (Carda-Auten et al., 2022; Casey & Bentley, 2019; Sufrin et al., 2022). Jails may be unable to continue prescribing a person's existing medication due to the limited formularies available in correctional settings (Morris et al., 2020). People in jail report instances of jail-based doctors refusing to give them their medications or changing their medication regimen without explanation; an experience they report as being harmful to their mental and physical health (Jacobs & Giordano, 2018).

People also lose access to treatment services while in jail because they are cut off from any services they receive in the community, and jails do not always (or often) provide their own services (AbuDagga et al., 2016). Lost care can result in lost housing and the decompensation of behavioral health conditions, which contribute to increased contact with law enforcement and jails (Herring, 2019).

The process of discharge from jail is abrupt and unpredictable, making it challenging to create and execute plans for assistance upon release. Sometimes people taking medications are discharged from jail without a supply, despite guidance to the contrary by organizations such as the American Public Health Association (Appelbaum, 2020). Being released without medications leaves people with a short window to get and fill a new prescription before symptoms return. Further, people may be removed from Medicaid while in jail, leaving them without health insurance coverage upon release (Regenstein & Rosenbaum, 2014). Jail-based providers and administrators must intentionally put processes into place to ensure that people have access to medication when released, especially in cases where people are released unexpectedly. In the absence of this intentional, coordinated care, people can be released from jail with no plan for accessing housing or behavioral healthcare (Clemans-Cope et al., 2017), increasing their chances for rearrest (Hicks et al., 2022), suicide (Johnson et al., 2020), and fatal overdose (Victor et al., 2022).

Racial and Ethnic Disparities in System Contact

Frequent jail contact can result from frequent interaction with law enforcement officers. Evidence suggests that people of color are more often the focus of law enforcement attention relative to white people (Pierson et al., 2020). This increased attention may arise from bias on the part of officers (Jones-Brown, 2007) or from the fact that people of color and Black people specifically, disproportionately live in areas that are more heavily surveilled by law enforcement (e.g., urban or lower-income neighborhoods; Brayne, 2020) and are disproportionately represented among populations that are more heavily surveilled (e.g., people experiencing homelessness; Jones, 2016). Increased law enforcement focus may also occur because police are increasingly called upon by members of the public and business communities to respond to medical, economic, and social problems (Herring, 2019). Racial discrimination may be at play when these calls are being made, resulting in more calls to the police being made to people of color. When law enforcement contact occurs, it is more likely to end in arrest for Black people compared to white people (Kochel et al., 2011; Lantz et al., 2021), especially when that law enforcement contact occurs in a neighborhood that is characterized by high crime rates because policing tends to be more punitive and enforcement-oriented in these environments (Skogan & Frydl, 2004).

At the same time, people of color can experience excessive contact with law enforcement, they can experience reduced contact with the behavioral health system. Research finds that people of color experience less access to behavioral healthcare than white people (VanderWielen et al., 2015; Wells et al., 2001). This difficulty is partly due to the dearth of behavioral health services available in urban and low-income neighborhoods (VanderWielen et al., 2015). Even when services are available, discrimination on the part of healthcare providers can make accessing care difficult – if not impossible – for people of color (Gates et al., 2022; Kugelmass, 2016; Kugelmass, 2019; Shin et al., 2016). To demonstrate, Kugelmass (2019) performed an audit study in which she had voice actors leave voicemails requesting a mental health appointment with a sample of licensed psychotherapists in New York City and assessed whether therapists offered an appointment. The study manipulated

callers' social class (middle or working), race (Black or white), and gender (man or woman). Among the middle-class group, Black callers were significantly less likely to receive an appointment than white callers, while therapist call-back rates were lower for both Black and white working-class callers compared to their middle-class counterparts, with no race difference in appointment offers found among this group. Lack of access to behavioral healthcare is detrimental – especially in the face of other risks like racism, financial precarity, and increased police attention – and can heighten the chances of experiencing repeated jail contact, as discussed in the previous section.

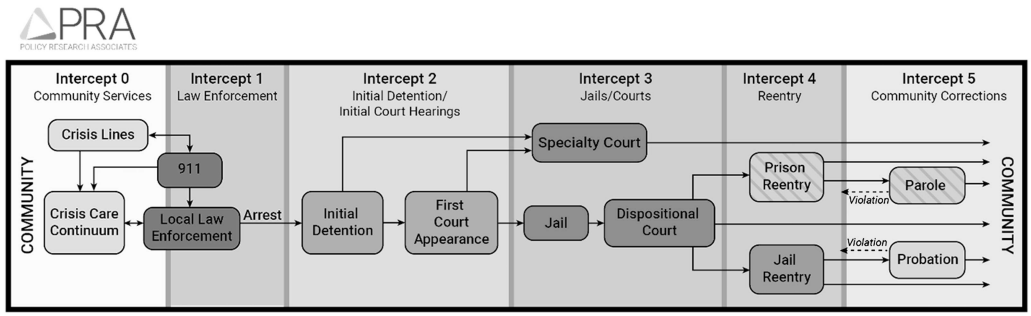
Summary

We focused here on the often-unmet housing and behavioral health needs present among people with frequent jail contact. We also discussed how a lack of coordination across systems and racial/ethnic disparities in system contact contribute to frequent jail contact. Understanding the factors that contribute to frequent jail contact is critical to developing effective interventions that target the appropriate causes and provide the necessary support to meet needs and end system contact.

Considering Interventions to Reduce Frequent Jail Contact

In practice, few interventions exist that were designed for people with frequent jail contact as a unique population. In this section, we describe two interventions specific to people with frequent jail contact and then briefly discuss other interventions intended for jail-involved people with behavioral health conditions more broadly. We use the Sequential Intercept Model (SIM; see Figure 18.2) as an organizing framework for our discussion.

The SIM was developed to understand system contact among people with behavioral health needs and the critical decision points where people can be diverted from the criminal legal system and into community-based supports and services (Abreu et al., 2017; Munetz & Griffin, 2006). The SIM includes six intercepts, each representing key stages in the criminal legal system where targeted interventions can prevent, interrupt, or reduce involvement in the criminal legal system and support community members' overall health and well-being. Intercept 0 represents community-based services that often contribute to diversion from the criminal legal system, including crisis lines and care services. Intercept 1 represents law



Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law, 35*(5-6), 380-395. https://doi.org/10.1002/bsl.2300

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Figure 18.2 Sequential Intercept Model (SIM).

enforcement and 911 emergency services that can contribute to a diversion through behavioral health co-response strategies that identify and appropriately refer people experiencing behavioral health crises. Intercept 2 includes initial court hearings and jail bookings, which may consist of pretrial services and coordinated care for behavioral health services. Intercept 3 is jails and courts, including treatment courts, dispositional courts, and services within detention facilities. Intercept 4 is reentry and transition from incarceration to the community. Finally, Intercept 5 Community Corrections includes community supervision and services intended to reduce supervision violations and re-incarceration.

Interventions Developed for People with Frequent Jail Contact

One example of an intervention for people with frequent jail contact, the Frequent Users Systems Engagement (FUSE) model, sits at Intercept 0 of the SIM. This supportive housing model addresses the needs of people with frequent contact across multiple systems by providing housing, wraparound support services, and a range of ancillary services. In the FUSE model, community partners share and examine data across homeless, criminal legal, and health services systems to identify the people with high use rates within and across systems (Corporation for Supportive Housing, 2021). FUSE programs are in place in over 35 communities (www.csh.org/fuse). In some cities, FUSE programs require that participants have a qualifying mental health diagnosis and a combination of frequent jail and shelter stays to reach a population that is high in need and that may be overlooked by another programming (Gilchrist-Scott, 2012). Two evaluations have found that people engaged by FUSE experience reductions in arrests, jail stays, shelter stays, substance use, and ambulance use compared to people receiving treatment as usual (Aidala et al., 2013; Listwan et al., 2018).

Another example of an intervention designed for people with frequent jail contact, this time at Intercept 2, involves enhanced services implemented in the context of existing jail diversion programs run by the Criminal Mental Health Project (CMHP) in Miami Dade County, Florida. The CMHP is a state- and county-funded, court-based initiative that identifies and diverts adults with mental illnesses and co-occurring substance use disorders who become involved with the criminal legal system into community-based treatment and support services. CMHP diversion programs were largely successful in diverting many people away from jail into community-based services (Iglehart, 2016). Yet system partners involved in the CMPH recognized that a subset of adults, representing 5% of all clients served by CMPH, continued to experience frequent jail contact after diversion programs were implemented. This subset of 97 adults accounted for nearly 2,200 arrests and 27,000 days in jail over 5 years. To address the needs of this group, the CMHP piloted an enhanced version of the existing programs that included care coordination and cognitive behavioral therapy. A study of this pilot program found that participants who received the enhanced services experienced the greatest reductions in days spent in jail during the 18-month follow-up period. Qualitative data suggested that care coordination supported the development of patient-centered care plans, delivery of individualized services, and access to a more comprehensive array of services. Despite low completion rates – about 30% of participants assigned to enhanced services received them – participants reported high levels of satisfaction with cognitive behavioral therapy. Low completion rates were attributable in part to feasibility issues; enrollment into cognitive behavioral therapy sessions was closed (as opposed to open or continuous) and sessions were only delivered at one provider agency in a geographically large county. Still, the findings of this evaluation suggest that care coordination and enhanced services can reduce the number of days spent in jail by people with frequent jail contact and can improve their

quality of life. About half of the participants who received enhanced services reported that services addressed most of their needs, and a majority said they would recommend the services to others (Desmarais et al., 2016).

Interventions for People with Any Jail Contact

In practice, people with frequent jail contact typically receive services available to anyone with any jail contact. We focus here on a few examples of broader interventions that attempt to increase communication across systems and provide increased access to more coordinated care across the intercepts of the SIM.

At Intercept 1, several interventions focus on improving police responses to calls involving people with mental health conditions. These interventions aim to prevent jail contact by reducing arrest rates and diverting people away from jail and into community-based services. One such model, the Crisis Intervention Team (CIT) model, involves providing self-selected officers with 40 hours of de-escalation and mental health training to improve their ability to respond to people in behavioral health crises. This training encourages officers to direct people to treatment services in the community rather than arresting and bringing them to jail, when possible. The CIT model is often adopted along with a broader focus on fostering system-level changes to reduce legal-system contacts and make crisis care more accessible to people with behavioral health needs (Compton et al., 2009; Compton et al., 2011; Reuland et al., 2009). Early evidence suggests that the CIT model may reduce arrest rates and criminal legal system costs compared to other pre- and post-diversion programs (Compton et al., 2008). However, more recent evidence suggests that both mental health service utilization *and* law enforcement encounters increase following the implementation of CIT (Willis et al., 2021). Another law enforcement intervention at Intercept 2 is the co-responder model. Under this model, law enforcement officers, usually those who have received CIT training, are paired with a licensed mental health practitioner, known as a co-responder, who accompanies officers in responses to calls involving people in a mental health crisis. Notably, co-responders are not present for all 911 calls, only those calls for services that are specific to mental health or other behavioral health needs. As part of their role during the call for service, the co-responder connects participants to treatment services and follow-up care. Evidence suggests that there are fewer arrests in situations where co-responders answer behavioral health-related 911 calls (Osher, 2018). Additional intervention may be necessary to reduce the long-term demand for emergency services or jail contact for people with frequent jail contact (Bailey et al., 2021).

Across Intercepts 3 and 4, several interventions target unmet needs and coordination of care. These approaches focus on increasing and maintaining access to mental health treatment services through partnerships between the criminal legal and mental health treatment systems (Morrissey et al., 2009). One intervention involves re-enrolling people with serious mental illness in Medicaid before their release from jail if they have been disenrolled during their stay. Re-enrollment ensures they have coverage for mental healthcare immediately upon release. Enrollment in Medicaid reduces the amount of time it takes people with serious mental illness to receive services in the community and increases the number of services they receive. Additionally, enrollment in Medicaid appears to contribute to small increases in the length of time before people have a new arrest compared to when they are released without Medicaid (Morrissey et al., 2007). There is also some evidence that expanded access to Medicaid following the Affordable Care Act is associated with reduced arrests, particularly arrests related to substance use (Fry et al., 2020; Simes & Jahn, 2022), though findings are somewhat mixed. Expanded access to Medicaid helps a person maintain access to treatment and medications,

which supports mental and physical health (Gertner et al., 2019; Wen et al., 2015) and reduces their chances of cycling through jail and other systems due to unmet health needs.

The use of outpatient mental health services, including the possession of psychotropic medication prescriptions, after release from institutional care, including jail, has been shown to reduce arrest rates for people with serious mental illness (Adily et al., 2020; Constantine et al., 2012; Van Dorn et al., 2013). Accordingly, a few interventions facilitate connection to treatment services following release from jail. Early or first-generation interventions (Bonfine et al., 2020) focus on ensuring that people are connected to traditional mental health treatment and include Assertive Community Treatment (ACT) and the variation targeting people in the criminal legal system, known as Forensic ACT or FACT (Cuddeback et al., 2020). These interventions can be implemented as early as Intercept 2. Both ACT and FACT involve teams of community-based medical, behavioral health, and rehabilitation professionals who work closely to provide wraparound support focused on the individual needs of each person they serve. FACT includes additional components to target people involved in the legal system, including having a criminal justice partner and a peer specialist with lived experience on the team and addressing criminogenic risks and needs as part of the treatment plan (SAMHSA, 2019b). While ACT/FACT show some positive outcomes, a gap in success has persisted for people involved in the legal system, especially those with substance use or co-occurring disorders, making this approach less ideal for people with frequent jail contact without significant adaptations to meet their treatment needs (Cuddeback et al., 2020).

Other interventions at Intercepts 3 and 4 involve assessing people's needs in jail and connecting them to treatment services in the community. For example, some jails determine the behavioral health needs of people shortly after booking and facilitate hand-offs to community-based providers immediately upon release (Gilbreath et al., 2020; Kopak et al., 2019). Jails may follow the Assess, Plan, Identify, and Coordinate (APIC) model for reentry planning that deemphasizes treatment in the jail and instead uses a person's time in jail to identify their behavioral health needs and provide crisis intervention and stabilization. Then, jails aim to connect people to community-based providers to begin receiving care in the community immediately upon release (Osher et al., 2002). One recent study found that the APIC model aided in increased rates of enrollment and maintenance of mental healthcare and decreased rates of rearrest in the pre-posttest comparison (Hicks et al., 2022). Finally, the risk-need-responsivity (RNR) model (Bonta & Andrews, 2007) is being implemented alongside more traditional treatment interventions to help match a person to the appropriate intensity of treatment and supervision and to identify and address barriers and protective factors that will influence a person's responsiveness to intervention (Rotter & Compton, 2021).

At Intercept 5, some jurisdictions provide specialty mental health probation to people with mental health conditions, particularly those with serious mental illness. Specialty probation is conducted by officers who receive ongoing mental health training and who coordinate treatment services for people on their caseload. Under this model, officers have smaller caseloads which afford them more time with each person. Additionally, officers engage in collaborative, problem-solving approaches to address barriers that impact people's compliance with the terms of probation and to link people to psychiatric services (Louden et al., 2012; Manchak et al., 2014). Specialty mental health probation officers address people's mental health needs at higher rates than traditional probation officers, likely due to a combination of their training, the additional time spent per person, and the more collaborative supervision strategy they adopt. People on specialty probation have a higher rate of engagement with mental health services than people on traditional probation (Van Deinse et al., 2022). Further, people on specialty mental health probation are less likely to be arrested; they

experience a roughly 20% decrease in arrest rates compared to people on traditional probation (Skeem et al., 2017). This evidence suggests that this probation model can increase contact with mental health services and decrease contact with the criminal legal system.

Summary

Most interventions delivered to people with frequent jail contact represent general strategies designed to reduce jail contact. What limited evidence exists on programs specific to people with frequent jail contact suggests that addressing unmet needs and providing coordinated, consistent care as people transition between systems and community settings will have the greatest likelihood of success in reducing frequent jail contact (Desmarais et al., 2016; Listwan et al., 2018). Jurisdictions that wish to specifically focus on people with frequent jail contact may have to be intentional in selecting interventions designed for this population. That said, more work is needed to evaluate whether the interventions discussed here meet needs and reduce jail contact for both people with and without frequent jail contact. More work is also needed to understand how interventions work at the intersections of race, gender, and the criminal legal system.

Future Directions

Based on our review of the existing research, we have five recommendations for future research and practice: 1) establish jurisdiction-specific guidelines; 2) identify the unique and shared causes and consequences of frequent jail contact; 3) use theory-informed approaches to research and intervention; 4) test the effectiveness of existing interventions; and 5) address the racial and ethnic disparities in frequent jail contact.

Recommendation 1: Establish Jurisdiction-Specific Guidelines

Our first recommendation is that jurisdictions develop formal guidelines or criteria to support the consistent operationalization and identification of people with frequent jail contact. Each jurisdiction will have its own resources, values, and goals in identifying the population of people with frequent jail contact. As a result, we do not recommend a national definition or standard set of criteria to establish frequent jail contact. However, jurisdictions can turn to the guidance offered by national organizations such as the National Association of Counties in their *Playbook for Developing a System of Diversion for Frequent Utilizers* (National Association of Counties, 2021). This resource outlines a process for following a data-driven strategy to identify people with frequent jail contact and to develop strategies to meet their needs and reduce jail contact. As jurisdictions establish their own guidelines for identifying and supporting people with frequent jail contact, differences in how this population is defined will continue to exist. These differences can be addressed by detailed descriptions of the guidelines or criteria, including how and why they were selected. Transparent reporting of guidelines will facilitate the sharing of results across jurisdictions and aid in creating a more extensive evidence base about the characteristics and needs of people with frequent jail contact and the successful attempts to meet their needs and reduce their jail contact. Researchers studying people with frequent jail contact should partner with jurisdictions in this work to ensure that the definitions or criteria used to identify this population in studies match those used by jurisdictions in practice. If researchers cannot partner with a jurisdiction, they should clearly report the criteria they use to identify people with frequent jail contact and

explain their rationale for selecting these criteria. If possible, researchers may consider statistically comparing differences in study findings based on the use of different criteria to aid in the development of best practices for defining this population.

Recommendation 2: Identify Unique and Shared Causes and Consequences

Our second recommendation is that researchers examine the unique and shared causes and consequences of any jail contact versus frequent jail contact. A great deal of research exists highlighting the causes or pathways that lead to legal system interaction and the far-reaching consequences that interaction can have on people's well-being (Kramer & Remster, 2022; Kurlychek & Johnson, 2019). Generally, this research focuses on people with one to a few jail contacts. Identifying similarities and differences in the causes and consequences of jail contact between people with frequent jail contact and the broader population of people with any jail contact will inform if and how to modify existing interventions to serve the population of those with frequent jail contact. Findings from this proposed line of research may also illuminate new directions for interventions specifically targeting the needs of people with frequent jail contact and, thus, are likely to have greater effectiveness in improving outcomes.

Recommendation 3: Use Theory-Informed Approaches to Research and Intervention

Much of the research and practice focused on people with frequent jail contact is data-driven and atheoretical. The atheoretical approach toward this population partly explains the inconsistency in attempts to understand and address the needs of people with frequent jail contact. Applying theories to work with people with frequent jail contact will allow for an organized understanding of the etiology of frequent jail contact, which will inform intervention strategies. Shared theories will also increase the consistency and appropriateness of the responses across all the systems with which people with frequent jail contact interact. Several existing theories can inform research and practice on this population moving forward. For example, applying cumulative disadvantage theory – which suggests that the disadvantages a person experiences early on build and compound over time (DiPrete & Eirich, 2006; Kurlychek & Johnson, 2019) – could help clarify differences in characteristics, needs, and experiences between people with frequent and infrequent jail contact. Similarly, describing factors that contribute to frequent jail contact across the socio-ecological model could clarify how individual factors are nested within families, communities, cultural norms, and structural laws and policies (Dahlberg & Krug, 2006). A socio-ecological approach considers the complex interplay of factors across multiple levels, an awareness that is necessary for developing interventions that target gaps in systems and services beyond and alongside the needs and capacities of specific people. Finally, the RNR model (Bonta & Andrews, 2007) could guide the provision of treatment services that would appropriately address people's individual needs while also placing them under a level of supervision commensurate to the risk they pose (if any) to public safety. Overall, a common understanding of the causes and impacts of frequent jail contact and a uniform approach to identifying and meeting needs will improve the coordination of social responses and increase safety and well-being.

Recommendation 4: Test the Effectiveness of Existing Interventions

Our fourth recommendation is to evaluate existing interventions for people with any legal system involvement to determine their applicability and effectiveness in improving outcomes

for people with frequent jail contact. Many jurisdictions have adopted programs or interventions, such as CIT or mental health jail diversion programs, that are delivered to people with varying frequencies of jail contact. Typically, evaluations of such programs or interventions examine effectiveness holistically rather than for the subset of people with frequent jail contact. This is a critical avenue for future research, as existing interventions may not adequately meet the needs of this unique population (Desmarais et al., 2016). Additionally, broader interventions intended for the entire legal system-involved population – as opposed to just those with behavioral health needs – must also be examined for effectiveness in reducing contact, specifically for people with frequent jail contact who often have behavioral health needs. Interventions will look different at each stage of the SIM, and evaluations must consider how earlier interventions affect movement through later intercepts. For people with frequent jail contact, it may be particularly useful to consider the effectiveness of interventions that occur at Intercepts 0 and 1, as these could prevent a person from even entering the jail in the first place. For example, many law enforcement agencies, which represent Intercept 1, have adopted the practice of issuing citations in lieu of arresting people for certain low-level offenses (International Association of Chiefs of Police, 2016). An approach like this certainly has the potential to reduce jail contact among people with frequent jail contact. Other interventions at Intercepts 0 and 1 may reduce cycling through the jail by meeting mental health, substance use, and housing needs. Moving forward, we must develop and implement general and targeted interventions that address the unique and shared needs of people with frequent jail contact while reducing legal system involvement.

Recommendation 5: Reduce Racial and Ethnic Disparities in Frequent Jail Contact

Our fifth recommendation, which should be applied in tandem with all other recommendations, is that jurisdictions seek to understand and address racial and ethnic disparities in frequent jail contact. Disparities in front-end processes of the legal system (e.g., police interactions, pretrial decisions, jail diversion offerings) are well-documented (Hinton et al., 2018; National Conference of State Legislatures, 2022) and contribute to the repeated cycling that people with frequent jail contact experience. Multi-level efforts will be required to target the causes of these disparities, ranging from individual attitudes and decision-making to structural-level biases in policing and court practices (Hinton et al., 2018; National Conference of State Legislatures, 2022). Jurisdictions must collect data on who is in contact with the criminal legal system and on the outcomes of their contacts to understand exactly what interventions are needed and, after interventions are put in place, to assess whether they are reducing disparities (National Conference of State Legislatures, 2022). Existing interventions, such as those discussed in this chapter, must also be evaluated to ensure that they serve people appropriately across race/ethnicity and bring about equitable reductions in jail contact and connections to behavioral health systems. To the extent that existing interventions are not racially/ethnically equitable (e.g., people of color being less likely to be recommended for jail diversion; Naples et al., 2007), changes must be made to eliminate the overrepresentation of people of color among people with frequent jail contact.

Conclusion

Among people with any jail contact, most experience only one contact. Yet there remains a group of people who repeatedly cycle between the jail and the community over shorter

periods. People with frequent jail contact are generally a small proportion of the total number of unique individuals involved in a jail system but account for a disproportionately large number of jail booking events. People with frequent jail contact are disproportionately Black and men. They also often have high levels of unmet needs, which include, but are not limited to, behavioral health treatment, medical treatment, and housing assistance. Likewise, frequent jail contact is often co-occurrent with frequent use of other services like EMS, crisis response teams, and emergency rooms. Without access to the appropriate resources, people with frequent jail contact remain stuck in a revolving door where their needs continue to go unmet, their quality-of-life declines, and they repeatedly interact with the criminal-legal system. To end frequent and repeated contact with jails, we must properly identify people with frequent jail contact and create and test the utility of interventions and programs that address this population's specific behavioral health needs in a racially equitable way.

Note

1 The study by SAS Institute (2017) and Desmarais et al. (2017) were both conducted in Wake County, North Carolina, over the same timeframe (January 2013 to June 2016 for Desmarais et al., 2017 and July 2013 to December 2016 for SAS Institute, 2017). These studies used different definitions of frequent contact so while there may be overlap in the people reported on in each study, they are different samples.

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