Treatment First Diversion: Replacing Jail Returns for Failed Drug Screens with Rapid, Community-Based Care

Southern New Hampshire University
Jessica Stevens
IDS-410- Problem Solving Social Change
Dr. Job Elliott
October 19, 2025

Jessica Stevens
IDS-410 FINALE PROJECT

Part One: Introduction

Routine re-incarceration for failed supervised drug tests treats relapse as a legal violation rather than a clinical display of a chronic substance use disorder. This practice disrupts continuity of care, destabilizes housing and employment, increases overdose and repetition risk, and disproportionately harms marginalized populations. This action plan proposes a court-linked Treatment First Diversion pathway that replaces short jail returns with immediate clinical triage, rapid initiation of medication-assisted treatment (MAT) when indicated, assertive case management, peer recovery support, and linkages to housing and employment services. The plan is designed for county-level piloting with formal memoranda of understanding (MOUs) among courts, probation, defense and prosecution offices, behavioral health providers, peer organizations, and public health agencies. Implementation phases include stakeholder convening, protocol development and training, a time-limited pilot, and iterative evaluation with expansion contingent on results. Evaluation will monitor process (referrals, time-to-treatment), implementation (MAT starts, case manager contacts), outcomes (treatment retention, 6- and 12-month recidivism, overdose events), economic impact (jail bed-days and cost offsets), and equity indicators (disparity reduction by race and income). The proposed pathway aligns public safety with public health and advances equity while providing a practical roadmap for jurisdictions seeking to reduce harms caused by disciplinary responses to relapse.

Investigation/ Background and problem description

Across many supervised populations, a positive or failed drug test commonly triggers a return to jail or other punitive sanctions. This response treats relapse as willful misconduct rather than as a clinical sign of a chronic medical condition, destroying care and worsening individual and community outcomes. Short jail stays interrupt medication continuity, sever links with

community providers, jeopardize housing and employment, and increase overdose risk upon release. The increasing effect is recurring supervision technical violations produce more incarceration, which produces more instability and higher downstream costs to both health and justice systems.

Contributing factors that created the issue

Multiple factors contribute to routine re-incarceration after failed drug tests. Supervision and court policies often classify positive tests as technical violations that justify immediate sanctions. This legal framework is reinforced by institutional incentives that emphasize control and punishment rather than treatment linkage. Community treatment capacity constrains alternatives; limited low-threshold MAT slots, long waitlists, transportation gaps, and convoluted benefits enrollment create barriers to rapid clinical response. Stigma and inadequate training among judges, probation officers, and court staff sustain punitive attitudes toward relapse. Structural inequities, racialized enforcement, poverty, unstable housing, concentrate supervision and punitive responses among marginalized groups and amplify harms (Efron & Ravid, 2018; Lyons, 2016).

Impact on the community

The practice harms individuals, families, and systems. For individuals, repeated short incarcerations interrupt treatment, increase risk of overdose, and erode employment and housing stability. Families face economic and emotional strain when members cycle in and out of custody. Correctional systems experience overcrowding, higher operating costs, and churn in supervision caseloads. Public health outcomes suffer through disrupted MAT continuity and increased emergency department utilization. Equity is tough because penalizing responses

disproportionately affect racial and socioeconomic minorities, perpetuating systemic harms (Mantel, 2022).

Specific, actionable aspect of the issue

The decision point immediately following a failed supervised drug test is a discrete, actionable opportunity for social change. Rather than authorizing automatic jail returns, jurisdictions can implement a Treatment First Diversion pathway that mandates rapid triage, expedited treatment linkage, and community supervision focused on recovery. Concentrating reform efforts on this decision point allows for targeted pilot testing, measurable process changes, and a clear line of accountability for stakeholders.

Rationale for actionability

This approach is actionable because it: (a) targets a defined operational moment (post-test response); (b) can be implemented via local protocols and MOUs without requiring major statutory overhaul; (c) enables measurable short-term process outcomes (time-to-treatment, referrals) and longer-term outcome evaluation (recidivism, retention); and (d) leverages existing evidence for diversion models, MAT, and peer supports to justify investment (Efron & Ravid, 2018; Lyons, 2016).

Part Two: Intervention

Routine re-incarceration for failed supervised drug tests treats relapse as a legal violation rather than a clinical manifestation of a chronic substance use disorder. This practice disrupts continuity of care, destabilizes housing and employment, increases overdose and recidivism risk, and disproportionately harms marginalized populations. This action plan proposes a court-linked Treatment First Diversion pathway that replaces short jail returns with immediate clinical triage,

rapid initiation of medication-assisted treatment (MAT) when indicated, assertive case management, peer recovery support, and linkages to housing and employment services. The plan is designed for county-level piloting with formal memoranda of understanding (MOUs) among courts, probation, defense and prosecution offices, behavioral health providers, peer organizations, and public health agencies. Implementation phases include stakeholder convening, protocol development and training, a time-limited pilot, and iterative evaluation with expansion contingent on results. Evaluation will monitor process (referrals, time-to-treatment), implementation (MAT starts, case manager contacts), outcomes (treatment retention, 6- and 12-month recidivism, overdose events), economic impact (jail bed-days and cost offsets), and equity indicators (disparity reduction by race and income). The proposed pathway aligns public safety with public health and advances equity while providing a practical roadmap for jurisdictions seeking to reduce harms caused by punitive responses to relapse.

Recommended strategy: Treatment First Diversion pathway

The proposed strategy integrates clinical, social, legal, and advocacy components into a coordinated diversion pathway described below.

1. Point-of-detection multidisciplinary diversion review

   When a supervised individual returns a positive drug test, probation or court liaison triggers a rapid referral (within 24–72 hours) to a diversion review team composed of a judicial liaison, public defender, prosecutor representative, behavioral health clinician, and peer recovery specialist. This team assesses safety concerns, diversion eligibility, and immediate clinical needs.

2. Expedited biopsychosocial assessment and risk stratification

   A brief, standardized assessment evaluates overdose or withdrawal risk, substance use

severity, co-occurring mental health conditions, housing and employment status, and treatment preferences. Risk stratification informs immediate clinical choices (e.g., need for supervised withdrawal, urgent MAT initiation) and diversion suitability.

3. Immediate linkage and low-threshold MAT access

   Eligible individuals are offered same-day or rapid access (within 72 hours) to treatment. When clinically indicated, MAT is initiated via on-site prescribers, expedited community appointments, or telehealth. On-site benefits navigation reduces delays in coverage and billing that often impede access.

4. Diversion agreements with therapeutic accountability

   Participants sign a diversion agreement specifying supports and expectations. Monitoring (including drug testing) functions as clinical feedback for treatment adjustment rather than as an automatic trigger for incarceration. Graduated responses prioritize therapeutic interventions for nonadherence, reserving jail for clear public-safety threats.

5. Assertive case management and peer recovery supports

   Case managers and certified peer specialists provide outreach, appointment coordination, transportation assistance, housing and employment linkages, and crisis stabilization. Peers bridge trust gaps and sustain engagement.

6. System-level enablers: MOUs, telehealth, and data sharing

   Formal MOUs among courts, probation, providers, and payers define roles and data-sharing parameters. Telehealth and mobile units expand access in areas with provider shortages. A secure dashboard monitors process, implementation, outcome, and equity metrics.

Implementation pathway and timeline

Phase 0: Stakeholder convening and planning (3 months) — secure MOUs, identify pilot jurisdiction, map capacity, and assign diversion coordinator.

Phase 1: Protocol development and training (2 months) — finalize triage processes, diversion agreements, and judicial/probation training.

Phase 2: Pilot launch (6–12 months) — accept defined caseload limits, use Plan-Do-Study-Act cycles, and collect process and early outcome data.

Phase 3: Evaluation and scale (months 12–36) — analyze impact, refine protocols, secure sustainable funding, and expand.

Resources required

Funding: seed grants, reallocated correctional funds, state/federal grants, and philanthropic contributions.

Workforce: diversion coordinator, rapid-access clinicians (MAT prescribers), case managers, peer recovery specialists, benefits navigators, and data analysts.

Infrastructure: telehealth equipment, mobile treatment capacity, transportation vouchers, and a secure data dashboard.

Legal/policy: MOUs, revised supervision protocols permitting diversion, confidentiality agreements for data sharing, and judicial buy-in.

Benefits to the community and individuals

- *Individual benefits*: continuity of care, increased treatment retention, decreased overdose risk, preserved employment, and housing, and strengthened family ties.

- *System benefits*: fewer short jail admissions, reduced correctional expenditures, and lower supervision churn.
- *Public health benefits*: improved continuity of MAT, reduced ED utilization, and fewer overdose events.
- *Equity gains*: elimination of punitive patterns that disproportionately harm marginalized populations (Mantel, 2022).

Potential unintended consequences and mitigation strategies

Capacity strain: sudden referral surges could overwhelm providers; mitigate with phased caps and funded slot expansion.

Political resistance: engage judicial champions early, provide transparent criteria, and share interim data to build support.

Perceived coercion: emphasize voluntary, evidence-based engagement and informed consent; include safeguards and grievance pathways.

Data privacy risks: implement HIPAA-compliant agreements, minimal datasets, and encrypted storage.

Part Three: Advocacy

Justification for implementation

Treatment First Diversion aligns public safety and public health. Evidence demonstrates that punitive short incarcerations disrupt treatment and increase harms while diversion with treatment reduces repetition and improves health outcomes. Presenting the plan as fiscally prudent and rights-respecting broadens appeal across stakeholders and funders (Efron & Ravid, 2018).

Projected societal impacts

Successful implementation could reduce overdose events, improve family and workforce stability, lower correctional expenditures, and reduce racialized disparities in supervision outcomes. Over time, jurisdictions may see net cost savings as jail bed-days decrease and community health improves.

Refuting likely opposition

"This is soft on crime." Diversion retains accountability via diversion agreements with monitoring and graduated therapeutic responses; evidence indicates these approaches reduce backsliding more reliably than short jail sanctions.

"This will be too costly." Initial investments are likely offset by reductions in jail bed-days, supervision burdens, and emergency care costs; the pilot will include economic evaluation to quantify net effects.

"Courts lack capacity." A small, supported pilot with MOUs and training will demonstrate feasibility; successes can be used to expand judicial capacity incrementally.

Advocacy strategy and communication approach

Audiences*:* judges, probation directors, prosecutors, public defenders, treatment providers, people under supervision, and community stakeholders.

Core messages: relapse is a health issue; diversion reduces harm and cost; structured treatment maintains accountability.

Tactics: targeted judicial briefings and trainings; one-page policy briefs for decision makers; infographics and testimonial videos for public education; town halls and stakeholder roundtables; social media and local news outreach.

Persuasion techniques: establish credibility with data and clinician voices; use social proof and

local success stories; tailor benefits to each audience; offer clear, actionable asks (e.g., sign an MOU, allocate seed funding, approve pilot eligibility).

Indicators of advocacy success

Policy adoption (MOUs and revised protocols), funding secured, number of stakeholder briefings and endorsements, positive local media coverage, and measurable process and outcome improvements in the pilot.

Measuring success: evaluation metrics and equity indicators

Process indicators: referrals to diversion team, stakeholder briefings, MOUs signed.

Implementation indicators*:* median time from positive test to first clinical contact, percent initiating MAT within 7 days, and number of case manager/peer contacts.

Outcome indicators*:* treatment retention at 3, 6, and 12 months; 6- and 12-month recidivism rates; overdoses and ED visits per 100 participants; jail bed-days avoided and cost offsets.

Equity indicators*:* change in diversion and outcome rates by race, ethnicity, income, and geographic access.

Data methods*:* baseline historical comparisons, matched cohort or interrupted time series analyses, and regular reporting to stakeholders for iterative refinement.

Conclusion and Recommendations

Replacing jail returns for failed drug screens with a Treatment First Diversion pathway is both a practical and moral imperative. The proposed multi-component model, immediate triage, rapid MAT access, assertive case management, peer support, and diversion agreements, offers measurable benefits for individuals, systems, and communities while advancing equity. Recommended next steps: convene stakeholders to secure MOUs and seed funding, finalize

triage protocols and diversion agreements, reserve rapid-access treatment capacity, and launch a 12-month pilot with clearly defined process and outcome measures to inform scale-up.

References

- Efron, S. E., & Ravid, R. (2018). Writing the literature review: A practical guide. Guilford Publications.
- Lyons, C. (2016). Restorative justice. CQ Researcher. https://doi.org/10.4135/cqresrre20160205
- Mantel, B. (2022). Wrongful convictions. CQ Researcher. https://doi.org/10.4135/cqresrre20220318
- Community Tool Box. (n.d.). Communication plan. University of Kansas. https://ctb.ku.edu/en/table-of-contents/participation/promoting-interest/communication-plan/main
- Community Tool Box. (n.d.). Principles of persuasion. University of Kansas. https://ctb.ku.edu/en/table-of-contents/participation/promoting-interest/principles-of-persuasion/main