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Michigan State University
Sheryl Kubiak, Ph.D., Principal Investigator
Liz Tillander, LMSW
Angie Gaabo
Celeste Rabaut
Edita Milanovic

Oakland University
Erin Comartin, Ph.D.

Statewide Jail Diversion Pilot Program Implementation Process Report April – September 2015

The Mental Health Diversion Council's Jail Diversion Pilot Program launched eight pilot programs across the state funded through the Michigan Department of Health and Human Services (MDHHS). The majority of the pilot programs were implemented by April 2015 and all are currently operating. The purpose of this report is to provide information about the collective process of implementing diversion programs in diverse communities and to document the structure and process of each of the diversion programs during the first six months of operation.

This report is provided as part of the evaluation of the diversion pilot programs funded by MDHHS in 2015 – 2016. The evaluation is led by principal investigator, Sheryl Kubiak, Ph.D., of Michigan State University.

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I. EXECUTIVE SUMMARY

Background

In 2014, the Mental Health Diversion Council (MHDC), through the Michigan Department of Health and Human Services (MDHHS), sought proposals for jail diversion initiatives statewide. The intent was to address the needs of mentally ill and developmentally disabled individuals, thus decreasing their involvement with the criminal justice system. Applicants were to propose interventions at one or more points along the Sequential Intercept Model framework. The overarching goal of the Diversion Council is to determine if these ‘pilot’ intervention strategies are successful, and if so, could they be replicated in other counties. Recognizing that communities would already have strengths and weaknesses in their jail diversion activities, the Diversion Council encouraged communities to utilize their resources to bolster gaps in diversion activities already underway within their community.

This report is the first in a series of reports that assess the processes and outcomes of these pilot projects. As the first, this implementation report provides preliminary data and a summary of the commonalities and differences across the sites. It will serve as a companion to the forthcoming outcome reports (i.e. short term outcomes report in fall 2016; long term outcomes 2017). Each report builds upon the others. The goal of the implementation report is to facilitate an understanding of the unique characteristics of each program, while understanding the common challenges and successes with implementation of diversion programs across the state. Understanding the unique characteristics of each program allows us to more fully appreciate the forthcoming outcomes, as well as the differences between programs. Similarly, understanding common success and challenges across programs assists the Diversion Council in their efforts to create intervention opportunities statewide and to facilitate state-level policy change.

Funded Pilots

Eight jail diversion pilot proposals were approved and funded by the Diversion Council in January 2015. The primary models chosen across site were Crisis Intervention Training (CIT) and Jail-based Diversion Services. These sites and the implementing agencies include:

- Barry County - Barry County Community Mental Health Agency (BCCMHA)
- Berrien County - Berrien Mental Health Authority (BMHA)
- Kalamazoo County - Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS)
- Kent County - Network 180, the community mental health authority
- Marquette County - Pathways Community Mental Health
- Monroe County - Monroe Community Mental Health Authority (MCMHA)
- Oakland County - Oakland County Community Mental Health Authority (OCCMHA)
- Wayne County - Detroit Central City Community Mental Health (DCC)

Findings Regarding Implementation of Crisis Intervention Team Training

Five of the eight sites piloted Crisis Intervention Team (CIT) training. The goals of CIT are to increase safety in police encounters and divert appropriate persons with mental illness from the criminal justice system to mental health treatment. Although *training proved beneficial, as evidenced by enhanced knowledge of resources in the community and de-escalation skills across sites*, CIT implementation varied and these variations are likely to influence outcomes. Findings regarding these factors include:

- **CIT Training Factors:** Variation across sites in factors related to training include the number of hours officers were trained (8 – 40 hours); the unit(s) of law enforcement officers trained (city, township, county); whether officers were engaged in community patrol or worked within jails; the proportion of officers trained within the community; and whether community training includes dispatch officers.
- **Community-Level Factors:** Variation in resources available in the community included the presence or absence of a 24-hour drop off that could be utilized by law enforcement; and the presence or absence of a community advisory council to develop, implement and problem solve the intervention
- **Measurement Factors:** Variation in how CIT influences diversion will differ by the definition of diversion used (i.e. does a criminal offense need to occur for a diversion to exist?); access to law-enforcement level data; and the presence or absence of ‘coded’ data (dispatch or officer data) that indicates existence of mental health issue during a call.

Findings Regarding Implementation of Jail Diversion Services

Seven of the eight sites engaged in jail-based services – all considered post-booking diversion programs. *An absolute strength of the diversion pilots is the enhanced collaboration between CMH and local law enforcement/jails across counties. This is particularly true of jail services, when CMH was involved in providing within jail services in three counties for the first time.*

An objective measure of the prevalence of serious mental health issues among those booked into the jail was conducted by the evaluation team and compared to the number of individuals identified as having mental health problems through routine processes within the jail. The agreement/disagreement between these numbers provides a baseline for the jails, as well as a potential impetus to examine jail practices.

The specific jail diversion model chosen by each county as well as how their programs are implemented has resulted in wide variability across the sites. Factors that will influence outcomes are as follows:

- **Jail-based Service Factors:** Because sites tailored their intervention plan to the unique circumstances of their community, differences across sites that may affect outcomes include: the intervention type (advocacy, treatment, and/or support services); identification and screening of mental health issues within the jail; coordination of care (i.e., Is jail-based care coordinated with a contracted provider or is it provided by the grantee?); and the amount of time mental health program personnel had to build trust with jail staff and administrators.
- **Community-level Factors:** Outcomes will likely be affected by the supportive community environment and availability of resources. Therefore, counties with access to a full continuum of care, including psychiatric beds and similar medication formularies, will likely have better outcomes. Similarly, resources to engage in jail ‘in-reach’ as well as continual community outreach will likely be associated with better mental health outcomes.

- **Measurement Factors.** In assessing later outcomes, there are specific issues that surfaced regarding measurement during the implementation period. Similar to CIT, a common understanding of the definition of diversion would be helpful (note: the evaluation team has coined ‘current’ and ‘future’ diversion activities). In addition, as program models were altered during implementation, programs need to be defined more specifically (i.e., When and how does an individual successfully complete the program? Duration of services? Aftercare?) to determine which service model is associated with positive outcomes.

Perspectives of the Current Projects: Lessons Learned During Implementation

The multiple approaches being implemented across the state offer a unique opportunity to assess the success and barriers of each approach and to think about lessons learned.

- **Importance of advisory council.** Ensure that criminal justice and mental health treatment decision makers are at the table from the very beginning and meet on a regular basis.
- **Time to build rapport and trust between partners.** Provide time during the initial stages of grant implementation for sites to build relationships and establish a stakeholder team.
- **Benefits of multi-year initiatives.** Launch diversion initiatives as multi-year, not one-year grants. Allow for modification and provide some flexibility and guidance for changes to the model mid-stream.
- **Desire for enhanced learning and communication across sites.** Provide regular cross-site learning opportunities and ongoing technical assistance.
- **Expand services to non-CMH enrolled individuals with mental health concerns.** Consider ongoing strategies that allow for services to be expanded to individuals with mental health concerns who are not enrolled in community mental health services.

Recommendations to Diversion Council

The information gathered through site visits, interviews, monthly calls, and ongoing data collection efforts offer several insights into program design and implementation which may be useful to the Diversion Council as it moves forward with implementing diversion programs throughout the State and addressing system-level changes.

→ Recommendations for Changes in Process to Support Best Practices

1. Define/operationalize the definition of diversion.
2. Require quantitative evidence of need/problem within the community: What/where is the need for diversion within in the county?
3. Utilize implementation findings to enhance current pilots and formulate new RFP.
4. Encourage the use of a brief validated mental health screening in all jails at intake.
5. Suggest improvement in the utilization of jail management information systems.
6. Insist upon identification of co-occurring disorders (COD) and integrated mental health and substance use disorder treatment.
7. Increase emphasis on family, particularly children, and community supports.
8. Encourage continuity of care between jail and community treatment and services.
9. Emphasize ‘criminogenic’ factors as well as mental health factors.

→ **Recommendations for System-Level Changes That Would Support Diversion**

1. Consider funding community mental health staff to provide in-reach services with incarcerated consumers and out-reach services upon community reentry.
2. Prevent the time lag for reinstatement of Medicaid coverage post-jail release.
3. Address the statewide need for acute care hospital beds for psychiatric emergencies.
4. Incorporate de-escalation skill training within police academy.
5. Enhance the spectrum of psychotropic medications available on jail formularies.

Next Steps for Evaluation

Considering the variability of programs and program implementation across sites, outcomes of diversion programs will need to consider the contextual and implementation variation across sites. This report provides information on program models; the evaluation team will then collect evidence to establish program outcomes. The next steps for the evaluation are as follows:

1. **Short-Term Outcomes Report.** Six-month jail recidivism outcomes for individuals receiving diversion services in 2015 plus comparison of jail mental health prevalence rates between 2015 and 2016. To be delivered to the Diversion Council in fall 2016.
2. **Long-Term Outcomes Report.** One-year jail recidivism and post-incarceration treatment engagement for individuals receiving diversion services in 2015 - 2016. To be delivered to the Diversion Council in fall 2017.
3. **Comparing Data-Warehouse and Other Administrative Data.** Comparison of data gathered on two pilot sites, Oakland and Kent, only. If data becomes available from the state-level data warehouse, additional outcomes will be assessed (i.e. morbidity, child welfare, state-level incarceration) and compared to data gathered through county-level administrative data. If data is available, it will be delivered to the Diversion Council in January 2018.

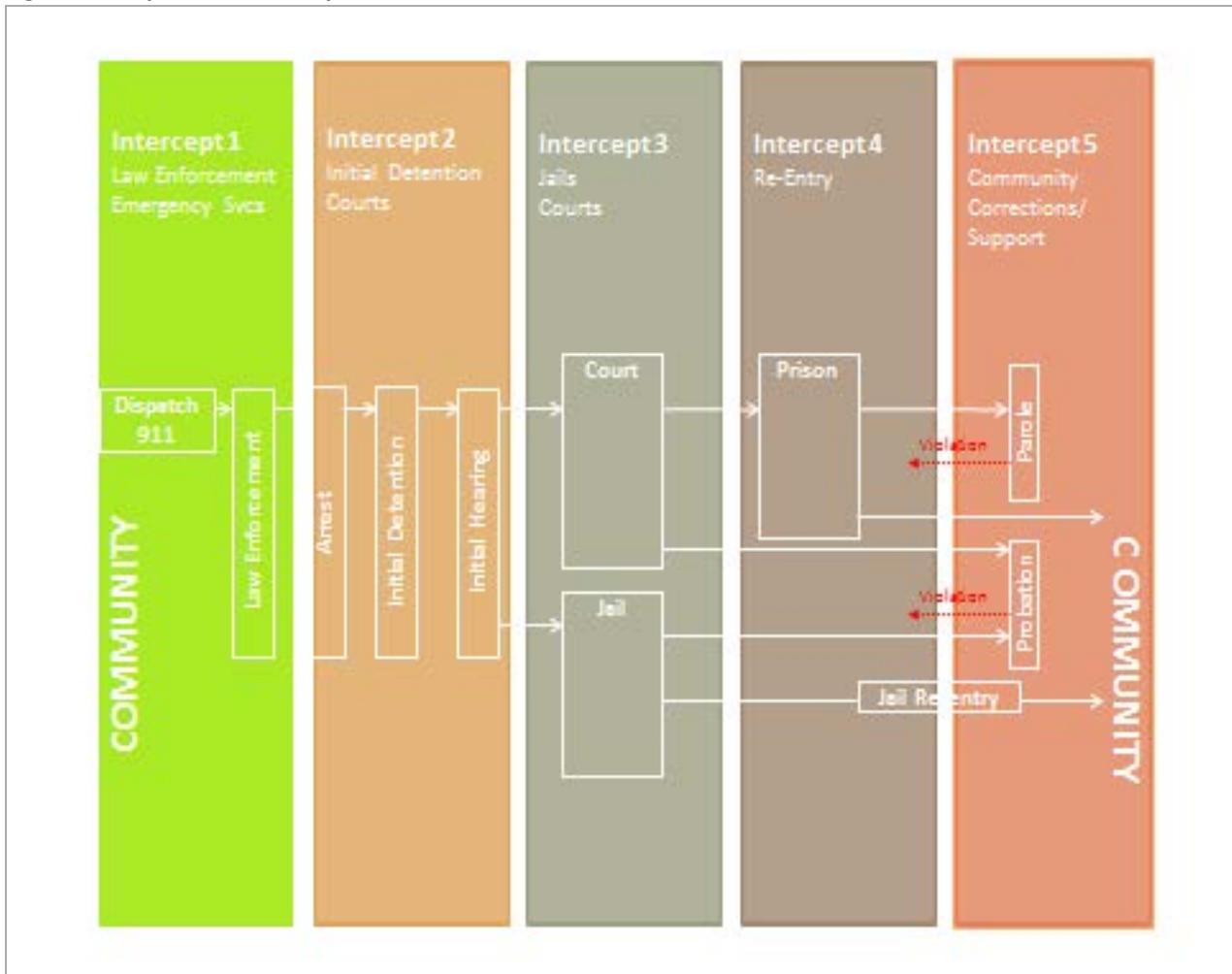
II. BACKGROUND

Mental Health Diversion Council Request for Proposals

In 2014, the Mental Health Diversion Council (MHDC), through Michigan Department of Community Health, now Michigan Department of Health and Human Services (MDHHS), sought proposals for jail diversion initiatives statewide. The intent was to secure proposals that would address the increasing needs of mentally ill and developmentally disabled individuals with the goal of preventing their involvement with the criminal justice system. Applicants were to propose 'pilot' interventions at one or more points along a framework known as the *Sequential Intercept Model*. Eligible applicants included agencies working extensively with the mentally ill and/or developmentally disabled populations including but not be limited to Community Mental Health (CMH) agencies, CMH providers, law enforcement, courts, jails and jail providers.

Points where actions can be taken along the Sequential Intercept Model shown in Figure 1 below include pre-arrest, pre-booking, post-booking, pre-sentencing, post-sentencing, and pre- and post-release from incarceration.

Figure 1. Sequential Intercept Model



Adapted from Munetz & Griffin, 2006

The purpose of the grant opportunity was to pilot and eventually replicate models around the State that would divert mentally ill and developmentally disabled persons from jail through innovative, sustainable, and replicable jail or community-based activities. Recognizing that communities would already have strengths and weaknesses in their jail diversion activities, the Diversion Council encouraged communities to utilize their resources to bolster gaps in diversion activities already underway within their community. Priority consideration was given to applicants that focused on the immediate goals of the state’s Mental Health Diversion Council. These priorities and how they link to the Sequential Intercept Model are shown in Table 1 below.

Recognizing that communities would already have strengths and weaknesses, MHDC encouraged communities to utilize their resources to bolster gaps in diversion activities already underway.

| Table 1. Alignment of Michigan Diversion Council Priorities With Sequential Intercept Model | |
|---|---|
| Diversion Council Priorities | Alignment with Sequential Intercept Model |
| Initiate or bolster efforts to expand the use of Alternative Outpatient Treatment through “Kevin’s Law”. | 1 |
| Initiate expanded services with law enforcement to include Crisis Intervention Teams (CIT) training among local police, first responders, and dispatch personnel through use of the 40-hour CIT training model including backfill funding for police officers during training. | 1 |
| Explore need for a centralized crisis assessment and/or treatment facility for law enforcement to utilize in lieu of jails. | 1 |
| Focus on comprehensive and enhanced mental health treatment for those in jail and transitioning out of jail including access to psychotropic medications during incarceration and upon release; bolstered housing efforts prior to and after release; minimal wait times to see doctors/psychiatrists in and out of jail; increased support systems prior to and after release; and use of educational and vocational opportunities pre- and post-release. | 3-5 |

Selected Counties for Diversion Pilot Programs

Eight jail diversion pilot proposals were approved and funded by the Diversion Council in January 2015. The selected counties and the implementing agencies are listed below. Note that all implementing agencies are CMH agencies.

- Barry County - Barry County Community Mental Health Agency (BCCMHA)
- Berrien County - Berrien Mental Health Authority (BMHA)
- Kalamazoo County - Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS)
- Kent County - Network 180
- Marquette County - Pathways Community Mental Health
- Monroe County - Monroe Community Mental Health Authority (MCMHA)
- Oakland County - Oakland County Community Mental Health Authority (OCCMHA)
- Wayne County - Detroit Central City Community Mental Health (DCC).

Table 2 shows the approved sites, the proposed Diversion Council priorities selected by the sites, and how those selected sites align with the Sequential Intercept Model.

| Table 2. Jail Diversion Pilot Programs Approved By Diversion Council, December 2014 | | | | | | | |
|---|-------------|----------------------|-----|------------------------|---------------|----------|-------------------|
| Mental Health Diversion Council Priorities | | Kevin's Law | CIT | Centralized Assessment | Jail Services | Re-Entry | Community Support |
| Sequential Intercept Model | | 1 | 1 | 2 | 3 | 4 | 5 |
| County | Grantee | Priorities Addressed | | | | | |
| Barry | BCCMHA | x | x | | x | | |
| Berrien | BMHA | x | x | | x | | |
| Kalamazoo | KCMHSAS | | x | | x | | x |
| Kent | Network 180 | | | | x | | |
| Marquette | Pathways | | x | | x | | |
| Monroe | MCMHA | | | | x | | |
| Oakland | OCCMHA | | x | | | | |
| Wayne | DCC | | x* | | x | | |

* Wayne County initially proposed a pre-arrest diversion programming involving Detroit Police, but was later modified.
 NOTE: All of the jail-based service programs engage in some type of discharge planning or follow-up, however re-entry was not the primary priority.

As shown in Table 2, the majority of proposals concentrated on Intercepts 1 and 3. Five of the eight sites focused on CIT interventions (Intercept 1) and seven of the eight sites focused on jail services (Intercept 3). Only two sites included a focus on Kevin’s Law (although neither implemented it) and none of the sites focused on exploring the need for centralized assessment within the community.

While there is a concentration on Intercepts 1 and 3, many of the counties are actually engaged in diversion activities that span across the sequential intercept model. However, for purposes of this report, the evaluation team is focusing solely on activities outlined in each proposal. (A more detailed discussion of the specific objectives proposed by each of the eight sites is included in Appendix I.)

Evaluation Process

This evaluation relies on multiple data sources to assess the implementation and outcomes of the eight pilots. These include initial site visits with each site, use of the K6 jail screening, developing individual site process maps to visualize how proposed services are being implemented, monthly data collection reports, monthly telephone calls with each site, implementation interviews with each site, and a second round of site visits. A more detailed description of these processes is included in Appendix II.

The result of these many data sources is that the evaluation is a highly interactive process. It allows each site to have regular and ongoing access to evaluation team members who can answer questions, clarify the purpose for which data is being collected and help modify data collection processes as needed in response to the needs of the individual sites. It also allows for the evaluation team to gain a deeper understanding of each site’s program.

Through the use of multiple methods and many data sources, the evaluation is a highly interactive process.

III. CRISIS INTERVENTION TEAM TRAINING (INTERCEPT 1)

Crisis Intervention Team (CIT) Training as an Intervention Model

CIT, a strategy under the Sequential Intercept Model 1, was developed in 1998. Following the shooting of a mentally ill man that year, Memphis Police Chief Sam Cochran put together a community task force comprised of treatment professionals, law enforcement personnel and mental health advocates to develop what is now known as the Memphis CIT Model. The primary goals of CIT are to increase safety in police encounters and divert appropriate persons with mental illnesses from the criminal justice system to mental health treatment. 'Appropriate' infers a person who does not pose a threat to public safety or someone who has not committed an assaultive offense.

The primary goals of CIT are to increase safety in police encounters and divert appropriate persons with mental illness from the criminal justice system to mental health treatment.

Core Elements of CIT

CIT has three core elements:

- A 40-hour police training model.
- Collaboration with community partners including mental health providers.¹
- A central, psychiatric emergency drop-off with a no refusal policy that gives police priority so officers can be back out on the street within 15–30 minutes.²

At a minimum, CIT training includes information on signs and symptoms of mental illnesses, mental health treatment, co-occurring disorders, legal issues and de-escalation techniques. The training is presented by experts in these various areas and includes experiential learning techniques of role plays using scenarios. In addition to the training of law enforcement officers, dispatchers can also be trained to increase their understanding of the signs and symptoms of mental illness and enhance their skills in dispatching appropriate services or personnel. Although most training is being conducted with community based law enforcement officers, many jails and prisons are also training their corrections staff.

While there has not been enough research to declare CIT an Evidence-Based Practice, it has been called a Promising Practice³ and a Best Practice model for law enforcement⁴.

Sites Implementing CIT

CIT programs are being implemented in five of the eight sites. Four sites – Barry, Berrien, Marquette and Oakland – did not have an existing CIT program and so their proposals focused on implementing a new program. One site – Kalamazoo – had an existing CIT program already in operation within the community⁵. Efforts in Kalamazoo focused on implementing CIT-Youth programming, an additional training module for officers who previously completed the adult training component.

¹ Dupont, Cochran & Pillsbury, 2007.

² Steadman et al 2001.

³ International Association of Chiefs of Police, 2010.

⁴ Thompson & Borum, 2006.

⁵ Kalamazoo began CIT training of officers in the year prior to this evaluation with similar pilot funding from the state. Evaluation of those specific program activities are not part of this evaluation report.

There is considerable variation across the pilots as shown in Table 3 below. The target audience for the training varies across sites, incorporating patrol officers, jail staff, and/or dispatchers. The length of training delivered also varies across sites. While the Request for Proposals called for the delivery of a 40-hour training model in reference to standard adult-focused CIT training, only two sites – Berrien and Oakland – delivered this model. Berrien officers attended a five-day training conducted by the Chicago Police Department in Chicago, IL. Oakland officers attended a five-day training facilitated by Sergeant Rafael Diaz from the Kalamazoo Department of Public Safety in Pontiac, MI. Barry and Marquette utilized abbreviated training models of 24- and 16-hours respectively. Kalamazoo provided an 8-hour training focused on youth-specific information and resources as an addendum to officers who had previously completed the 40-hour adult training.

Under this grant, CIT was introduced in four Michigan counties: Barry, Berrien, Marquette and Oakland. A fifth county – Kalamazoo – added a training for officers interacting with youth.

| Table 3. Comparison of Crisis Intervention Team Pilots | | | | | | | | |
|--|-------------|------------------------------------|-----------------|----------|------|------------------------------------|----------------------------------|--------------------------------------|
| | New Program | Population Trained: Youth or Adult | Training Target | | | No. of Officers Trained (Proposed) | No. of Officers Trained (Actual) | Length of Training Delivered (Hours) |
| | | | Patrol | Dispatch | Jail | | | |
| Barry | x | Adult | | | x | 3 | 9** | 24 |
| Berrien | x | Adult | X | x | x | 6 | 14 | 40 / 24 |
| Kalamazoo* | | Youth | X | | | 89 | 90 | 8 |
| Marquette | x | Adult | X | x | | 40 | 17 | 16 |
| Oakland | x | Adult | X | x | | 80 | 111 | 40 / 8 |

* Note: in a previous diversion grant award, Kalamazoo trained city, county and township officers in adult CIT.

** In Barry, 3 of the 9 individuals trained were mental health staff.

The number of persons trained varies as well. Some counties exceeded their initial training goals because of additional dollars provided through a second year of funding offered by the State. Two sites – Berrien and Oakland – implemented a second round of CIT training later in the first year of the grant period. Berrien developed an abbreviated 24-hour training model in order to accommodate a larger number of patrol officers from the sheriff’s office. In Oakland County, an abbreviated 8-hour training model customized for dispatchers was delivered.

Although it is not CIT (thus not included in Table 3 above), it should be noted that Monroe has had great success in training jail-based sheriff officers in Mental Health First Aide. This 8-hour training also focuses on increasing knowledge and skills and decreasing stigma, through information and scenario-based learning.

Similarities and Differences in Implementation of the Five CIT Pilots

All five CIT programs share some common characteristics.

- All programs (except Kalamazoo) are new. Kalamazoo previously implemented adult CIT within the community under the first diversion grant.
- All are focused on diverting the adult population; Kalamazoo is also focused on diverting youth population.

- Most counties are focused primarily on training patrol officers, including sheriff deputies and/or local police officers. Barry (exclusively) and Berrien County trained jail officers to complement their implementation of jail services within the county jail.

They also vary in several distinct ways.

- The types of specialty training provided. Some counties used the same training for law enforcement and dispatch while one provided a less intensive training for dispatch. One offered additional training on interactions with youth.
- The organizational unit of law enforcement trained. While all programs trained patrol officers, in some counties sheriff’s deputies were trained, while in others, local police or university law enforcement officers were trained. Jail staff was also trained. Some counties trained staff from multiple law enforcement units within the same geographic region.
- The penetration rate of CIT within the community, i.e. the ratio of officers trained in any specific geographic location in comparison to the total law enforcement staff.
- The presence/absence of a 24-hour drop-off mental health or crisis facility for law enforcement to access. In the absence of such a facility, some communities provide on-call staff to conduct assessments. In others, officers utilize local hospital emergency rooms. Generally, officers dislike using emergency rooms due to the wait time, which ties up the officers and prevents them from being out on patrol.

The CIT programs varied in the length of specialty training provided, the organizational unit of law enforcement that was trained, the percent of officers trained, the presence or absence of a 24-hour drop off facility, and the presence or absence of a community advisory council.

Table 4 below provides a glimpse of the implementation differences in CIT across sites.

| Table 4. Comparison Across CIT Sites | | | |
|--------------------------------------|--|--|--|
| County | Organizational Unit of Law Enforcement Trained | Availability of 24-hour drop off | Presence of an Advisory Council |
| Barry | County Sheriff (mostly jail staff) | No | No |
| Berrien | County Sheriff (patrol and jail staff) | No, utilize hospital ER | In process (formation of committee around grant) |
| Kalamazoo | Multiple (multiple cities plus county, one township, and university law enforcement) | No, but CMH staff are on call to do assessments 24/7; a mental health crisis unit is also available for youth 24/7 | Yes, liaison in place between all organizational units of police within the county and community mental health |
| Marquette | Multiple (multiple cities plus county and university law enforcement) | No | Yes, liaison leads advisory group comprised of representatives from law enforcement agencies within county. |
| Oakland | County Sheriff plus local law enforcement | Yes, Common Ground | No |

Is CIT Training Effective?

The goal of CIT training is to create change in knowledge, attitudes and skills of law enforcement officers in how they respond to individuals with mental illness and in their knowledge of community treatments for this population. In order to measure the effectiveness of the training, the evaluation team used two empirically derived instruments utilized by Broussard, Compton and colleagues (2011) in their evaluation of CIT in one state.

The two instruments – the *Opinions of Psychiatric Treatment (OPT) Measure* and the *De-escalation Scale* – were given to participants immediately prior to taking the training (pre-test) and then after completion of the training (post-test). A total of 118 officers took both the pre and the post test⁶. The majority were male (n=88, 75%) with an average of 14 years on the force (range from 0 to 37 years). Half (50%) of the participating officers had a Bachelor's degree. These are described in more detail in Appendix II. Outcomes of each instrument are described below.

- *Opinions of Psychiatric Treatment (OPT) Measure*
This 20-item validated measure was developed to assess the officers' attitudes and knowledge about psychiatric treatments within the community. The OPT assesses attitudes about psycho-pharmacotherapy, psychotherapy, and psychosocial interventions such as day treatment programs, residential facilities, and case management. Responses are given a six-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The possible range of scores is 20–120. Sample items include “More tax money should go to support residential facilities for people with serious mental illnesses” and “Day treatment programs may help people with serious mental illnesses recover”.
- *De-Escalation Scale*
This 8-item instrument was designed to measure: de-escalation skills. Officers' opinions on the effectiveness of specific actions in the situation were rated on a four-point Likert scale ranging from 0 (very negative) to 3 (very positive). Total subscale scores range from 0 to 24. The scale is completed in response to vignettes depicting scenarios that could realistically be encountered by patrol officers. Sample items include “Keeping some space between you and David while you talk to him” and “Arresting David for disorderly conduct”.

→ Outcomes of CIT Pre/Post Tests

Significant increases in scores from pre- to post-test for both measures would demonstrate that the training did have an impact on knowledge and skill development. To date, significant changes have been noted in skills and knowledge between pre and post training tests. Details of the results of the two instruments are described on the following page.

The goal of CIT training is to create change in knowledge, attitudes and skills of law enforcement officers in how they respond to individuals with mental illness and in their knowledge of community treatments for this population.

To date, significant changes have been noted in skills and knowledge between pre and post training tests.

⁶ There were some differences between individuals who took both the pre and post test when compared to those who only took the pre test: Those with only a pre-test had significantly lower de-escalation scores than those who took both tests (average 24 versus 26 $t(15.8)=-2.4$, $p<.05$); .

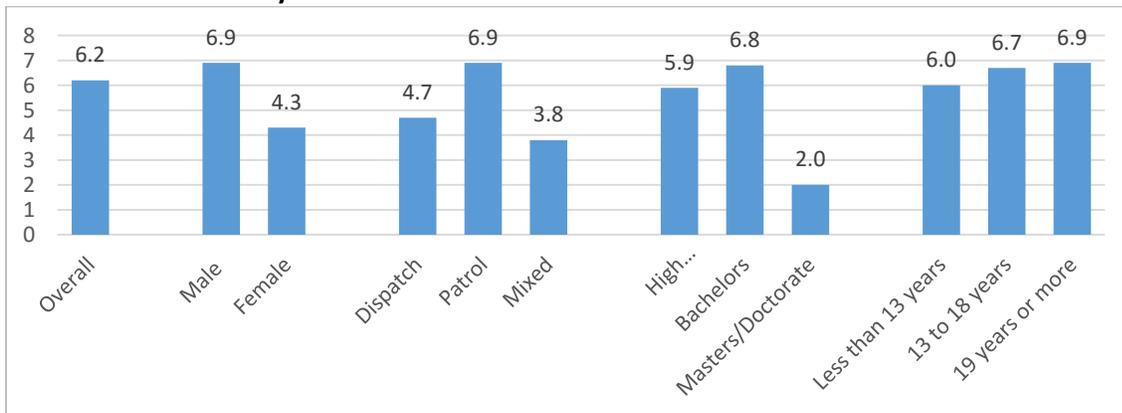
Knowledge/Opinions of Psychiatric Treatment Measure

At pre-test, the average score was 72.8 and at post-test it was 79.0, showing a statistically significant increase in the average score⁷. Since a higher score indicates greater and more accurate knowledge about psychiatric treatments for the mentally ill within the community, CIT was successful in changing officers' knowledge of mental health treatment in the community.

Examining the degree of change based on various characteristics of officers we can see some variation in the amount of change. Figure 2 below shows the extent of change in knowledge by gender, type of training, education level and years on the force that resulted due to the CIT training; the higher the number, the greater the change in knowledge. It should be noted that there was a significant difference in change scores by gender, with males demonstrating a greater increase in their knowledge acquisition.⁸ There were no significant differences in change scores on the OPT scale by education level, or number of years in law enforcement.

CIT was successful in changing knowledge of treatment in the community.

Figure 2. Change Scores in Knowledge of Psychiatric Services Between Pre- and Post-Test Overall and by Officer Characteristic



De-Escalation Scale

At pre-test, the average score was 26.1 and at post-test, the average score was 27.4, a statistically significant increase.⁹ Thus, CIT was successful in increasing de-escalation skills among patrol officers, jail staff and dispatchers.

Figure 3 on the next page shows the extent of the change in de-escalation skills by gender, type of training, education level and years on the force: the higher the number, the greater the change. There were no significant differences in change scores on the De-Escalation Scale by gender, type of officer, education level, or number of years in law enforcement.

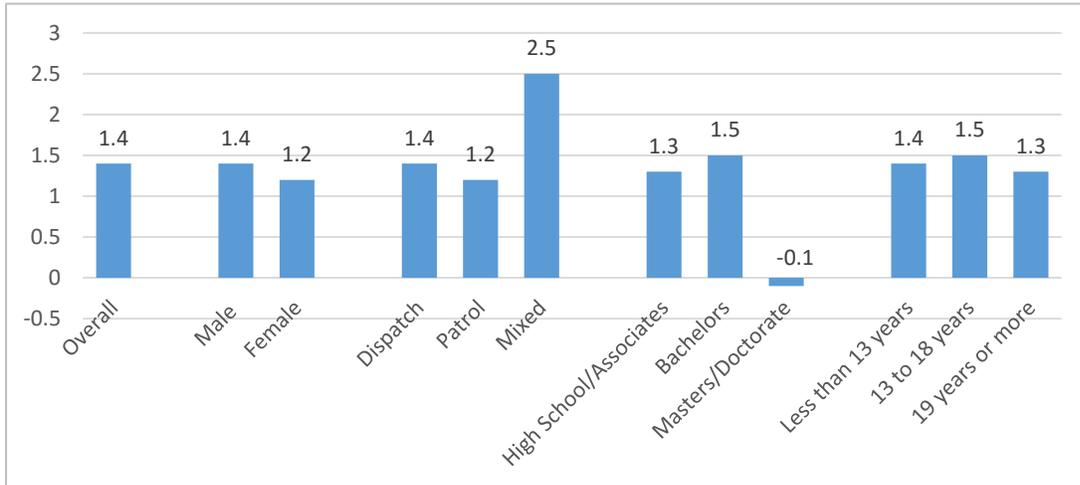
CIT was successful increasing de-escalation skills among patrol officers, jail staff and dispatchers.

⁷ Statistically significant differences suggest that the change was not a result of 'chance' and therefore the change is the result of the intervention – in this case, the training. Average change score of 6.2 ($t(117)=11.5, p<.001$)

⁸ Males increased their knowledge on the scale by an average of 6.9 points, compared to 4.3 points for females ($t(116)=2.097, p<.05$).

⁹ Again, this statistically significant result indicates the change was not a 'chance' occurrence. Average change score of 1.3 between pre and post ($t(116)=-6.135, p<.001$).

Figure 3. Changes in De-Escalation Scores Between Pre- and Post-Test Overall and by Officer Characteristic



Differences in CIT Training Outcomes by County

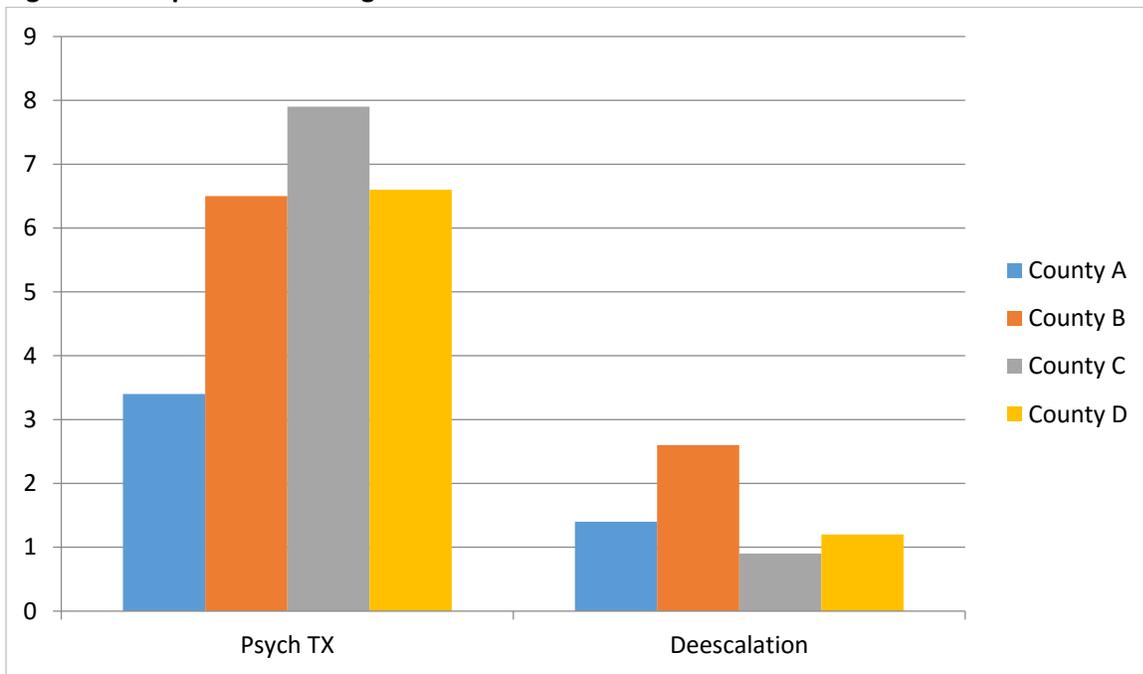
While the evaluation did not set out to compare counties to each other, a natural experiment is occurring among the pilot sites because of the differences in the trainings being offered across the counties.

To understand whether there is any variability in training outcomes across the sites, differences in pre/post test scores of patrol officers (n=87) on the two scales were examined. Patrol officers were chosen across sites to increase the similarities for this comparison. The majority of these officers were male (n=77, 86%). Approximately one-third of these officers had been in law enforcement for less than 13 years (n=31, 36%), one-third between 13 and 18 years (n=29, 33.7%), and the remaining third had been in law enforcement for 19 years or longer (n=26, 30%).

Figure 4 on the next page illustrates the variation in change scores (improvement between pre and post) between four of the five counties involved in CIT training. There are differences in improvement in training between sites, for example County A had a change score of 3.2 on the Opinions of Psychiatric Treatment scale compared to 7.9 for County C. However, these differences on both scales are not statistically significant. The lack of statistical differences in these scores could be a reflection of small numbers in some of the counties. However, these differences should be monitored over time as more training is completed because factors such as training length could create differences in these short term outcomes.

Variation in change scores could be related to variation in training across sites and should be monitored over time.

Figure 4. Comparison of Change Scores Across Counties



Lessons Learned: What Needs to be Considered When Proposing, Implementing and Evaluating CIT?

Enhancing the knowledge and skills of law enforcement officers in relation to persons with mental health problems is an important endeavor. In many communities, officers have discussed the absence of such information in the academy or in subsequent training. Pre/post-tests demonstrate that officers are gaining new knowledge about community resources and treatment as well as skills in de-escalation. ***But will this new knowledge and skills lead to diversions from jail? And, will officers utilize treatment options within the community?***

The wide variations within the CIT programs being implemented across the State under this Jail Diversion pilot, as suggested by the data being collected, along with a review of the literature, suggests **multiple factors that should be considered when implementing and assessing the outcomes of CIT interventions**. These training, community, and measurement level factors are important as they not only impact a community’s capacity to fully implement CIT but also to evaluate its outcomes in relation to the goal of diversion. These factors include:

CIT Training Factors

1. **Hours of training.** Although the RFP from the State

Enhancing the knowledge and skills of law enforcement officers in relation to persons with mental health problems is an important endeavor. But will new knowledge and skills lead to diversions from jail? And, will officers utilize treatment options within the community?

requested 40-hour CIT training, some counties have found that the cost and officer time associated with a 40-hour training was too great and have developed more concise training modules. The variation in training hours may affect the desired outcomes.

2. **Unit of law enforcement trained and relationship between law enforcement units within the county.** Roles of various law enforcement agencies within a particular county differ, as does the working relationship between the agencies. Decisions about which officers to include in CIT training should consider the role of the law enforcement agency and the desired outcome of the intervention.
3. **Patrol or jail officers.** The target of the training should be considered (i.e., whether it is focused on community patrol officers, jail officers, or both), as outcomes may differ based on the role of the officer.
4. **The proportion of officers trained.** Counties training fewer officers may take longer to realize change than those training a higher proportion of the law enforcement officers. Although the impact on the law enforcement organization may be substantial, short-term outcomes are difficult to realize in communities with fewer trained officers.
5. **Include dispatch in training and planning.** The inclusion of dispatch in both planning and CIT training will aid in implementing CIT within the community. Dispatch staff who can identify a mental health problem can proactively request that a CIT-trained officer respond to the call. Dispatch codes may also need to be modified to accurately reflect mental health-related calls or diversions as CIT is implemented within the community.

Community-Level Factors

1. **24-hour drop off.** The availability of an emergency drop-off site for community law enforcement (or equivalent resource) that makes it easy for officers to divert an individual with mental health needs from jail is helpful. The lack of psychiatric beds in the community may also impede alternatives to incarceration.
2. **Relationship between dispatch and law enforcement.** The relationship and structural interface between dispatch and the unit of law enforcement being trained needs to be considered. In particular, whether there is a corresponding training of dispatchers, and if data on the number and outcomes of mental health-related calls can be collected.
3. **Active advisory council.** The presence of an ongoing advisory council comprised of criminal justice and mental health professionals and advocates can enhance implementation as well as ongoing success and sustainment.
4. **Develop specific outcome objectives.** Many studies have demonstrated few effects of CIT on arrest. Prior to CIT, many officers in community settings seem to be using jail as the last resort for those identified as having a mental health problem (after first using community alternatives and hospitals), so defining decreased arrests as an outcome may not be the best measure for some communities. However, there are other possible outcomes and reasons to employ CIT model of training within the community. CIT exposes officers to new information about availability of other community resources/treatments, as well as needed de-escalation skills. Identification of intended objectives should be clear prior to execution.

Measurement Factors

1. **A concrete definition of diversion.** Several questions arise when considering measurement of outcomes: Is any interaction with law enforcement synonymous with arrest or the potential for arrest? Is diversion defined solely as an absence of arrest/jail during an encounter with law enforcement? Is clear evidence of a 'crime' required for diversion?
2. **Mental health code in police/dispatch data.** Coding of law enforcement/dispatch records that indicate that a 'mental health' problem was identified. Awareness of mental health and an increase in the number of law enforcement calls coded as 'mental health' could imply greater diversion.
3. **Access to police data/information.** Assessing various diversion activities by law enforcement requires access to specific information from police records (or alternatively, training of 'liaisons' to capture such data). In addition, multiple organizational units of law enforcement involved (i.e., city, township, county, university) complicates data collection and permissions for access.

IV. IMPLEMENTATION OF JAIL SERVICES INTERVENTIONS (INTERCEPT 3)

Jail-Based Services as an Intervention Model

Jail services conceptualized in these proposals are aimed at diversion. Per the initial RFP priority consideration, jail services “focus on more comprehensive and enhanced mental health treatment for those in jail and transitioning out of jail. Efforts funded under the proposal may include access to psychotropic medications, bolstered housing efforts, minimal wait times for doctors/psychiatrists, increased support systems and enhanced educational and vocational opportunities.”

It is hypothesized that establishing or enhancing jail-based mental health services for persons with mental health disorders will help stabilize individuals in crisis, enhance engagement in community-based treatment and improve community functioning, thereby, reducing future recidivism.

Sites Implementing Jail Services: What Are They Providing?

Seven of the eight sites are implementing some type of jail services. Programs vary along four dimensions: whether engaging in activities that will result in a current vs future diversion; whether implementing a new program or continuing or enhancing an existing program; the type of service model being implemented (i.e., advocacy, supportive services such as referrals and crisis support, or treatment); and the organizational structure of jail mental health services prior to the grant award. As with CIT, the specific jail services model chosen by each county, as well as how the program was implemented, resulted in wide variability across the sites.

Table 5 on the following page summarizes the jail programs being offered in the seven sites. A detailed description of the jail services program implemented within each county is provided in Appendix I. This grant represents the first time community mental health providers were permitted to deliver services within the jail in Barry, Berrien, and Wayne counties. The enhanced collaboration between CMH and jail administrators resulted in providing space within the jail and/or expedited access to the jail for diversion team members.

Table 5. Comparison of Jail Services Programs Across Seven Sites

| | Current vs Future Diversion | | New Program | Model | | | |
|-----------|-----------------------------|--------|-------------|-----------------------------|---------------------------------|-------------------------------|---------------------|
| | Current | Future | | Advocacy | Treatment | Supportive Services | |
| | | | | Advocates for Early Release | Full Treatment Provided In Jail | Discharge Planning & Referral | Discharge Follow-Up |
| Barry | | X | X | | | X | X |
| Berrien | | X | X | | | X | |
| Kalamazoo | X | X | | X | | X | X |
| Kent | X | X | | X | X | X | X |
| Marquette | | X | X | | | | |
| Monroe | | X | X* | | | X | X |
| Wayne | X | X | X | X | X | X | X |

*Monroe had an existing jail program, but has expanded it to be available to formerly ineligible persons.

*Barry and Berrien Counties engage in some advocacy efforts, but it is not a primary function of the program.

→ **Current vs. Future Diversion**

Diversion activities can be viewed as either current or future. A current diversion is when an individual’s current jail time is reduced due to some activity by jail or mental health staff. Future diversions are activities such as treatment within the jail or linkage to community resources that will promote reductions in subsequent (future) jail time and recidivism. Both definitions of diversion are being used across the various sites within Michigan.

Three of the seven sites – Kalamazoo, Kent, and Wayne – are engaged in current diversion activities. Current diversion activities generally encompass some kind of advocacy and intervention when the individual is booked into the jail. This may entail speaking with the prosecutor or judge or working with the individual’s community case manager. All of these advocacy activities are dependent upon strong screening and case finding processes within the jail.

All of the sites are focused on providing services that will result in decreasing recidivism and, thus, future diversions. Sites are using grant funding to either begin or augment services within the jail. Programs vary by site but include enhancements to services within the jail, discharge planning, and/or case finding. Barry implemented mental health and substance abuse treatment groups within the jail.

Berrien and Monroe added a CMH liaison within the jail who is working to identify and assist individuals identified as having a mental health problem. Marquette expanded its Moral Reconciliation Therapy (MRT) program to those serving jail sentences. Wayne added new services within the jail to assist with case finding and identification.

A **current diversion** is when the individual’s current jail time is reduced due to some activity by jail or mental health staff. **Future diversions** are activities such as treatment within the jail or linkages to community resources that will promote reductions in subsequent (future) jail time and recidivism. Both definitions of diversion are being used across the various sites within Michigan.

→ **Continuation, Enhancement or New Service**

Two sites – Kalamazoo and Kent – focused on existing jail mental health programs, either continuing or enhancing the services already in place. The remaining five sites – Barry, Berrien, Marquette, Monroe, and Wayne – focused on new jail mental health programs or new service components.

→ **Type of Service Model Used**

Each of the grantees proposed differing service models containing various elements to be provided through the grant. The various models of intervention included:

- Advocacy, which focuses on current diversion or release from jail for persons with mental health disorders. Jail-based advocates focus on case-finding within the jail.
- Treatment, which focuses on providing a full continuum of mental health treatment within the jail by mental health professionals.
- Supportive Service, which focuses on providing crisis counseling, referrals and community linkage.
- Combined, which provides one or more of the above.

This grant represents the first time community mental health providers were permitted to deliver services within the jail in Barry, Berrien and Wayne counties. The enhanced collaboration between CMH and jail administrators resulted in providing space within the jail and/or expedited access to the jail for diversion team members.

→ **Organizational Structure**

In some county jails, prior to diversion funding, mental health services were funded and/or contracted directly by the jail/sheriff and not by a CMH organization. In other counties, a CMH provider was providing mental health services within the jail. In still other counties, partnerships existed between existing jail-funded or contracted services and CMH staff/providers. Figure 5 below illuminates the organizational variation in mental health services within the jail prior to the diversion grants.

Figure 5. Variations in How Mental Health Services Were Provided Prior to Diversion Grant Funding



Each of these organizational structures provided challenges and opportunities for grantees. Counties that used diversion funding to alter their pre-existing organizational structure had more demanding implementation issues to overcome prior to service delivery. The grant funding and determination to

improve outcomes within the county have led to more collaborative processes in all sites, as shown in Table 6 below.

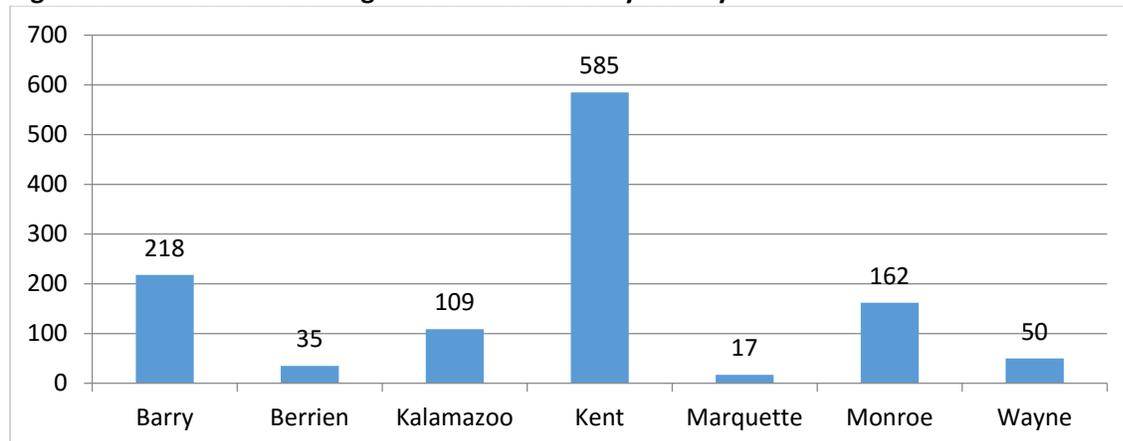
| Table 6. Changes in Organizational Structure of Mental Health Services Within Jails | | |
|---|----------------------------|----------------------------|
| County | Pre-Award Structure | Post-Award Structure |
| Barry | Jail Supported | Collaborative |
| Berrien | Jail Supported | Collaborative |
| Kalamazoo | Collaborative | Collaborative |
| Kent | Collaborative | Collaborative |
| Marquette | Jail-Supported | Increasingly Collaborative |
| Monroe | Collaborative | Collaborative |
| Wayne | Collaborative/CMH Support* | Collaborative |

*Note: Wayne has had general funding from CMH prior to this award, but this award enhanced collaboration between one provider and the jail.

Numbers of People Served in Jail-Based Programs Across Sites

Figure 6 below depicts the number of individuals by county receiving services paid for through this specific diversion funding. The wide variety in the numbers being served is in no way indicative of the quality or intensity of the services being provided, but is instead the result of how each county defines diversion (current vs future) and how data is reported.

Figure 6. Individuals Receiving Diversion Services by County



A comparison between Barry and Kalamazoo illustrates the variation in how diversion is defined and who is counted. Barry, for example, is establishing new mental health services in the jail, providing mental health and substance abuse group interventions. Each CMH consumer who attends one of these group sessions or who is seen by the mental health professional is counted as someone who receives services as a result of the grant. The county defines this as an activity toward a future diversion.

In contrast, Kalamazoo has a long established jail-based intervention program. Grant funds allowed them to add a second mental health professional to their program. These two professionals have provided services to over 1,200 individuals. But since Kalamazoo’s activities with these individuals span a broad array that includes court advocacy, medication assistance

The wide variation in the number of individuals receiving services is the result of how each county defines diversion (current vs future) and how they report their statistics.

and resource/referral, they are counting only individuals who are true current diversions – in other words, those whose jail stays are shortened due to the efforts of the jail mental health staff.

Recognizing these wide variations in the numbers and to further understand the differences across sites, the evaluation team has asked Kalamazoo to include information on future diversion services. This would include discharge referral services provided non-CMH consumers who are in need of support or treatment within the community because in the process of providing discharge referrals with these individuals, they are engaging in activities associated with future diversions.

Assessing the Need for Mental Health Services: Objective and Expressed Need

Some counties struggled to clearly articulate the need for mental health services in their proposals because measurement of mental health problems was not always routinely collected within the jail. Moreover, because jails use various methods for assessing mental health problems, the numbers across counties were difficult to define, interpret or compare.

→ Objective Need vs Expressed Need for Mental Health Services

Because of these variations in methods used to screen for mental health problems across county jails, the evaluation team was interested in using an objective measure that would ensure consistent measurement across sites. All jails agreed to use the same validated short screening measure, called the K6, for a specified period of time to screen all persons booked into their jails. Therefore, **objective need is defined as the number of individuals identified as having a serious mental health problem through the use of a empirically validated screening instrument.**

Each jail also has its own process for identifying and screening for potential mental health problems and a corresponding process of referral to a mental health professional. This number is referred to as the **expressed need - or the number of individuals that jail personnel have identified as needing professional screening and potential services in the course of 'business as usual'**. Articulating the differences between *objective need* and *expressed need* would show if the jail is identifying those with mental illness within the jail (expressed need) in a proportion similar to the objective need determined with the K6 screening instrument.

Table 7 on the following page illustrates the differences in each county between objective and expressed need. Note that the final column shows the percent difference between the objective need (K6) and expressed need (number actually screened for mental health within the jail). A positive percent indicates that the sites are identifying a greater number of persons with mental illness than would be anticipated using the K6. It is noted that K6 collection was not conducted in Oakland County due to the county's sole focus on CIT under this grant.

| Table 7. Estimating the Mental Health Service Needs In the Jails, Overall and by Site | | | | | | |
|---|---------------------------------------|---|--------------|--|--------------|--------------------|
| | Total Jail Bookings: Six Month Period | Objective Need Number and Percent of Estimated Need for Mental Health Services Based on K6 | | Expressed Need Number and Percent of Persons Referred for Jail Mental Health Services | | Percent Difference |
| | | # | % | # | % | |
| COUNTY | 42,202 | 11,047 | 27.9% | 10,244 | 24.3% | -3.6% |
| Barry | 1,044 | 175 | 16.8% | 200 | 19.2% | +2.4% |
| Berrien | 3,701 | 1,406*** | 38.0% | 342 | 9.2% | -28.8% |
| Kalamazoo | 6,473 | 1,443 | 22.3% | 1,277 | 19.7% | -2.6% |
| Kent | 12,396 | 2,628 | 21.2% | 4,240 | 34.2% | +13.0% |
| Marquette | 857 | 320 | 37.3% | 77 | 9.0% | -28.3% |
| Monroe | 3,179 | 1,014 | 31.9% | 900** | 28.3% | -3.6% |
| Wayne | 14,552 | 4,060 | 27.9%* | 3,208 | 22.0% | -5.9% |

* Note: Due to reliability issues associated with the screening in Wayne County, we have used the state average as the predictor of need.

** Note: Monroe is currently refining their data reporting and this number is to be verified.

***Note: K6 screening in Berrien was conducted later in the jail process at classification, while all other sites collected earlier in the jail process at booking. This later collection could potentially yield a higher rate of need for mental health services.

→ Why Are ‘Objective And Expressed Need’ Important to Understand?

The data show that in some counties there is congruence, or near congruence, between the measures of objective and expressed need for mental health services in the jail. In other words, the percent of individuals identified as having a severe mental illness via the objective assessment screening tool, the K6, is close to the percentage of individuals needing mental health services as identified via the jail’s own screening methods.

In other counties there are a greater number of individuals with mental health concerns found in the jail than would be anticipated from the objective assessment (K6). In still others, the expressed need – the number identified via the jail’s own screening tool - is far lower than the estimated objective need. Each of these scenarios is explained in greater detail in individual county reports found in Appendix I.

While variation in some counties may be attributable to when and how mental health need is measured or identified within the jail, these numbers assist in facilitating planning processes for mental health identification and services within the jail and, as such, understanding why there is incongruence is important. If identification is the issue, amending the initial screening process at booking will remedy the incongruence by improving detection. Similarly, a lack of resources within the jail to conduct screening and assessments may be solved through increased collaboration with CMH.

In February 2016, a second round of data collection at all of the jails will determine if the proportions of objective need remain consistent over the course of the year. These findings will be presented in the short-term outcomes report to be provided to the Diversion Council in fall 2016. Note that in the individual county reports in Appendix I information on objective and expressed need is provided and may be helpful to county administrators in revealing continued unmet need.

Commonalities and Differences Across the Seven Jail Services Pilots

As described earlier, the jail services programs across the seven sites varied in terms of the scope and services provided.

- Just three programs - Kalamazoo, Kent, and Wayne - actively advocate for the early release, or diversion, of individuals from jail to treatment (i.e., current diversions).

- Two counties - Kalamazoo and Kent - had jail-based program services that were already in existence while other programs are new. These new programs are being used to strengthen or implement screening, referral, assessment, and/or case finding.
- Some programs provide mental health treatment within the jail, while others offer in-jail crisis-related services such as referral, support, and linkages with community providers.
- Some programs – Barry, Kalamazoo, and Kent – are considered to be the mental health unit for the jail, providing all mental health and substance abuse treatment for inmates. All other programs operate in tandem with an existing mental health unit.

However, whether new or existing, all programs share the following characteristics:

- All programs are considered to be post-booking diversion programs. There are no pre-booking diversion activities in place at any of the pilot sites at this time.
- All programs provide services within the county jail.
- All programs are accessible to all inmates experiencing mental health concerns, regardless of whether they are considered to be a Community Mental Health consumer.
- Most programs offer some level of discharge planning prior to jail release. The only exception to this is in Marquette, where these services are provided by the jail mental health unit.

All programs are post-booking diversion programs, provide services within the county jail, and are accessible to all inmates regardless of whether they are a CMH consumer. Most offer some level of discharge planning.

Lessons Learned: What Needs to be Considered When Proposing, Implementing or Evaluating Jail-Based Diversion Services?

An absolute strength of the diversion pilots is the enhanced collaboration between CMH and local law enforcement/jails across counties. This is particularly true of jail services, when CMH was involved in providing within jail services in three counties for the first time. **In investigating the efficacy of these efforts toward the goal of diversion (current or future), the evaluation team will be assessing the long-term recidivism and treatment engagement of individuals who received direct services from staff supported with pilot funding**

As with CIT, there is wide variation across counties in the scope of jail services being implemented, as well as wide variation in how data is collected. These variations serve to highlight some factors that need to be considered when implementing jail-based diversion services. Again, as with CIT, these are important as they not only impact a community’s capacity to implement jail-based services, but

An absolute strength of the diversion pilots is the enhanced collaboration between CMH and local law enforcement/jails across counties.

also to evaluate outcomes.

Jail-based Service Factors

1. **Jail intervention type.** Jail services across the counties encompass various types of services and intervention strategies (advocacy, treatment, or supportive services). Outcomes will likely vary by type of intervention strategy. For example, some provide advocacy and little treatment, while others provide considerable treatment and little advocacy. Still others provide supportive services and referrals, but little in the way of advocacy and treatment. Distinguishing between these various strategies may lead to greater accuracy in determining what works in diversion.
2. **Identification and screening of mental health within the jail.** Variation and accuracy in mechanisms within the jail to detect mental health problems can result in wide variation in need estimates. Moreover, dependence on subjective measures may result in 'missed opportunity' for intervention. Automated screening systems may provide jail personnel with pertinent information, but the ability to attain and share that information within the jail is generally limited. Processes for detection and screening can be reviewed and/or refined. A first step could be examination of the 'objective and expressed needs' data in this report to assess discrepancies between what was found with the valid screening measure and who was identified within the jail.
3. **Coordination of care within the jail.** County sheriffs responsible for jail administration have enacted various strategies for meeting the mental health needs of detainees. Sometimes this includes the CMH and sometimes it does not. When CMH is not involved, it results in either hiring professionals as employees of the jail or contracting with a private health/mental health services entity for services. When CMH providers are working with other mental health professionals within the jail there is another level of collaboration necessary between mental health professionals. Regardless of what mechanisms are used, clear lines of operation need to be developed so that jail staff and administrators know where and how to refer individuals.
4. **Time to build rapport and trust prior to diversion advocacy.** Establishing a mental health presence within the jail was challenging for counties in which a relationship did not exist before the grant. Time to establish these relationships and build rapport may be necessary before advocacy services can be delivered. Therefore, whether CMH jail services were newly acquired versus enhanced under this grant will be a salient factor in measuring outcomes. There may be a continuum in the jail/ CMH relationship that begins with allowing CMH providers to enter the jail to provide services in order to build trust. Only after trust has been established does it become possible for CMH professionals to successfully advocate for diversion.

Establishing a mental health presence within the jail was challenging for counties in which a relationship did not exist before the grant.

Community-Level Factors

1. **Advisory council.** A community-level advisory council is an important factor to aid in implementation or problem-solve ongoing issues. Comprised of criminal justice and mental health professional and advocates, the advisory council acts as a mechanism for communication between direct practitioners (jail and CMH) and decision-makers in both sectors. The absence of

this council results in delays in implementation and limited options for problem-solving concerns

2. **Availability of a comprehensive continuum of services.** Most county administrators discussed issues between what might be considered best practices and what was available in the community. For example, there was nearly a unanimous exclaim over the shortage of psychiatric beds across the state and issues with the discrepancies between jail and CMH formularies for psychotropic medications. There are two concerns: 1) the lack of available beds may impact jail programs as the lack of treatment options results in jail as a last resort, and 2) medication instability as a result of changing drugs, will result in behavioral issues/subsequent charges within the jail.
3. **In-reach/outreach services.** Although research discusses the importance of relationship building in order to form therapeutic alliance, there are few CMH resources available for staff to engage in either in-reach or outreach services with CJ-involved consumers. Sometimes, even if resources are available, there are obstacles with jail access. Furthermore, outreach activities in the community allow CMH staff to pursue consumers in their home environment, to encourage continued service involvement as well as to support the individuals' needs. Some counties have figured out ways to engage in in-reach, outreach or both – hypothetically decreasing psychiatric instability.

Measurement Factors

1. **Definition of diversion.** The number of diversions and how it can be quantified will depend on how diversion is defined. There can be multiple definitions, but a common understanding of how diversion is defined and measured will be necessary to assess outcomes. For purposes of this report, and future outcome studies, the evaluation team has coined the terms 'current' and 'future' diversions to differentiate activities/services that result in a current reduction of jail time versus future diversion which is defined as services that are likely to reduce future recidivism.
2. **Program definition.** The variation of jail service programs provides a rich tapestry of possibilities for replication. However, replication – and measurement of outcomes – will be restricted if counties are not able to articulate a specific model of intervention. For example, is one service or contact considered a program? Will this contact lead to enhanced diversion outcomes? How do sites providing a wide range of services (i.e., referral to intensive case management) differentiate the intensity of services delivered (i.e., high, medium, and low level services)? When does an individual successfully complete the program or is this defined by the number of days, services, type of services, or some other action (i.e., discharge from jail)? Due to variation in implementation from what was initially proposed, the evaluation team is working with individual counties to produce a definition of the program and to operationalize the intensity of program services.
3. **Tracking recidivism and mental health outcomes.** Specified outcomes for diversion programs are reductions in recidivism and engagement in mental health treatment. Tracking jail recidivism at six-month and one-year intervals can be achieved through data extraction from jail management information systems. Tracking continued engagement in mental health service utilization post-release from jail will be conducted through use of 'encounter' data from the statewide CMH data. However, for individuals who are not enrolled in CMH services, tracking utilization will be extremely difficult. Access to physical or mental health data from private

practitioners will be prohibitive, unless Medicaid eligible individuals can be tracked within the states data warehouse. In addition, tracking psychiatric functioning and medication adherence in community settings will not be possible in this evaluation design, but should be considered in subsequent studies.

V. INTERVIEWS WITH COMMUNITY STAKEHOLDERS

In August 2015, interviews focused on implementation issues were conducted by telephone with criminal justice and/or community mental health stakeholders at seven of the eight Jail Diversion project sites including Barry, Berrien, Kalamazoo, Marquette, Oakland, and Wayne Counties. The purpose of these interviews was to learn more about the process each site had undertaken to implement their project. Implementation interviews were not conducted with Kent County because their diversion program was an existing program.

Each interview lasted on average 60 minutes and focused on the primary objective of each site (i.e., either jail services or CIT). Questions were asked about the following:

- Highlights of the project to date.
- Aspects of the project which were unanticipated or surprising.
- Problems or barriers to implementation.
- The level and kinds of collaboration that have been achieved to date.
- Additional supports that would benefit implementation of the pilot.
- Any advice sites would offer to others who are considering implementing a diversion project.

Program Highlights

Stakeholders were asked to describe three or four highlights of the project to date. Four themes emerged: collaboration, service enhancement, positive impact of services, and sense of accomplishment.

→ Collaboration

All stakeholders commented on the increased sense of collaboration that has occurred between the community mental health and criminal justice systems. Comments such as *“It feels like we are now both trying to achieve the same goals”* and *“The collaboration is far better than we ever dreamed it could be”* were shared throughout the interviews. As one community mental health stakeholder said, *“the relationships are key”* to success.

All stakeholders commented on the increased sense of collaboration that has occurred between the community mental health and criminal justice systems.

The amount of collaboration between staff members/administrators within the criminal justice system was highlighted by both criminal justice system and community mental health stakeholders. More than one stakeholder described conversations they witnessed between criminal justice staff about how *“we need to do things differently now.”* One criminal justice stakeholder described being approach by a jail

inmate who told him that *“this mental health program you’ve got going on, it’s the best thing that’s been done in the jail in a long time.”*

→ **Service Enhancement**

In submitting their proposals to the State for consideration, sites were given the opportunity to select one or more points along the Sequential Intercept Model to expand services to individuals suffering from mental illness. Regardless of which point or points they selected, the opportunity to expand services to these individuals was something that both community mental health and criminal justice stakeholders described as a major highlight of the project.

As noted earlier, while there was some activity across all intercepts, the majority of proposals concentrated on Intercept 1, offering CIT training, or Intercept 3, solidifying in-jail mental health services or expanding the number of inmates who received mental health services in the jail. Some also focused on Intercept 5, expanding community-based services such as housing coordination or mental health groups, both of which offer an increased opportunity for inmates with mental health issues to succeed once they are released. Two projects are using peer support specialists to engage consumers upon release, help them secure housing and ensure that they stay linked with community mental health services.

Although CIT was viewed as a service enhancement, getting CIT off the ground proved complicated for all of the sites who implemented it. As one stakeholder said, *“It will take years of work.”* But all believe it is making a difference. As one criminal justice stakeholder commented, *“It gives you an open mind on how to deal with the mentally ill.”*

One community mental health stakeholder expressed surprise that more jails do not train their staff in CIT. Trained jail staff are good at spotting consumers in the jail who need mental health services. *“They are our eyes and ears when we [community mental health] can’t be there.”*

“CIT gives you an open mind on how to deal with the mentally ill.”

→ **Positive Impact of Services**

Once services were in place, stakeholders from the sites implementing jail services began to see the impact. One community mental health stakeholder now has an office in the jail and a key to the main door so staff can come and go as needed. Another stakeholder talked about going from serving no consumers in the jail at the start of the project to now having served over 50. As one stakeholder commented, *“Seeing someone enter recovery, when we can negotiate them out of jail and into recovery”* is one of the things of which he is most proud.

Three sites who provided either CIT or Mental Health First Aid training commented on the positive outcomes they have witnessed or heard from officers who participated. As one community mental health stakeholder said *“It humanized people with mental illness for them.”* One stakeholder described seeing a difference in how the corrections officers are approaching the inmates. Inmates at one site commented to community mental health staff on the new way that corrections officers are handling people who are decompensating. One community mental health stakeholder noted that as far as she knew, no training had previously been provided to law enforcement on how to interact with people who are mentally ill and in crisis. However, since the training, several of her staff members have noticed how the police are de-escalating situations with her agency’s consumers.

In at least three of the sites, stakeholders described ways in which community mental health stakeholders have been extremely responsive of the needs of the criminal justice staff. One community mental health stakeholder has given all of the police chiefs in the county his personal cell phone number. Another community mental health stakeholder described getting an email on a Friday night from the jail regarding a consumer who was about to be released. The jail was concerned about the individual being released into the community without a service plan in place. The community mental health staff contacted his team members and, that evening, coordinated services so that the individual would be engaged in care upon release. As the stakeholder said, *“We didn’t get the call on the front end but at least we got it on the back end and were able to help.”* At another site, a criminal justice stakeholder described contacting their community mental health contact because of an in-jail death. *“She was there within 30 minutes. There’s no contract for her to do this, but I called and she said ‘I’ll be right over.’”*

→ **Sense of Pride in Implementing the Project**

All stakeholders spoke with a great sense of pride about successfully implementing their pilot programs. For one community mental health stakeholder, there was pride in being able to move the dialogue with local criminal justice stakeholders through a conversation about past failures of the agency and toward what is now possible with the renewed collaboration. For several, there was a sense of pride in accomplishing complex hiring or contracting processes. For a few, it was the fact that the proposed services were new to their community and they had no idea what to expect. As one community mental health stakeholder said, they had to *“tackle the hurdle of being able to go into the jail and provide services, be welcomed into the jail, and be able to coordinate with the jail.”* But throughout all of the interviews, even for those who had not been able to implement everything that they had planned, there was a deep sense of accomplishment.

All stakeholders spoke with a great sense of pride about successfully implementing their pilot programs.

Unexpected Aspects of the Project

Stakeholders were asked about some of the most unexpected aspects of the project. Collaboration emerged as one, as did time, some of the limitations they encountered, but also a sense of personal fulfillment.

→ **Collaboration**

In addition to being a highlight, collaboration was also frequently mentioned when stakeholders were asked about the more unexpected aspects of the project. Six sites noted their surprise at the level of cooperation and collaboration that they are experiencing. Phrases such as *“how everyone is supportive of this project,” “the relationships we now have,”* and *“the relationship the jail now has with community mental health”* were their immediate responses to this question. One stakeholder noted that *“we weren’t really expecting to be surprised by anything”* and yet they too were surprised at how much cooperation they are receiving from the jail. When asked why they thought this was the case, they concluded that it was *“because we are actually solving the problem.”* One criminal justice stakeholder, after describing the positive relationship they have with

The level of cooperation and collaboration the sites experienced was unexpected.

their community mental health agency, expressed dismay that the vast majority of jail administrators he talks with do not have this.

→ **Time**

The amount of time it takes to implement the project and manage a grant of this scope and size was something that was also unexpected. This includes the time it takes to: build and maintain the relationships; hire and retain the right staff; get the K-6 screening data collection implemented; figure out all the budgeting and contractual components of grant implementation; and do the data collection. For those sites implementing CIT, the time it took to coordinate the trainings and identify presenters was beyond what they had expected. (This is described in more detail in the Problems section.)

The amount of time it takes to implement the project and manage a grant of this scope and size was unexpected.

For each site, the level of time spent on implementation of the pilot program depended on several factors including the relationships that were already in place between the lead agency (community mental health) and the criminal justice system; the ability of staff to focus on this project in the context of their other work responsibilities; logistics such as locating a space in the jail to work; and getting clarity on exactly how the project would work, such as how referrals would come from the jail to the community mental health agency or how services would be implemented within the jail.

→ **Limitations**

As noted earlier, stakeholders expressed disappointment in not being able to implement everything they had planned for the pilot or at the pace at which they had intended. For all sites, this was due in part to time. The fact that this was a one-year grant increased the pressure to be up and running quickly. For example, there was no room in this timeframe to compensate for the very real challenges of locating and hiring staff. One site described receiving a considerable number of applications from recent college graduates who did not have the experience she believed essential to work in a jail. *“I had a lot of apprehension hiring someone too green given the population we are working with.”* When she did finally find the right person, they ended up taking a different job, so the search started all over again. Another stakeholder echoed this. *“You can’t give the jail just any mental health worker. It’s very complex work.”*

An unexpected limitation encountered by one of the sites that implemented CIT was union contracts. Participating in CIT training is not part of the union contracts for officers and therefore required overtime. Another unexpected limitation, encountered by one pilot program that encompassed a housing component, is that landlords are often afraid to take renters with criminal backgrounds, particularly anyone convicted of using methamphetamines. Both of these limitations impacted the capacity of the lead agency to implement the program as fully as they had intended.

“I feel like I am making a difference. I haven’t felt that in a long time.”

→ **Personal Fulfillment**

Two community mental health stakeholders offered that this project has given their work new meaning and importance. Despite the challenges and frustrations, they were amazed at how much energy and life it has brought

to their careers. One stakeholder commented that *“This is work worth doing.”* The other stakeholder echoed this sentiment, noting that this project has given her a sense of purpose. *“I feel like I am making a difference. I haven’t felt that in a long time.”*

Others perceived a noticeable difference in the law enforcement officers who had been trained in CIT. *“It has sparked a shift in them. They are now wonderful advocates for CIT.”*

Problems With or Barriers to Implementation

When asked to describe any problems or barriers the stakeholders had encountered in implementing the project, five themes emerged: time and logistics with CIT; systems issues with CIT implementation; resistance; data management; and barriers to accessing needed community services.

→ Time and Logistics of CIT

Even with sites that had experience in bringing projects to scale quickly, those that implemented CIT were unprepared for the amount of time the program requires to get off the ground. One stakeholder shared that he and his staff worked 16 hours/day for every day the CIT training was offered, plus the Sunday before and the Saturday after. This did not count the months it took to identify and recruit the 30 speakers needed to present 26 different modules, nor the time it took to clean and paint the facility where the training was to be held.

Finding speakers who are comfortable presenting to police officers also proved to be challenging. As one stakeholder noted, *“Law enforcement officers are the hardest to teach. If you are not an expert, they will call you out on it. They must respect you in order to listen to you.”*

All stakeholders who implemented CIT talked about the challenges of implementing a training of the scope and size of CIT within the complex processes and policies of their various local law enforcement agencies.

The time required to attend CIT was also a problem. One site did not get the number of attendees they had hoped as it *“took too much time”* for them to attend, even though there was considerable excitement about it. A community mental health stakeholder discussed the challenge of educating other community stakeholders about the value of CIT, as it is difficult to translate CIT training into a specific number of diversions.

→ Systems Issues with CIT Implementation

All of the stakeholders who implemented CIT talked about the challenges of implementing a training of the scope and size of CIT within the complex processes and policies of their various local law enforcement agencies. The most frequently cited challenge was the cost to individual police or sheriff departments to send officers to CIT training. Many sheriff departments around the state have contracts with communities to provide a minimum number of policing hours per week. Pulling officers off the street to attend a CIT training requires that these positions be filled with other officers to ensure that the appropriate level of policing is maintained at all times. Not all departments have sufficient overtime funding in their budgets to pay for this. As a solution to these issues, many communities opted for shorter training periods (i.e., two days) rather than the 40-hour training that is considered the ‘standard’ treatment model.

→ **Resistance**

The challenge of back-filling police positions for training was not the only barrier to implementation of CIT. Several sites discussed resistance from officers, primarily as they did not understand what the training was about.

Just one community mental health stakeholder described resistance to implementing diversion services in the jail. But, as this stakeholder reported, it did not seem to be opposition to the program itself. Instead, it was because *“so many things start up and then end. But they are seeing the results now. It can be slow, so that can be confusing, but they are seeing that we are available and trying to build trust.”*

→ **Data Management**

All of the sites talked about data management as a challenge, although the type of challenge varied greatly between the sites. One of the smaller sites uses a manual process to compare all jail booking sheets with the community mental health agency’s data base. This is quite time-consuming and, combined with all of the other responsibilities tied to the grant, leaves little time to ask *“What am I learning from this?”* Another site regrets that they did not put funds towards purchasing data collection services (*“It would have considerably slowed my aging process!”*). A third site described the problem of multiple police jurisdictions within the county, each with their own data tracking system, making it difficult to accurately capture what is happening with CIT county-wide.

All sites talked about data management as a challenge.

One of the corrections officers interviewed suggested that one of the challenges around recording CIT data is the possibility of liability. He wondered if officers in his community who use CIT were fearful that a crisis may develop with the same individual a day or two later, possibly leading to violence or death. If they had arrested the individual and not used CIT, they might have prevented the violence from occurring. So if something violent occurs, *“Now they are liable, and they have to live with that.”*

→ **Barriers to Needed Community Services**

The question of community placement for those diverted from jail was an issue for several sites. As noted earlier, one site described the difficulty of finding landlords who are willing to rent to individuals with criminal records, which significantly impacts the ability of the community mental health agency to continue to provide services. As this stakeholder reflected, *“If they stay in the community we can work with them but if they leave, they’re lost.”*

One site continues to struggle with getting their local mental health crisis center to accept someone the police have encountered and deemed in need of crisis services. In one example, a criminal justice stakeholder spoke about an individual an officer was trying to divert to a drop-off center who, due to delays and confusion at the center, became *“riled up and the officer ended up having to use force”*. Another site struggles with coordinating the timing of release of individuals from the jail to an Adult Foster Care facility. If the AFC owner arrives after they are released, the individual may simply walk away.

The question of community placement for those diverted from jail was an issue for several sites.

The challenge of Medicaid insurance was mentioned by both community mental health and criminal justice stakeholders. Individuals who have Medicaid insurance lose coverage upon entry into the jail. While they are given two weeks of medication upon discharge, it can take upwards of 45 days for Medicaid insurance to be reinstated. This gap in coverage results in lack of medication.

One site described the lack of hospital beds for treatment. If the local hospital is full or will not accept the individual, community mental health staff must spend considerable time looking around the state for a bed. The community mental health stakeholder noted that, *“It often takes two months to get a bed for someone.”* If the individual ends up hospitalized outside the county, it is unknown whether the individual will return back to the county and whether they will end up being lost to the mental health system of care.

What Advice Would Stakeholders Offer to Other Sites?

All of the stakeholders were asked what advice they would offer to someone who was considering implementing a diversion program elsewhere. Their recommendations centered on building relationships and transparency, knowledge of the program, strategies for collaborating with law enforcement, and keeping focused on the goal.

→ Building Relationships and Transparency

Not surprisingly, all sites stressed the importance of building strong relationships between the community mental health agency and law enforcement. Both community mental health and criminal justice stakeholders stressed the importance of some kind of a steering committee or team that meets regularly to discuss issues, share information and solve problems. Further, this committee needs to be comprised of people who have decision-making authority so that processes or systems can be changed or modified as needed and in a timely manner to enhance the delivery of services. But as one stakeholder advised, *“Advance slowly. It takes a long time to develop these relationships.”*

All sites stressed the importance of building strong relationships between the community mental health agency and law enforcement.

Transparency is essential to these relationships. As one stakeholder said, *“It’s important that you let people know why sometimes you can’t do what they want you do to. You need to let people know where you are coming from. If that is absent, they will fill in the blanks on their own, and you have no control over what they do with those blanks of information.”*

→ Knowledge of the Program

All stakeholders discussed the importance of all partners being educated on the programs they are proposing to implement, particularly CIT, and on the sequential intercept model of intervention. No site that implemented CIT expressed any regret about their decision, but several said that they wished they had known more about what was required before they had begun.

→ Strategies for Approaching Law Enforcement

The third recommendation came from the community mental health stakeholders, who would encourage new projects to remember that law enforcement officials are concrete, action-oriented

individuals, so as a community mental health agency, it is important to have “a concrete plan in place before you approach them”.

It is important to realize that CIT training is the first step in the implementation of CIT; ongoing collaboration is required to fully implement and maintain the program. Continuous dialogue between the community mental health and law enforcement partners is needed to encourage officers’ use of de-escalation and diversion techniques and to monitor results. As one criminal justice stakeholder noted about diversion, “It is important to know that officers will try this only once. If they have to spend three hours on someone and it doesn’t work, it’s just easier to take them to the Emergency Room. That only takes 30 minutes.”

It is important to realize that CIT training is the first step in the implementation of CIT; ongoing collaboration is required to fully implement and maintain the program.

→ **Keeping Focused on the Goal**

Finally, everyone would encourage new projects to keep in mind that “this is a positive thing” and to not get discouraged. As one stakeholder noted, “We are trying to catch up with twenty years of dealing with mental health issues.” One criminal justice stakeholder described learning in the CIT training that it can take several tries before a person with a mental illness is on the right medication. As a result of this knowledge, she would encourage new projects to remember “to not give up on the person.”

VI. LESSONS LEARNED REGARDING IMPLEMENTATION ACROSS SITES

Each of the programs under the State Jail Diversion pilot is unique, as are the counties in which the project is situated. This report makes no claims that programs can or should be compared to one another. However, the diversity of programs and variation in county demographic characteristics is an asset in terms of determining what works. The multiple approaches being implemented across the state offer a unique opportunity to assess the success and barriers of each approach and to think about lessons learned.

Collectively, the information gathered to date through site visits, interviews, monthly calls and ongoing data collection provide several insights into program design and implementation which may be useful to the Diversion Council as it moves forward with implementation of diversion programs. The recommendations below are divided into three clusters: 1) those learned from the experiences of the current programs, 2) system-level changes that would support diversion and 3) those focused on evaluation outcome activities.

Implementation Factors: Experiences of the Current Projects

1. **Have an Advisory Council: Decision-makers need to be at the table from the very beginning and meet on a regular basis.** Whether CIT or jail services were implemented, this is an observation that was made by all of the stakeholders, either directly or indirectly. The challenge to achieving this in the more populated counties where there are multiple agencies, systems and decision-makers appears far more complicated than in the smaller, less populated counties where there are fewer layers to navigate. While challenging to establish, it was clear that

projects that had a team of criminal justice and community mental health stakeholders at the table on a regular basis were able to mutually identify problems and develop strategies to address them quickly, allowing them to keep a laser focus on the consumers they are serving.

- 2. Build Rapport/Trust: Provide time during the initial stages of grant implementation for sites to build relationships and establish a stakeholder team.** The capacity of communities to implement diversion projects hinges to a great extent on the relationships between community mental health and criminal justice systems. Establishing a mental health presence within the jail was challenging for counties in which the relationship did not exist before the grant. Time to establish these relationships and build rapport may be necessary before services can be delivered, and communities that do not already have a well-established stakeholder team should be allowed a period of time in the initial stage of grant funding to establish one. The benefits appear to far outweigh the cost of time.

There may be a continuum in the jail-community relationship building strategy that begins with allowing CMH providers to enter the jail to provide services in order to build trust. Only after trust has been established does it become possible for CMH professionals to successfully advocate for diversion.

- 3. Plan Multi-Year Efforts: Launch diversion initiatives as multi-year, not one-year grants.** All but one site described significant challenges in implementing a project of this scope within the one-year time frame. Recruiting, interviewing and hiring staff who have the knowledge and expertise to implement this kind of a program and who are willing to work for a project that will last only one year; getting contracts with police departments or sheriff offices reviewed, authorized and signed in a timely manner; modifying systems of assessment, review and/or notification within the jail; and simple logistics such as finding office space or installing internet capabilities in the jail are challenges that can take weeks or months, not days, to resolve. Because of these challenges, several sites were not able to launch services as quickly as anticipated. A multi-year pilot period would allow sites time to adequately develop the program and collaboration with program partners, establish processes and protocol, hire and retain staff, develop program sustainability and, most importantly, successfully divert the mentally ill from the criminal justice system.
- 4. Accommodate Modifications: Provide some flexibility and guidance for changes in the model mid-stream.** One site realized that the model of jail services proposed was, upon implementation, not the best fit for their population. The opportunity to modify their approach would have allowed them to increase the number of individuals they serve. More time and the ability to make programmatic and budgetary adjustments during the pilot period would permit sites the ability to adjust their program to better suit the needs of their community. Guidance from the state on the process and degree of the modification would be helpful.
- 5. Increase Cross-Site Engagement and Learning Opportunities: Provide regular cross-site learning opportunities and ongoing technical assistance.** It was clear that stakeholders have extremely high expectations for themselves to implement the best programs possible. Several expressed the wish that they could interact with other sites on a regularly, both to know more about what is going on around the State and also to learn how other sites are handling similar challenges. Building an ongoing dialog among sites, whether through monthly meetings, a listserv discussion group or other methods would allow sites the opportunity to share their rich

knowledge as well as learn from each other's experiences. In addition, technical assistance from the State on issues such as program implementation of CIT, data collection and building stakeholder collaboration may help reduce implementation delays.

- 6. Expand Services to Include Non-CMH consumers: Consider strategies that allow for the program to be expanded to non-community mental health consumers.** While enhanced collaboration with the local CMH agency is a big step in addressing the needs of the seriously mentally ill housed within the jails, the current system often cannot accommodate the needs of those who are ineligible for CMH services.

From the perspective of the jail, there is no distinction between those who are or are not eligible for services. However, for community mental health agencies, this is not always the case. One pilot wants to provide services to all seriously mentally ill inmates in the jail, but is able to bill only for those who are already consumers of the agency. Though some of the pilots provide services regardless of CMH status, the level of service available for non-CMH individuals is often lower than their CMH-eligible counterparts, both in the jail and upon discharge into the community.

Similarly, if there is a specific mental health provider engaged in collaboration with the courts or jail, individuals who are not already enrolled with this agency, but who need services are not eligible. Although this may be a function of the 'pilot' status of many of the programs, as the programs expand past the pilot phase, diversion should be an option for everyone meeting criteria within the county and not depend on provider enrollment.

VII. RECOMMENDATIONS FOR THE MENTAL HEALTH DIVERSION COUNCIL

Based upon the information collected from the project sites and the analysis of the data, the evaluation team provides these observations and recommendations to the Governor's Diversion Council.

→ Recommendations for Changes in the Process to Support Best Practices

- 1. Define/operationalize the definition of diversion.** The use of the Sequential Intercept Model allows for a system wide perspective in diversion program planning and creates a wide spectrum of activities aimed at fostering diversion. However, it also creates a wide range across programs in perceptions of what are considered diversion-related activities.
- 2. Require quantitative evidence of need/problem within the community.** What/where is the need for diversion within the county? Evaluation of change relies on evidence of a presenting problem as a baseline of measurement. In some sites there was difficulty articulating evidence of a problem beyond anecdotal information. This may be an artifact of the lack of systematic identification of mental health problems within the criminal/legal system or specific data collection systems. However, communities should have some objective measure of the actual problem provided within their proposal to facilitate measurement of change.

- 3. Utilize implementation findings to enhance current pilots and formulate new RFPs.** This report provides information useful to the individual sites, as well as the Diversion Council, as they continue to improve diversion efforts. For example, examination of the discrepancy between 'objective and expressed need' should lead to an assessment of internal processes associated with identification of mental health problems within the jail. Furthermore, examination of the variation in implementation across sites might refine the Diversion Council's intention in terms of diversion and create a more specific call for intervention (i.e., advocacy versus services within the jail).
- 4. Encourage the use of a brief validated mental health screening in all jails at intake.** Although all jails provide some level of observational and question-based screening for mental health problems by jail staff, the process varies. Generally officers refer individuals for professional screening when they detect issues upon observation. Some jails use specific questions regarding previous mental health services. If early detection is a goal, then a brief, empirically-validated mental health screening measure should be utilized during the booking process.
- 5. Suggest improvement in the utilization of jail management information systems.** Most jails use a management information system to operate day-to-day activities. These systems often incorporate mental health screening questions, but information gleaned from the screening is not disseminated to jail administrators or mental health staff. Although the screening questions could be improved upon (see above), the information is important in assessing system wide needs, as well as communication with needed staff.
- 6. Insist upon identification of co-occurring disorders (COD) and integrated mental health and substance use disorder treatment.** Pilot sites are uneven in their approach toward identification and treatment of COD. The research on individuals with serious mental illness is consistent in finding that those with co-occurring substance use disorders are more likely to go to jail and return to jail multiple times. More emphasis on the detection of substance use disorders – as well as the use of integrated treatment approaches that treat both disorders simultaneously – is needed.
- 7. Increased emphasis on family, particularly children, and community supports.** Research demonstrates that strengthening family support and community 'pro social' networks are effective interventions for individuals with mental health disorders. Similarly, the identification of minor children involved with the target individual may prove to prevent future mental health disorders associated with neglect and early trauma.
- 8. Encourage continuity of care between jail and community treatment and services.** While many of the programs engaged in jail-based services promote discharge planning and follow-up, these efforts could be strengthened, particularly for those who are not enrolled in CMH services. Jail can be a powerful motivation for behavioral change, but the struggles of reentry can diminish an individual's resolve for change. Research demonstrates that 'patient navigators' have been successful in assisting those with chronic physical health care needs transition from acute to ongoing care and management of their chronic health conditions. Similar attention (beyond a phone call) for those transitioning from jail would be helpful in managing their chronic psychiatric conditions.

- 9. Emphasize ‘criminogenic’ factors as well as mental health factors.** The primary emphasis for all of the pilot programs has been appropriately mental health services. However, research indicates that mental health symptoms are responsible for a very small proportion of the ‘criminal behavior’ associated with arrest. Hence, recent research has called for interventions that target criminogenic risk factors as well as mental health symptom management¹⁰ including ‘criminal thinking’ such as rationalizing and blaming others, lack of motivation, impulsivity, trauma and poverty.

→ Recommendations for System Level Changes That Would Support Diversion

- 1. Consider funding community mental health staff to provide in-reach services with incarcerated consumers and out-reach services upon community reentry.** Some of the pilots are providing in-reach services into the jail. In this model, a CMH staff person or case worker engages with an incarcerated consumer to provide crisis intervention and advocacy services during incarceration, as well as support for community re-entry. This is not considered a billable service per CMH regulations and, as such, is a barrier to an effective continuum of care. While some communities find in-reach an essential practice irrespective of funding, others feel that the lack of reimbursement limits the availability of human resources needed to provide this important service.

Similarly, out-reach post-jail release actively seeks the individual within the community to ensure access to and engagement in ongoing services. This is particularly important for medication adherence and assistance in management of side effects of medication.

- 2. Prevent the time lag for reinstatement of Medicaid coverage post-jail release.** Suspension of Medicaid during confinement has long been a practice within the State. However, the 45 days to re-instatement creates an insurmountable barrier to medication continuity, increasing the probability of de-stabilization. Medicaid should be effective upon jail release to ensure continuity of medication past the two-week supply provided by most jails upon release. This would ensure that individuals have continuous access to needed medications, which would increase their capacity to succeed in the community and potentially reduce recidivism.
- 3. Address the statewide need for acute care hospital beds for psychiatric emergencies.** Several pilots discussed the dwindling number of psychiatric hospital beds available. When a psychiatric bed is not available locally, individuals end up being placed in hospitals outside the county, greatly increasing the difficulty in coordinating mental health and community services upon release. Moreover, the absence of available hospital beds may increase the probability of officers using jails as the most prudent mental health facility available.
- 4. Incorporate de-escalation skill training within the policy academy.** Officers discussed the absence of training on mental health issues and de-escalation techniques in standard law enforcement training. At a minimum, it would seem that the incorporation of de-escalation techniques into standard training would prevent injuries of officers and citizens and perhaps prevent exacerbation of a situation and corresponding criminal charges.

¹⁰ Wolff et. al.(2013). Practice informs the next generation of behavioral and criminal justice interventions. *International Journal of Law & Psychiatry*, 36; 1-10. Epperson, et. al., (2014). Envisioning the next generation of behavioral health and criminal justice interventions. *International Journal of Law & Psychiatry*, 37; 427-438.

5. **Enhance the spectrum of psychotropic medications available on jail formularies.** Medication is an ongoing concern at many sites, including the destabilization that occurs for an individual when medications change upon entry to the jail. The more restricted availability of drugs on the jail formulary means that the medication regimen prescribed in the community is abruptly halted and switched to a comparable drug in the jail. This switch in medications can result in behavior changes and poorer management of symptoms. Mental health and jail personnel are concerned that these disruptions put both the individual and jail staff at risk and may result in elongated jail stays.

VIII. EVALUATION: NEXT STEPS

As explained previously, this report on program implementation services as necessary background information for future outcome reports. Understanding the variation across programs assists in understanding variation in outcomes. The next steps for the evaluation team, also shown in Table 8 on the following page, are:

→ **Short-term Outcomes Report**

The short-term outcomes report will use individual-level data to assess jail recidivism six months beyond the intervention. The report will follow individuals who received services from each program during the implementation period (April – September, 2015). Individual-level data will be collected from each of the participating jails to assess jail activity (i.e., jail bookings, jail releases, and related offense types) before and after the diversion intervention. Jail mental health screening data comparing mental health needs from 2015 to 2016 using the K6 instrument at seven county jails will also be presented. The short-term outcomes report will be delivered to the Diversion Council during the fourth quarter of 2016.

→ **Long-Term Outcomes Report**

The long-term outcomes report will follow-up report of recidivism and treatment outcomes for those admitted into a diversion service from April 1, 2015 – March 31, 2016. In addition, this report will cover individuals who received services during the implementation period (April – September 2016) in the two additional jail diversion pilot sites launched in 2016 in Oakland and Livingston Counties. The long-term outcomes report will be delivered to the Diversion Council during the fourth quarter of 2017.

→ **Comparing Data-Warehouse and Other Administrative Data**

This report will assess data gathered on the two pilot sites, Oakland and Kent. Data will be collected from the state-level data warehouse and compared against data gathered through individual administrative data pulls (i.e., jail, treatment, and Michigan State Police data) to compare outcomes. The comparison report will be delivered to the Diversion Council during the first quarter of 2018. It is noted that the outcome of this report is dependent upon the availability and accessibility of data through Optum and the State.

| Table 8. Illustration of Upcoming Data Collection and Report Writing for Evaluation Team | | | | | | | | | | | | |
|---|-----------------------------------|-----------|-----------|-----------|-----------------------------------|-----------|-----------|-----------|-----------------------------------|-----------|-----------|-----------|
| PROJECTS TASKS | Year 01 1/1/15-12/31/15 | | | | Year 02 1/1/16-12/31/16 | | | | Year 03 1/1/17-12/31/17 | | | |
| | <i>Q1</i> | <i>Q2</i> | <i>Q3</i> | <i>Q4</i> | <i>Q1</i> | <i>Q2</i> | <i>Q3</i> | <i>Q4</i> | <i>Q1</i> | <i>Q2</i> | <i>Q3</i> | <i>Q4</i> |
| Data Collection Cohorts (begin individual level data Q2) | | | | | | | | | | | | |
| Initial Sites: Cohorts of individuals served by diversion programs, by quarter, are identified for data collection to determine outcomes for recidivism and treatment engagement. (Original 8 sites funded in 2015) | | C1 | C2 | C3 | C4 | | | | | | | |
| Additional Sites: Individual Cohorts (n=2 sites projected to be added in 2016) | | | | | | C5 | C6 | | | | | |
| Initial Sites: Data collection from jails related to short-term outcomes (6 month jail recidivism) | | | | C1 | C2 | X | | | | | | |
| Initial Sites: Long-term outcomes (1 year); recidivism and treatment engagement | | | | | | C1 | C2 | C3 | C4 | X | | |
| Additional Sites: short-term outcomes (6 month jail recidivism) and data collection (X) | | | | | | | | C5 | C6 | X | | |
| Data Collection on All: data warehouse, state administrative data (jails included) | | | | | | | | | | | X | X |
| Report Writing | | | | | | | | | | | | |
| Implementation/Process Report | | | | X | X | | | | | | | |
| Short-Term Outcomes: County jail recidivism at 6 months and mental health screening pre/post compare (K6). | | | | | | | | X | X | | | |
| Long-Term Outcomes: Recidivism and treatment continuity (any tx; time to tx; type of tx; any jail recidivism; type of recidivism; time to recidivism) | | | | | | | | | | | X | X |
| Expanding outcomes using State data warehouse* | | | | | | | | | | | | X |

*This deliverable is subject to availability and accessibility of data from Optum and State of Michigan

Appendix I-A: Barry County Site Summary

Introduction

The proposal put forth by Barry County Community Mental Health Agency (BCCMHA) introduced a comprehensive plan across the criminal justice continuum that involved training law enforcement and courts; providing screening, assessment, and mental health services within the Barry County Jail (BCJ); implementing a process to identify community mental health (CMH)-eligible individuals for enrollment into jail-based services; and advocating on behalf of consumers for diversion from jail to community-based treatment. Additionally, the proposal included one-time training in support of Kevin’s Law, one of the five key priorities set forth by MDHHS.

The ambitious plan put forth by BCCMHA is led by a single individual who, for a large part of the implementation period, operated all aspects of the jail services and CIT programs single-handedly. Although the plan was comprehensive in nature, actual implementation revealed some barriers.

This report details the implementation process during Year 1. It includes:

- A description of the program being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team’s first site visit conducted in March 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the evaluation team’s two site visits (March 2015 and March 2016).

Description of Program Implementation in Barry County

Implementation of Crisis Intervention Team (CIT) Training in Barry County: Intercept 1

The implementation of CIT within Barry County focused on disruptive and assaultive behavior experienced within the jail. Given the limited resources within the community, the jail routinely houses individuals diagnosed as severely mentally ill (SMI) or developmentally disabled (DD) who are experiencing a mental health crisis and exhibiting unstable and disruptive behavior. It is reported that these individuals constitute most of the behavioral problems within the jail. CIT training was requested to improve jail management by improving officer skills in preventive and de-escalation techniques to more readily diffuse crisis situations.

The program delivered a 24-hour CIT training curriculum to a total of nine individuals: six jail officers (three per shift) and three CMH staff (one case manager, one clinician, and one certified peer support specialist). The training was held in Barry County on July 13 – 16, 2015 and conducted by a trainer from Crisis Response Connection, LLC. The training session, called Assisting Individuals in Crisis and Group Crisis Intervention, was tailored to be a 3-day “power session” that combined two offered by the International Critical Incident Stress Foundation (ICISF) - the Critical Incident Stress Management: Group Crisis Intervention and the Assisting Individuals in Crisis and Peer Support Crisis Intervention curriculum. Both ICISF trainings are normally 2-day, 16-hour courses). It was anticipated that the initial group of trainees, i.e. jail-based sheriff’s officers, would eventually serve as trainers within Barry County in order to train larger numbers of officers in the jail and the community.

To date, there have been no subsequent CIT trainings conducted in Barry County. As discussed during the March 2016 site visit, limited resources and minimal staffing practices within the Barry County Sheriff Department (BCSD) make the implementation and sustainment of a CIT program problematic. Specifically, the training, even an abbreviated 24-hour training as initially provided in the county, severely strained staff resources as the BCSD simply does not have the resources to cover or backfill officer positions during the training. Going forward, the stakeholders plan to offer Mental Health First Aid (MHFA) training beginning in the second year of the grant period to all community first responders including jail and patrol officers of BCSD and the Hastings Police Department. Currently, the trainings are scheduled for June, September, and November. The shorter eight-hour MHFA curriculum is thought to be a better training fit for the community than CIT since it places less demand on staff resources. Over time, the stakeholders hope to build a program that can acquire and sustain CIT within the community.

Implementation of Jail Services in Barry County: Intercept 3

BCCMHA, in partnership with the BCSD proposed to increase the number of mental health services provided within the Barry County Jail. Specifically, through its Jail Diversion (JD) program, BCCMHA expanded the number of mental health services provided to all inmates (CMH and non-CMH) in the jail to include individual and group therapy, advocacy, medication reviews, discharge planning, enrollment of non-CMH inmates into BCCMHA services, and facilitation of Medicaid enrollment via a partnership with the Michigan Department of Human Services (DHS). Prior to this grant, mental health services provided in the jail were limited to three days per week and included men's and women's substance abuse groups, a court-ordered cognitive behavioral therapy group, and response to kites or staff referrals for mental health services for one hour per day.

Due to limited resources within the county, BCCMHA employs an expanded clinical eligibility in order to allow individuals with low-level or situational mental health issues to access services. This expanded eligibility facilitates full access to mental health services for all inmates (CMH and non-CMH) with the exception of maximum security inmates who are ineligible for group therapy. The program is accessible by inmates who are referred to the jail diversion program by jail staff or who initiate a "kite" for this service on their own. The process map, included as Figure A5 on the last page, illustrates the program operation, as well as process numbers during the implementation period.

The Jail Diversion team also actively advocates for inmates who are already demonstrating an effort to advocate for themselves. Advocacy activities include drafting letters of support, consultation with judges and prosecutors, and collaboration with community case managers and jail staff. These activities result in either a reduction of jail days as individuals are diverted from jail to community-based treatment or placement, or diversion from prison in favor of jail time or participation in the Swift and Sure Sanctions Probation Program. These activities result in *current diversion*, while other services provided by the Jail Diversion team, including treatment groups, individual therapy, and crisis care are considered to be *future diversion*, with the goal to reduce jail recidivism through supportive services and community linkages while in the jail.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to the collection and analysis of the K6 mental health screening conducted at the jail during program implementation, the Evaluation Team worked in tandem with stakeholders to identify and measure key process indicators within the implementation of jail services in Barry County. Based on the

results of the initial consultation with the stakeholders during the first site visit, the following process indicators were to be collected from Barry County beginning in April 2015.

- Name, title, affiliation of CIT trainees
- Pre/Post-CIT Training survey
- # Jail Bookings
- # K6/Suicide Screenings
- # Jail Consults/Referrals to BCCMHA JD
- # BCCMHA consumers booked to jail
- # MH Assessments Conducted by BCCMHA JD
- # Cases Opened/Reactivated by BCCMHA JD
- # Consumers (Current, Open/Reactivated) Receiving MH Services in Jail
- Name, Booking #, M/F, DOB of Current, Open/Reactivated Cases

As BCCMHA implemented and grew their jail diversion program, the evaluation of the pilot program was adapted as well. Specific changes were implemented in the collection of process data to appropriately reflect changes to the program as implemented. These changes included adjusting the way in which the number of BCCMHA consumers booked to the jail is determined and which individuals served by the Jail Diversion team will be tracked for short- and long-term outcomes. Additionally, some changes were made to align process indicators collected in Barry County with cross-site indicators collected at the other jail diversion pilot sites. The identified cross-site variables include jail bookings, mental health screenings, mental health assessments, and individuals receiving services.

The final list of process indicators was revised to include the following. These are indicated on the process map (Figure A5).

- | | |
|----------|--|
| | Name, title, affiliation of CIT trainees |
| | Pre/Post-CIT Training survey |
| | # Jail Bookings |
| | # K6/Suicide Screenings |
| | # Jail Consults/Referrals to BCCMHA JD |
| Adjusted | # BCCMHA consumers booked to jail |
| | # BCCMHA consumers booked to jail* |
| | # MH Assessments Conducted by BCCMHA JD |
| | # Cases Opened/Reactivated by BCCMHA JD |
| Adjusted | # Consumers (Current, Open/Reactivated) Receiving MH Services in Jail |
| | # Individuals Receiving Services (Current, Open/Reactivated) Receiving Services from BCCMHA JD |

**BCCMHA consumers booked to jail is estimated by manually tabulating K6 surveys in which individuals responded "yes" to "Have you received mental health services in the past month?".*

The long-term outcome evaluation to be conducted by Evaluation Team and reported in 2017 will follow those BCMHA consumers served by the jail diversion team to assess treatment engagement in the community and recidivism.

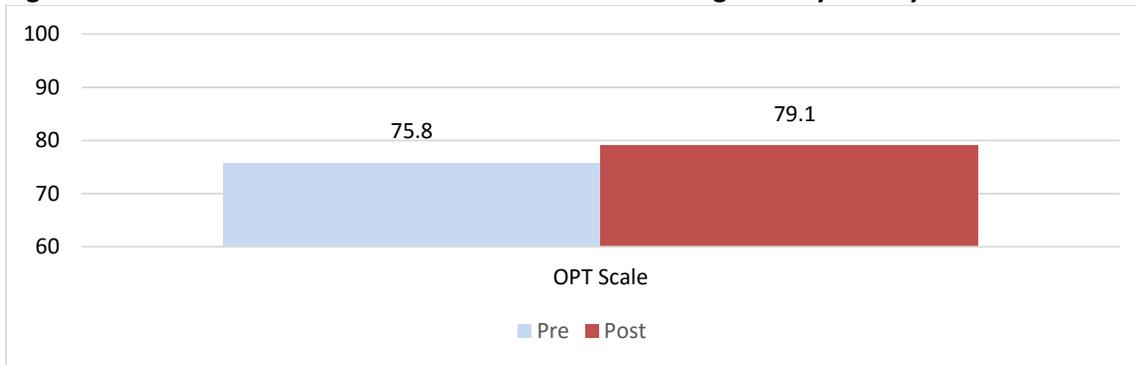
CIT Pre/Post Training Indicators

Eight of the nine individuals who attended the training completed both pre- and post-test assessments. The pre- and post-tests were implemented immediately prior to (pre-) and following (post-) the training and were based on two instruments: the *Opinions of Psychiatric Treatment (OPT) Measure* and the *De-escalation Scale*. The 20-item validated OPT Measure assesses officers' attitudes and knowledge about

psychiatric treatments within the community and attitudes about psycho-pharmacotherapy, psychotherapy, and psychosocial interventions. Responses are given a six-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The possible range of scores is 20–120. The 8-item De-Escalation Scale measures officers’ de-escalation skills. Officers’ opinions on the effectiveness of specific actions in various situations were rated on a four-point Likert scale ranging from 0 (very negative) to 3 (very positive). Total subscale scores range from 0 to 24.

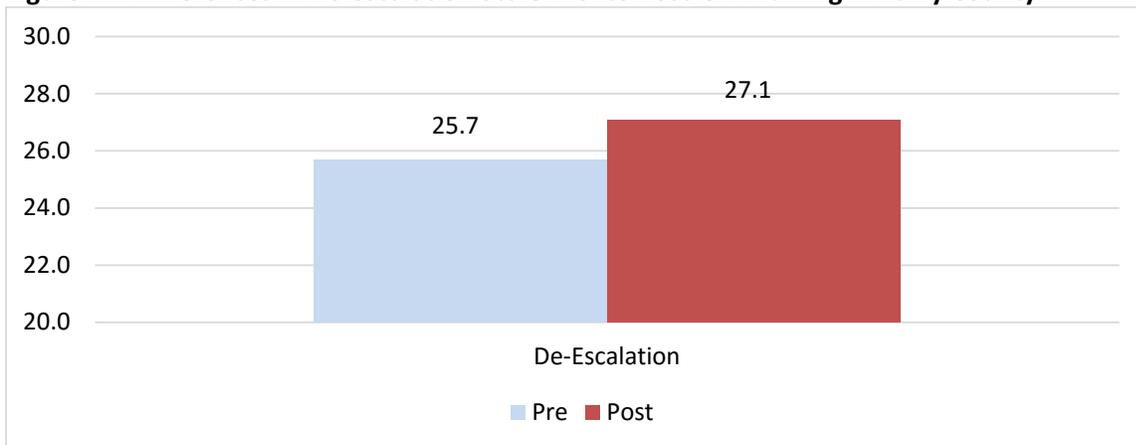
As shown in Figure A1 below, there was an average change score from pre- to post-test of 3.4 points on the OPT scale. This change was not statistically significant (although a small sample), suggesting that the training had little effect on the knowledge of different treatments for individuals with mental illness. The ‘non-significant’ findings here between pre- and post-test could be also attributable to three of eight individuals in the training being mental health professionals and presumably already aware of mental health treatment.

Figure A1. Differences in OPT Scale Pre- to Post-CIT Training in Barry County



Similarly, as shown in Figure A2 below, there was a 1.4 point non-significant increase in skill/knowledge regarding the de-escalation of an individual with mental illness. As suggested earlier, the non-significant findings could be attributable to the small sample size or the participation of mental health professionals as part of the training.

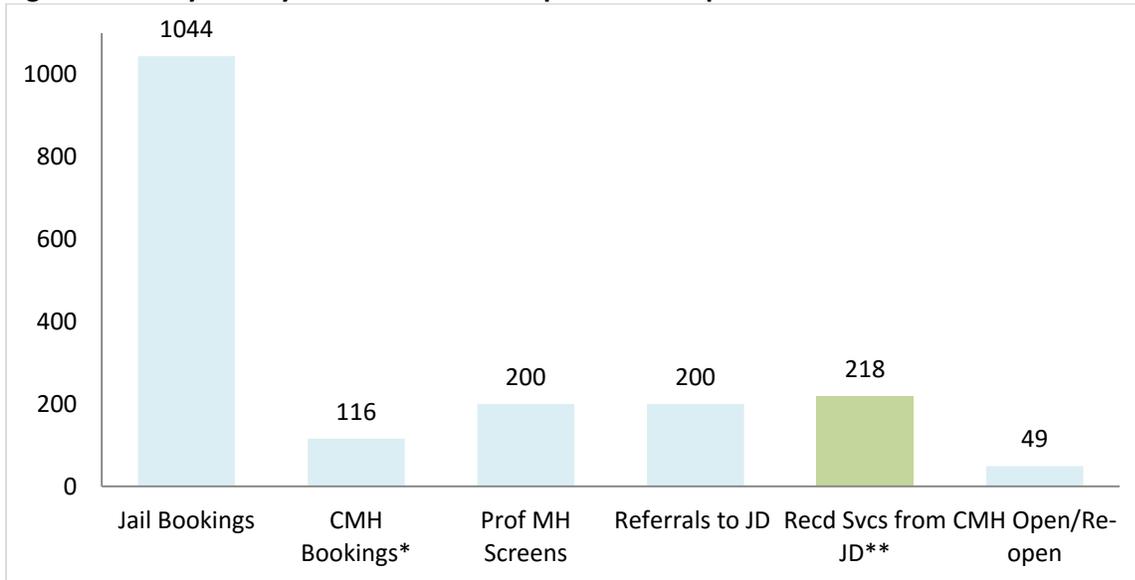
Figure A2. Differences in De-escalation Scale Pre- to Post-CIT Training in Barry County



Program Referral/Enrollment

As shown in Figure A3 below, the proportion of individuals booked into BCJ and referred for mental health services to the jail diversion team was 19% (200 of 1,044). It is estimated that during the same time period, approximately 11% (116 of 1,044) of individuals booked into the jail were CMH consumers. Of the 200 individuals referred to the jail diversion team for services, 25% (49 of 200) were opened or reactivated for CMH services.

Figure A3: Barry County Process Indicators April 2015 – September 2015



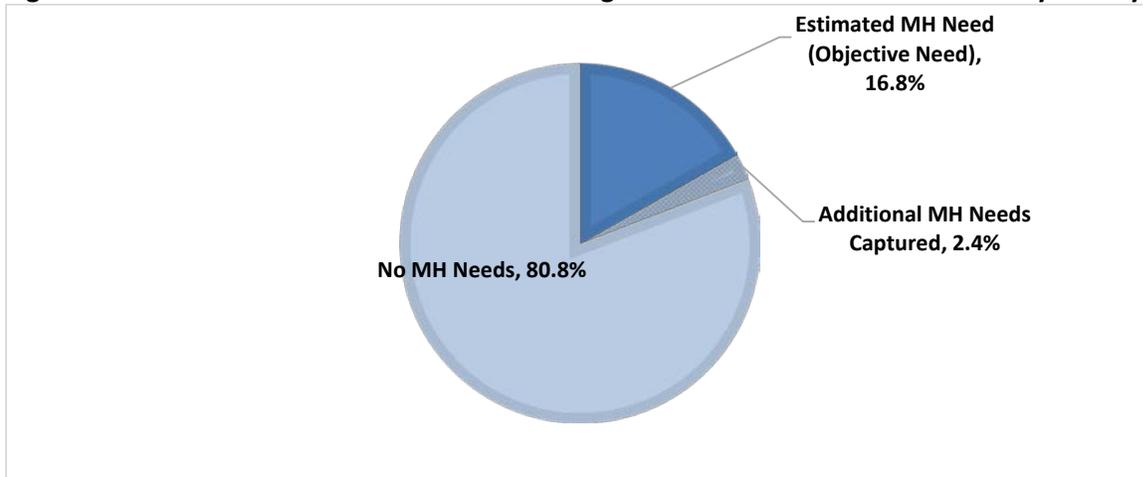
*CMH Consumers Booked in Jail is determined by the number of positive K6 screens conducted by jail staff.

**A total of 218 individuals who received services from the jail diversion program including all current, opened, or reactivated CMH consumers; these individuals will be tracked for short- and long-term outcomes including jail recidivism and mental health treatment utilization.

Need for Mental Health Services

Figure A4 on the following page shows the expressed need for mental health services in the Barry County jail. Using the objective measure of estimated need for mental health screening/services derived from the previous study that used the K6 assessment to screen all individuals booked into the jail, approximately 16.8% of individuals booked into this jail would be expected to require mental health services (i.e., objective need). Using this estimate and comparing to the number of referrals to mental health diversion in the jail, an additional 2.4% of the jail population was identified as potentially requiring services (i.e. additional need captured).

Figure A4. Estimated Need for Individuals Needing Mental Health Services in the Barry County Jail



Progress on Year 1 Short-Term Objectives

The following short-term objectives were developed by stakeholders during the proposal process as well as jointly between the Evaluation Team and stakeholders during the first site visit and address both the jail services and CIT programs. Progress associated with each stated goal is based on information and feedback generated during monthly data collection calls and the second site visit. Overall, the program is on track to successfully meet most objectives related to both jail services and officer training.

1. Improve jail officer preventive and de-escalation skills through CIT training.

Progress: Goal partially met. A total of nine individuals – six jail officers and three community mental health professionals – attended the CIT training conducted in the county in July 2015. The officers who attended were strategically selected to represent the two work shifts operated within the jail to ensure CIT-trained officers were available within the jail 24/7. Details of the pre-/post-tests administered at the training are provided earlier in this report (see Implementation of CIT in Barry County: Intercept 1). Going forward, stakeholders plan to provide jail and patrol officers with Mental Health First Aid across three trainings in 2016 (see Next Steps).

2. Reduce the number of sentinel events experienced within the jail through CIT training.

Progress: Goal partially met. In order to track reductions in the number of sentinel events experienced at the jail it would be necessary to establish a baseline for sentinel events – the average number of events occurring before CIT training – and then assess the number of sentinel events occurring after CIT training. Unfortunately, this level of data is not currently available from the jail. However, during the second site visit in March 2016, one sergeant reported anecdotal evidence of improvements within the jail including a decrease in sentinel events, the ability of CIT-trained officers to resolve crises sooner than before, and a decrease in the use of lockdowns to control disruptive or assaultive behavior.

3. Strengthen system to identify BCCMHA consumers booked into jail each day.

Progress: Goal partially met. As illustrated in the process map for Barry County (Figure A5), the jail diversion program received referrals via two sources: from the jail staff, including those self-identified through the initial screening process with SMI, on psychotropic

medications, at risk for suicide, or who are known BCCMHA consumers; and from those observed by the jail officers to have mental health concerns. The Jail Diversion team can also be accessed directly by inmates through the kite process. These two mechanisms have provided the Jail Diversion team with a steady stream of individuals potentially in need of mental health services. Though initially attempted, the process of gaining referrals through review of the daily booking report from the jail was not implemented because of limited staff resources. The process has relied solely upon referrals from the jail officers and kites to feed the program.

4. Develop system to identify, assess, and open/reactivate individuals within the jail assessed as having an SMI who are not current BCCMHA consumers.

Progress: Goal met. As illustrated on the process map for Barry County (Figure A5), the Jail Diversion team receives referrals and kites from individuals who may not be current CMH consumers, but who may screen positive for SMI or suicide risk or kite. The Jail Diversion team actively assesses those individuals who are not current CMH consumers. During the six-month implementation period (04/15 – 09/15), the jail diversion team opened or reactivated 49 individuals into CMH services.

5. Attempt to identify individuals suitable for pre-booking and pre-charge diversion by reducing the time to assessment/referral.

Progress: Goal not met. Progress in identifying individuals suited for pre-booking diversion continues to be difficult. Currently, the Jail Diversion team is unable to identify individuals suited for diversion until they are booked to the jail. It is reported that there is currently no plan to implement a pre-booking or pre-charge diversion program within the county. However, the Jail Diversion team is actively engaged in post-booking diversion for individuals with SMI, substance use disorder, or those with co-occurring mental health and substance use disorders. During the implementation period, it was reported that 13 individuals were diverted post-booking from jail to community-based treatment or from prison into intensive probation or jail.

6. Initiate stakeholder trainings regarding Kevin’s Law.

Progress: Goal abandoned. Due to issues related to the specific legislation supporting Kevin’s Law currently being addressed at the state level, the Kevin’s Law training proposed by BCCMHA was not implemented.

Next Steps

The second site visit revealed a number of positive changes and initiatives for Barry County slated for the second year of the jail diversion pilot program. The first step, which was discussed earlier in this report, is listed below in summary form only.

- 1. Increase community awareness of mental illness through Mental Health First Aid training for the community’s first responders.**
- 2. Increase post-booking diversion through the implementation of evidence-based MRT within the jail.** During the second year of the pilot program, the Jail Diversion team plans to implement a Moral Reconciliation Therapy (MRT) group within the jail. Though the transition is currently being negotiated, the team plans to replace the current “Change for Wellness”

group to the more narrowly focused, evidence-supported MRT group. The new MRT group will target felons and/or misdemeanants with previous probation failures who are mandated to the program by the judge. Completion of the in-jail MRT group will result in release from jail as ordered by the judge. Stakeholders anticipate that the change to MRT will increase the opportunity for post-booking diversions and provide participants with more positive long-term recidivism outcomes.

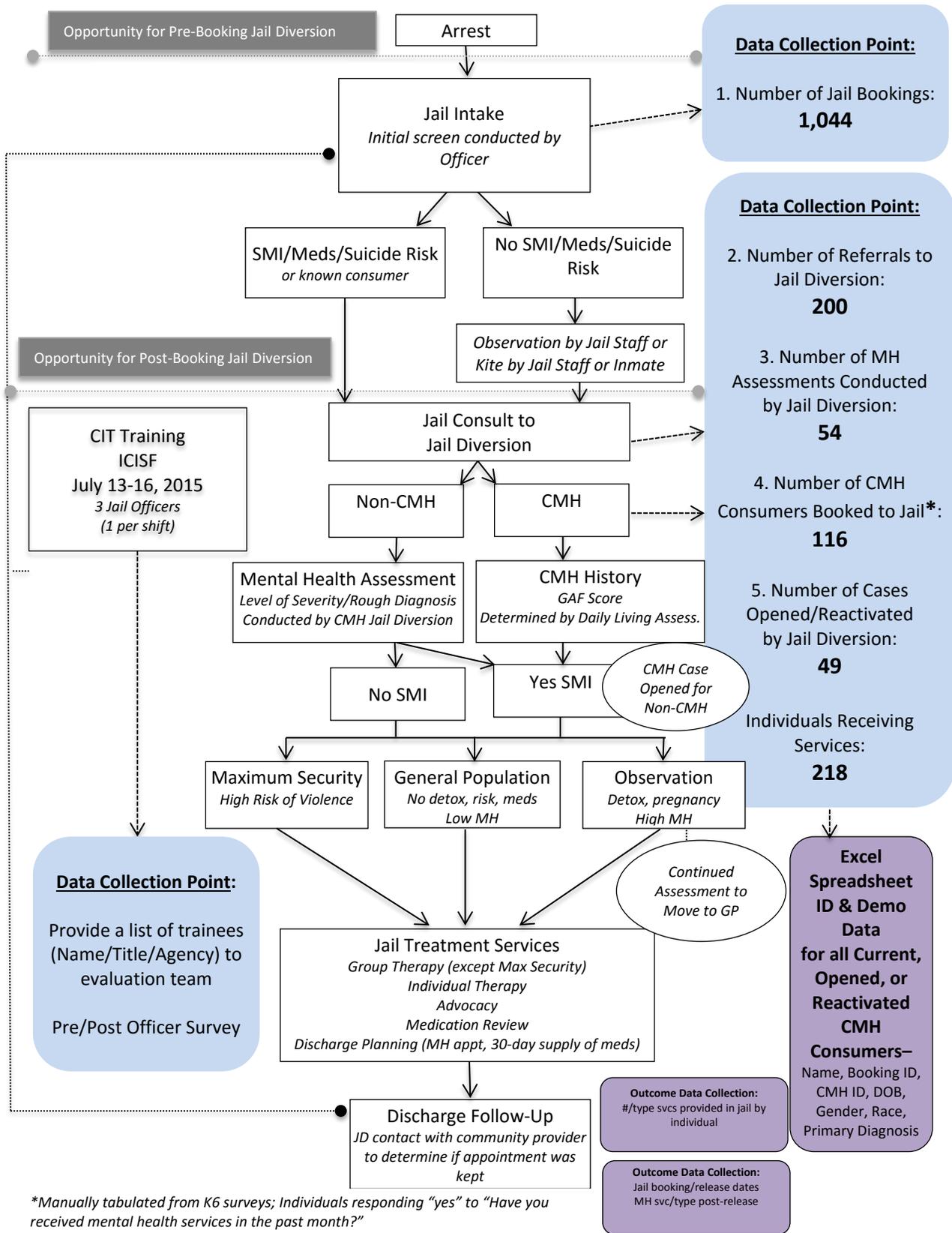
- 3. Strengthen discharge services and support through the implementation of a Peer Group/Resource Meeting within the jail.** The Jail Diversion team will implement a peer group resource meeting within the jail for inmates who are within 30 days of release. The group, to be facilitated by certified peer support specialists, will provide support, referrals, and guidance through the discharge period. It is anticipated that this level of discharge planning will result in future diversion of those who attend the group.

Evaluation Team Recommendations

In addition to the above initiatives, the Evaluation Team recommends the following:

- 1. Identify BCCMHA consumers booked to jail.** The ability to implement a more automated process to proactively identify BCCMHA consumers booked into the jail would conceivably result in swifter and more consistent access to mental health services within the jail. This process would proactively identify consumers within the jail in a more objective manner than the current referral/consult and kite process solely utilized to identify those inmates with possible mental health concerns.
- 2. Implement a community advisory council.** Presently there is no active mental health/criminal justice advisory council operated within Barry County. An advisory council comprised of criminal/legal professionals, mental health professionals, mental health advocates, and law enforcement that can engage in problem-solving and monitoring of diversion programs across all points of intercept will facilitate problem solving as well as future planning efforts.

Figure A5. Barry County Process Map



*Manually tabulated from K6 surveys; Individuals responding "yes" to "Have you received mental health services in the past month?"

Appendix I-B: Berrien County Site Summary

Introduction

The proposal put forth by Berrien Mental Health Authority focused on the provision of Crisis Intervention Team (CIT) training for Berrien County Sheriff's Office (BCSO) dispatchers and officers, as well as the introduction of a post-booking jail diversion program located within the Berrien County Jail (BCJ). Specifically, Riverwood, the lead community mental health (CMH) provider involved with the grant, intended to target services to those inmates identified as having serious mental illness (SMI) who are not currently affiliated with the CMH. Additionally, the proposal emphasized the development of an overarching Coordinating Council – a consultative body with members from law enforcement, dispatch, the Prosecutor's Office, the courts, and mental health providers – to streamline and close gaps in Berrien County's jail diversion initiatives including jail diversion, drug court, and mental health court.

This report details the implementation process during Year 1. It includes:

- A description of the program being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team's first site visit conducted in early 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the evaluation team's two site visits (early 2015 and January 2016).

Description of Program Implementation in Berrien County

Implementation of CIT in Berrien County: Intercept 1

The implementation of CIT within Berrien County focused on calls dispatched by the Berrien County 911 & Public Safety Communication Center including calls initially identified and dispatched as mental health calls (e.g. probate orders and psych calls) and as well as those determined by the responding officer (local police or sheriff office) to be mental health related, such as disturbance calls. The initial focus was on training six sheriff deputies. It was intended that this initial group of trainees would, in turn, serve as trainers within Berrien County in order to train officers of BCSO and local police departments throughout the county. Six Berrien County sheriff deputies attended a 40-hour training in Chicago, IL conducted by the Chicago Police Department on April 20 – 24, 2015. Trainees included three patrol officers, two Berrien County Jail officers, and one dispatch officer from Berrien County 911 & Public Safety Communication Center.

A second round of training, an abbreviated 24-hour model, was added later during Year One. The training was conducted in Berrien County on November 2 – 4, 2015 and was facilitated by Riverwood's Jail Diversion Supervisor and BCSO officers trained during the initial training in Chicago. The abbreviated training model contained less time devoted to the Berrien County mental health system and county-specific resources and focused more on de-escalation techniques. Nine BCSO officers attended the second training, including eight patrol officers and one dispatch officer.

Implementation of Jail Services in Berrien County: Intercept 3

Riverwood, in partnership with the BCSO, proposed to enhance the level of services currently provided to those within the BCJ who are identified as having serious mental illness (SMI). Specifically, Riverwood

intended to target services to those inmates identified as having SMI who are not currently affiliated with the CMH.

Inmates are referred to a Jail Diversion (JD) team located within the county jail by the jail's mental health clinician. Services provided by the JD team include opening/reactivating CMH services, advocacy for medication for consumers, individual consults and discharge planning. The process map, included as Figure B5 on the last page, illustrates the program operation as well as process numbers during the implementation period.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to the collection and analysis of the K6 mental health screening conducted at the jail during program implementation, the Evaluation Team worked in tandem with stakeholders to identify and measure key process indicators within their implementation of CIT and Jail Services in Berrien County. Based on the results of the initial consultation with stakeholders during the first site visit, the following process indicators were to be collected from Berrien County beginning in April 2015.

| | |
|----------------|---|
| CIT: | Name, title, agency affiliation of CIT trainees Pre/Post-CIT Training survey # Total Calls to Dispatch # Calls Coded as MH at Dispatch # CIT Report Forms Received by Jail Diversion Team at Riverwood ¹ # Calls Cleared as MH at Dispatch ² Final Disposition of MH Coded Calls (jail, hosp, AC, shelter, home, no tx) Copies of CIT Report Forms received by Riverwood JD |
| Jail Services: | # Jail Bookings # Initial Screenings # Riverwood Consumers Booked Into Jail per Booking List # Individuals Identified as MH at Initial Jail Screening (Jail Officer) # MH Referrals to Jail Clinician # Assessments by Jail Clinician # Referrals to Riverwood Jail Diversion Team # Cases Opened/Reactivated by Riverwood Jail Diversion Team # Consumers (Current, Open/Reactivated) Receiving In-Reach/Other Service by Riverwood Case Manager in Jail Name, Booking #, M/F, DOB of Current, Open/Reactivated Cases |

As Riverwood implemented and grew their CIT and jail diversion programs, the evaluation of the pilot program was adapted as well. Specific changes were implemented in the collection of process data to appropriately reflect changes to the program as implemented. These changes included adjustments to reflect process indicators that could or could not be quantified (i.e., elimination of assessments

¹ The Evaluation Team is requesting the addition of five questions to the CIT Report form provided by Chicago PD and intended to serve as a CIT Referral form in Berrien County. These questions will be asked across all pilot sites implementing CIT during the pilot period. These questions, to be answered by law enforcement, are: 1. Was the subject arrested? 2. Could you have arrested the subject? 3. Are you seeking charges? 4. Was the subject taken into protective custody? 5. Other services provided. Since the current CIT Report already addresses "other services provided" (i.e., disposition) in the Member Actions section, adding questions 1 – 4 would suffice.

² The collection of Dispatch clearance codes is dependent on the development and implementation of new clearance codes at Berrien County 911 & Public Safety Communication Center.

conducted by jail clinician) and a focus on the individuals enrolled in the Jail Diversion program for purposes of short- and long-term outcomes (i.e., addition of number enrolled in Jail Diversion program). Additionally, some changes were made to align process indicators collected in Berrien County with cross-site indicators collected at the other jail diversion pilot sites. The identified cross-site variables included jail bookings, mental health screenings, mental health assessments, and individuals receiving services.

The revised process indicators are provided below.

| | |
|-------------------|--|
| CIT: | Name, title, agency affiliation of CIT trainees Pre/Post-CIT Training survey # Total Calls to Dispatch # Calls Coded as MH at Dispatch # CIT Report Forms Received by Jail Diversion Team at Riverwood # Calls Cleared as MH at Dispatch Final Disposition of MH Coded Calls (jail, hosp, AC, shelter, home, no tx) Copies of CIT Report Forms received by Riverwood JD |
| Jail Services: | # Jail Bookings # Initial Screenings # Riverwood Consumers Booked Into Jail per Booking List |
| <i>Eliminated</i> | # Individuals Identified as MH at Initial Jail Screening (Jail Officer) |
| <i>Adjusted</i> | # MH Follow-up Sessions Conducted by Jail Clinician # Assessments by Jail Clinician # Referrals to Riverwood Jail Diversion Team # Cases Opened/Reactivated by Riverwood Jail Diversion Team |
| <i>Eliminated</i> | # Consumers (Current, Open/Reactivated) Receiving In-Reach/Other Service by Riverwood Case Manager in Jail |
| <i>Added</i> | # Individuals Enrolled in JD Program Name, Booking #, M/F, DOB of Current, Open/Reactivated Cases |

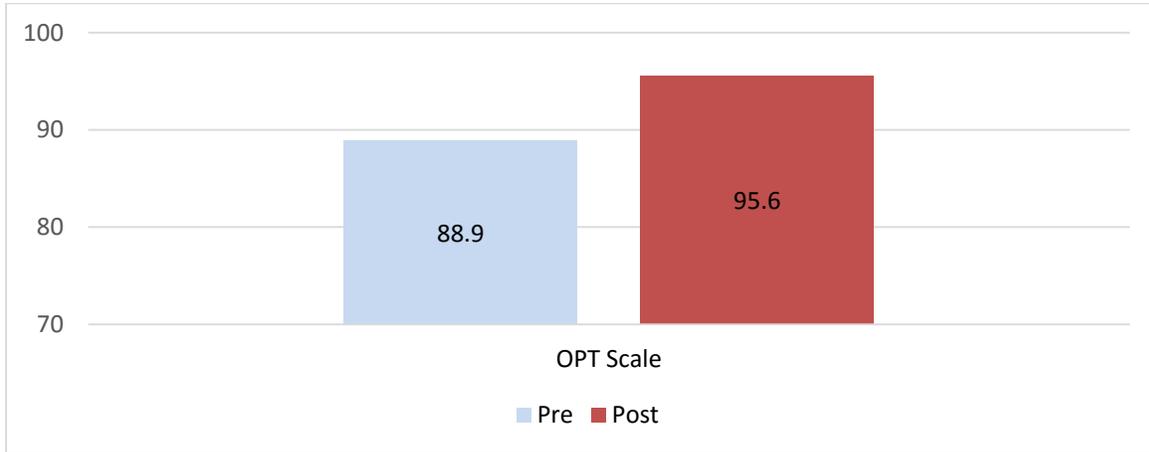
CIT Pre/Post Training Indicators

A total of 14 of the 15 officers/dispatchers who attended the two trainings completed both pre- and post-test assessments. The pre- and post-tests were implemented immediately prior to (pre-) and following (post-) the training and are based on two instruments: the *Opinions of Psychiatric Treatment (OPT) Measure* and the *De-escalation Scale*. The 20-item validated OPT Measure assesses officers’ attitudes and knowledge about psychiatric treatments within the community and attitudes about psycho-pharmacotherapy, psychotherapy, and psychosocial interventions. Responses are given a six-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The possible range of scores is 20–120. The 8-item De-Escalation Scale measures officers’ de-escalation skills. Officers’ opinions on the effectiveness of specific actions in the situation were rated on a four-point Likert scale ranging from 0 (very negative) to 3 (very positive). Total subscale scores range from 0 to 24.

As shown in Figure B1 on the next page, there was an average change score from pre- to post-test of 6.8 points on the OPT scale. Although a small sample size, this change from pre- to post-test was statistically

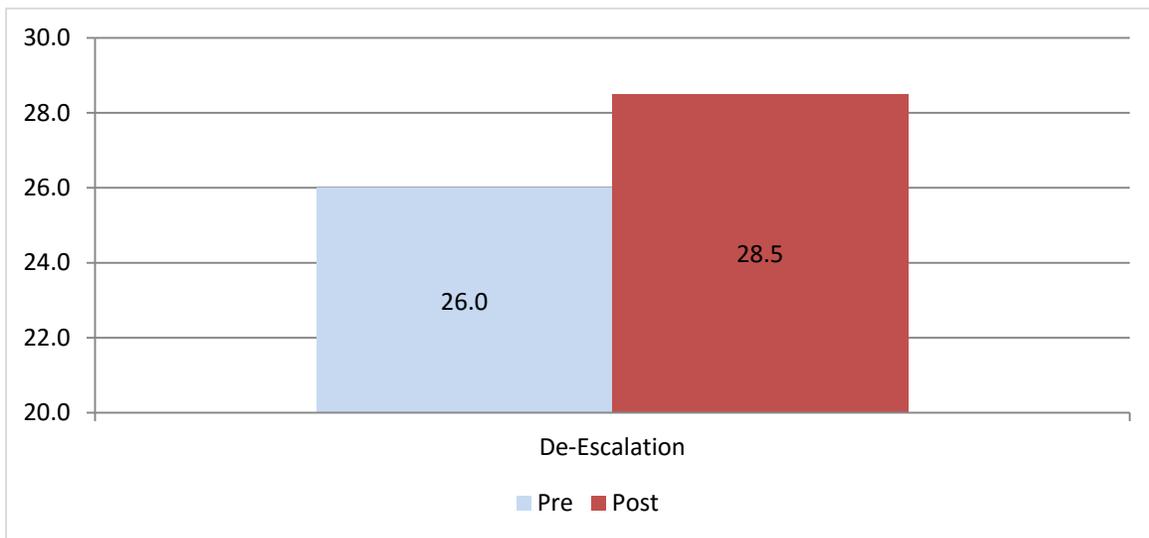
significant³, indicating that the training likely had a positive effect on the officers' knowledge of different treatments for individuals with mental illness.

Figure B1. Differences in OPT Scale Pre- to Post-CIT Training in Berrien County



Similarly, Figure B2 below shows that there was an average 2.6 point increase in skill/knowledge regarding the de-escalation of an individual with mental illness. Although a small sample, this change was also statistically significant⁴, indicating that the training likely had a positive effect on officers' skill and knowledge regarding de-escalation.

Figure B2. Differences in De-escalation Scale Pre- to Post-CIT Training in Berrien County



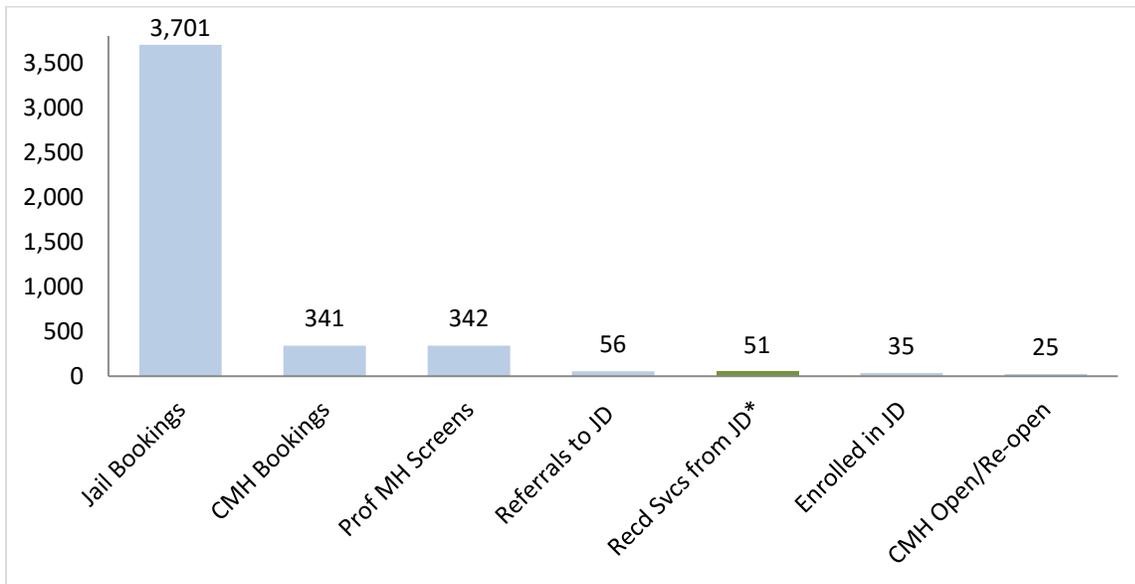
³ Note: Paired t-tests were used to test individual level change scores on the OPT scale ($t(13)=4.444, p<.05$). The statistical significance of this finding suggests that these results are highly unlikely to occur due to chance.

⁴ Note: Paired t-tests were used to test individual change scores on the De-escalation scale ($t(12)=3.237, p<.05$). The statistical significance of this finding suggests that these results are highly unlikely to occur due to chance.

Program Referral/Enrollment

As shown in Figure B3 below, the proportion of individuals booked into the jail and identified for mental health screening conducted by the jail’s mental health clinician was 9% (342 of 3,701). Approximately 9% of those booked into the jail were current CMH consumers (341 of 3,701). Of those screened by the Jail Clinician, 56 were referred to the JD program. Of these, 35 individuals were enrolled in the JD program and 25 were opened or reactivated for CMH services.

Figure B3. Berrien County Process Indicators April 2015 – September 2015

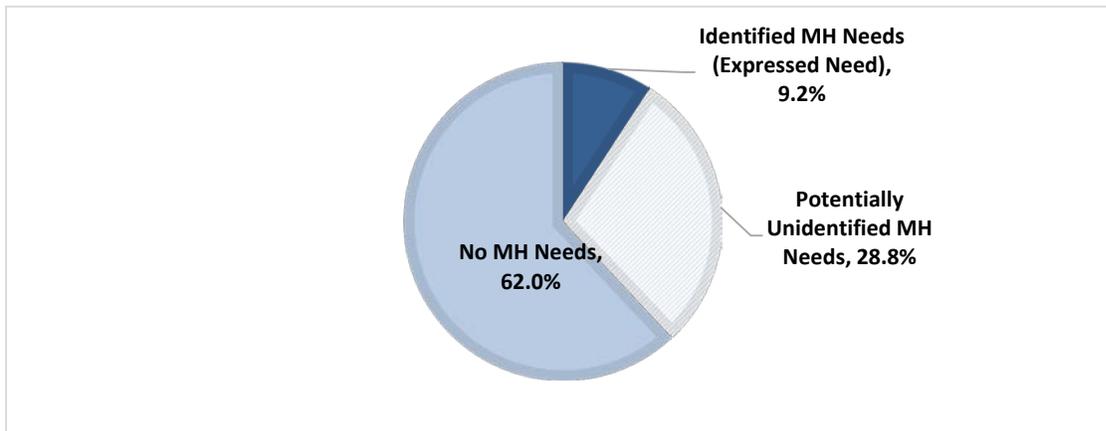


**A total of 51 individuals who received services from the jail diversion program, including 35 who were enrolled into the program, will be tracked for short- and long-term outcomes including jail recidivism and mental health treatment utilization.*

Need for Mental Health Services

Figure B4 on the following page shows the expressed need for mental health services in the Berrien County jail. Using the objective measure of estimated need for mental health screening/services derived from the previous study of K6 screenings of individuals at classification in BCJ, it is predicted that 38% of individuals might require mental health screening/services. Because only 9% were identified for mental health screening ('expressed need'), it is possible that there were many unidentified individuals with mental health problems (29%) resulting in a potential 'uncaptured' need.

Figure B4. Estimated Mental Health Service Needs in the Berrien County Jail



However, it should be noted that the objective need estimate of 38% of those entering the jail having symptoms associated with serious mental illness (SMI) as determined by the K6 may be inflated. The K6 screening process occurred during classification at Berrien County Jail, while all other sites conducted the screening at booking. Classification occurs later in the jail admission process, so the screens could have been conducted up to 48-hours after booking. Screenings conducted later in the jail admission process could potentially yield higher numbers of individuals screening positively for mental health concerns.

Progress on Year 1 Short-Term Objectives

The following short-term objectives were developed by the stakeholders during the proposal process as well as jointly between the Evaluation Team and stakeholders during the first site visit conducted at Riverwood in early 2015. Progress associated with each stated goal is based on information and feedback generated during monthly data collection calls and the second site visit.

The plan put forth in Berrien County was ambitious. Both interventions, CIT and the post-booking jail diversion program, were new initiatives for the community, requiring Riverwood to first establish relationships with BCSO, BCJ, and the Berrien County 911 & Public Safety Communication Center before the actual work of implementation could begin. The process of establishing rapport among the partner agencies went exceedingly well and paved the way for a successful implementation of both initiatives. Overall, the program is on track to successfully meet most objectives related to both jail services and CIT.

- 1. Develop a system and protocols to identify and code distress calls to dispatch that possibly involve experiencing a mental health crisis within the community.**

Progress: Goal met. Upon completion of the initial CIT training in April 2015, the Berrien County 911 & Public Dispatch Safety Communication Center implemented two new codes within the call system to capture and report mental health-related calls. The code provides dispatchers the option to code/open a call as “mental health” to indicate to responding officers that the call likely involves a mental health crisis. Similarly, responding officers are provided a code to clear/close a call as “mental health” if/when it is verified that the call responded to involved a mental health crisis.

2. Gain more specific information from dispatch calls to enhance system-level planning.

Progress: Goal partially met. The implementation of a mental health code to open and close dispatch and police calls has resulted in the ability to generate information that might assist the county's planning efforts. The information available on the calls provides date, time, type (psych, suicide, suspicious, welfare check etc.), location, disposition, and a brief narrative of the call. These call reports have been provided to the Evaluation Team for analysis (see Next Steps).

3. Improve screening at dispatch to effectively and efficiently determine if disturbance calls are related to a mental health issue or crisis.

Progress: Goal not met. The dispatcher supervisor from the Berrien County 911 & Public Safety Communication Center attended the initial CIT training conducted in Chicago in April 2015. However, it was determined that changes to the way calls are screened at the dispatch center would not be possible due to the tightly prompted system the dispatchers follow. Going forward, in-service training will be provided to dispatchers. The focus of the training will be the use of the CIT referral form developed by the Jail Diversion team to track pre-arrest diversions resulting in the referral of individuals to mental health services.

4. Increase in collaboration between the Sheriff's Office, the Jail and Riverwood via CIT Referral Form.

Progress: Goal met. Stakeholders proposed the development of a Coordinating Council comprised of members of law enforcement, dispatch, the courts, the Prosecutor's Office, and treatment providers to streamline and address gaps in the county's diversion initiatives including the jail diversion program, drug court, and mental health court. This council was to be in addition to a higher-level Advocacy Council already in place in the community and would conceivably serve as a forum for CIT collaboration and sustainment. It is reported that the Coordinating Council is in place and actively attended by two Riverwood administrators.

In addition, the Jail Diversion Supervisor identified two additional forums to promote and/or discuss CIT. First, a CIT Trainer meeting was implemented immediately following the first training session. Participants include the first cohort of trained officers. Additional trained officers are invited to attend if interested. The group meets monthly to troubleshoot, enhance the training, and discuss and resolve any field issues. Second, the Jail Diversion Supervisor regularly attends the Police Chiefs meeting, a monthly meeting hosted and attended by police chiefs from area police departments. Attendance at this meeting is intended to promote CIT among the local police chiefs. It is reported that promotion of CIT at these meetings, while yielding some additional participation from the local police departments, has been met with some resistance among the chiefs. The stakeholders plan to address this resistance during the second year of the program (see Next Steps).

5. Strengthen system and protocols to identify current Riverwood consumers who are booked at the jail each day.

Progress: Goal met. Riverwood actively monitors the jail's daily booking report Monday – Friday in a process that is separate from the jail diversion initiative as shown on the process map (Figure B5). Stakeholders report that this process includes the identification of consumers, notification of case managers, and release of medical records to the jail's mental health clinician.

- 6. Develop a system to identify, assess, and open/reactivate individuals within the jail assessed as having a serious mental illness (SMI) who are not current Riverwood consumers.**

Progress: Goal met. As illustrated on the process map (Figure B5), the jail mental health clinician refers individuals assessed as having an SMI and who may qualify for the Jail Diversion program to the Jail Diversion team. These individuals may or may not be current CMH consumers. Of the 43 individuals referred to Jail Diversion during the implementation period (April-September), 25 were opened or reactivated to CMH services by the Jail Diversion team.

- 7. Attempt to identify individuals suitable for pre-booking/pre-charge diversion by reducing time to assessment/referral.**

Progress: Goal partially met. The Jail Diversion team implemented a CIT referral form for use among patrol officers and dispatchers to track individuals diverted to treatment within the community. The Jail Diversion team actively follows up on these diversions to help ensure that the diverted individuals engage with treatment in a timely manner.

Next Steps

The second site visit revealed a number of positive changes and initiatives for Berrien County slated for the second year of the jail diversion pilot program.

- 1. Explore opportunity for a 24-hour drop-off.** Community stakeholders will consider exploring the opportunity to implement a 24-hour drop-off for individuals experiencing mental health crisis in the community. The implementation of such a resource would provide patrol officers with an additional treatment option other than the hospital emergency room (ER) or the jail. The drop-off would also provide the opportunity to increase pre-arrest and pre-booking diversion activities, both of which could potentially reduce the number of individuals with mental health concerns booked in to the jail.
- 2. Involve law enforcement to improve participation in CIT.** Stakeholders plan to encourage CIT-trained officers to attend the Police Chiefs meeting with the Jail Diversion Supervisor. During Year One, the Jail Diversion Supervisor attended most of the meetings alone. It was acknowledged by law enforcement stakeholders at the second site visit that law enforcement officials are more likely to listen to other law enforcement officials and/or are more likely to be interested in CIT if “sold” on “what’s in it for them” including reduction of paperwork, less wait time at the hospital ER, and providing tools and resources to more effectively deal with individuals in crisis. It is anticipated that active participation in these meetings by CIT-trained officers will improve local law enforcement’s participation in CIT.

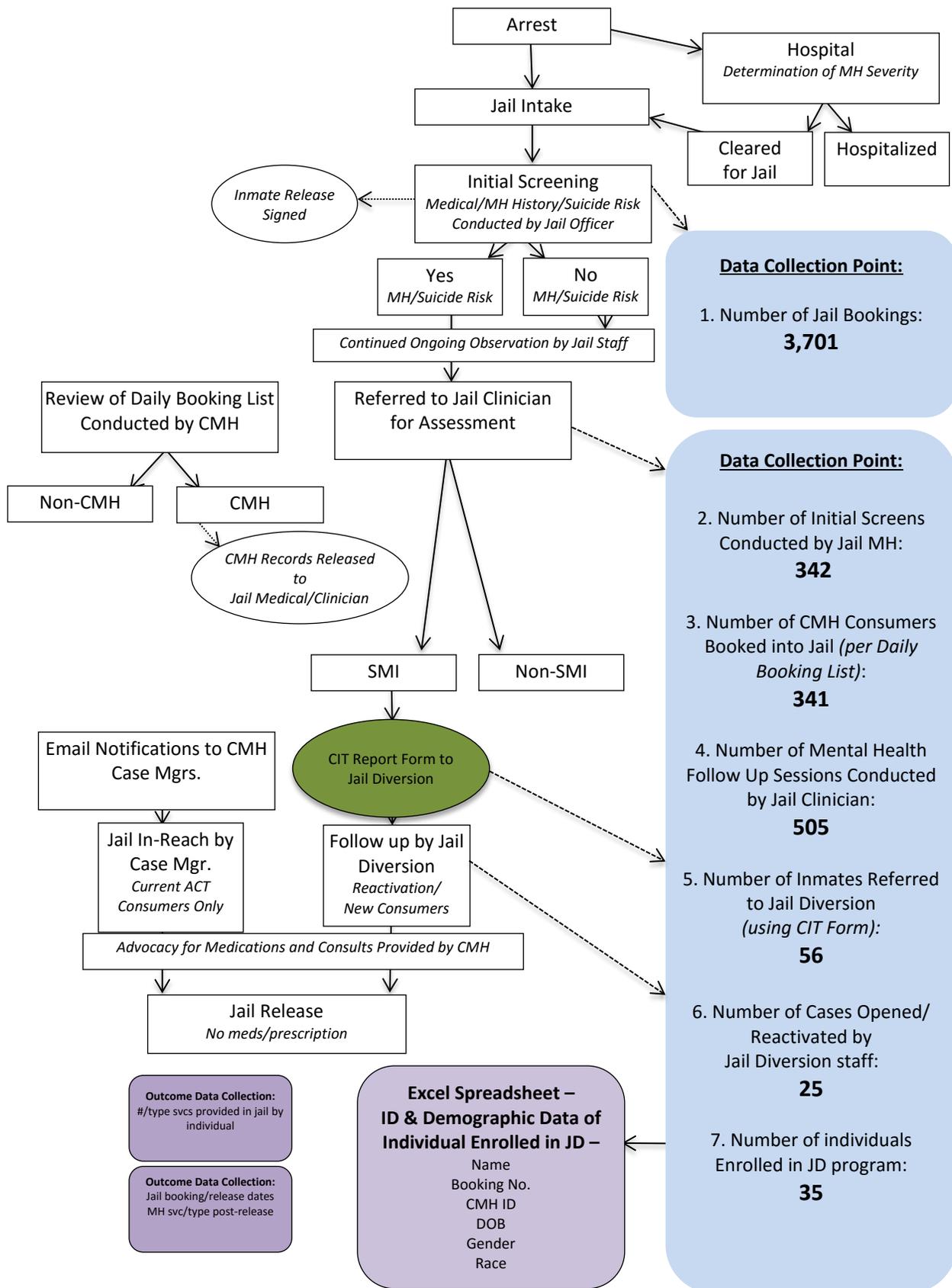
Evaluation Team Recommendations

In addition to the above initiatives, the Evaluation Team recommends the following.

- 1. Continue to assess effects of CIT training.** During the implementation period, Berrien County offered two different CIT training models which varied in terms of training length (40 v. 24 hours), location (Chicago vs. Berrien County), and trainers facilitating the training. The Evaluation Team will focus some effort to assess difference in scores based on which training was attended to determine if length of training time effects outcomes.

- 2. Define the diversion program model and eligibility criteria.** A key item to be addressed by the JD team is the jail diversion program model, in specific defining the target population of the program (e.g. CMH or non-CMH, mental health diagnosis, substance use disorder diagnosis, offense type, specific exclusions) and the standard services provided by the JD program (e.g. individual/group therapy, crisis care, community referrals, discharge planning, discharge follow-up, etc.). Based on site visit discussions, another point to consider would be if services are provided individuals who are ineligible/not enrolled in the JD program and, if so, the type and scope of those services. It is anticipated that clearly defining eligibility and services provided through the program will improve the number of qualified referrals from the jail's mental health clinician, as well as from other referral sources.
- 3. Assess advocacy efforts by the jail diversion team resulting in current diversion.** During the second site visit it was revealed that the JD team has provided advocacy services to some individuals that resulted in a current diversion (i.e., experienced fewer jail days due to an action or advocacy taken by JD team member). The Evaluation Team will continue to monitor these current diversions as identified by the JD team.

Figure B5: Berrien County Process Map



Appendix I-C: Kalamazoo County Site Summary

Introduction

The proposal put forth by Kalamazoo County Mental Health and Substance Abuse Services (KCMHSAS) for calendar year 2015 implementation, encompassed the enhancement of existing jail mental health services provided by the KCMHSAS jail team at the Kalamazoo County Jail (KCJ) and the training and implementation of CIT-Youth throughout Kalamazoo County.

This report details the implementation process during Year 1. It includes:

- A description of the program being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team's first site visit conducted in March 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the evaluation team's second site visit conducted in January 2016.

Description of Program Implementation in Kalamazoo County

Implementation of CIT in Kalamazoo County: Intercept 1

As part of the state diversion grant awarded to KCMHSAS, the Kalamazoo Department of Public Safety implemented a youth-specific Crisis Intervention Training (CIT-Y) for police officers. This particular training is only available to officers who have completed the 40-hour adult CIT training (this training was funded through the 2014 diversion funding). Three 8-hour training sessions were conducted by Sgt. Raphael Diaz of the Kalamazoo Police Department and Susan Davis, Program Manager of the Mobile Crisis Response Unit. The trainings were conducted on September 17, 25, and 29, 2015. A total of 89 officers attended the training.

Implementation of Jail Services in Kalamazoo County: Intercept 3

KCMHSAS, in partnership with the KCJ, proposed to enhance mental health services provided in the jail through expanding KCMHSAS clinical staff from one to two full-time jail clinicians. The clinicians handle all post-booking jail diversions as well as screening/assessment, coordination of care, discharge planning and ongoing consultation and advocacy between criminal justice officials and mental health and substance abuse treatment providers. Referred to as the 'housing' grant, this program also focuses on the use of a certified peer support specialist (CPSS) to assist in housing placement. Jail detainees are referred to KCMHSAS jail team by jail staff or by kite initiated by the individual. The process map, included as Figure C5 on the last page, illustrates the program operation as well as process counts achieved during the implementation period.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to the collection and analysis of the K6 mental health screening conducted at the jail pre- and post-program implementation, the Evaluation Team worked in tandem with key stakeholders to identify and measure key process indicators associated with the jail mental health services and the implementation of CIT-Y within Kalamazoo County. Based on the results of the initial consultation with the stakeholders, the following indicators were collected from Kalamazoo County starting in April 2015.

- # Jail Bookings
- # KCMSAS consumers booked to jail (from booking reports)
- # Referred to KCMHSAS Jail Clinicians
- # Screened by KCMHSAS Jail Clinicians
- # Referrals to Community-based Treatment by Jail Clinicians (Re-entry forms)
- % Occupancy of Housing Units
- Name, ID, M/F, Race, DOB of Inmates Diverted by Jail Clinicians

As KCMHSAS grew their jail diversion program, the evaluation of the pilot program was adapted as well. Specific changes were implemented in the collection of process data to more appropriately reflect the program. These changes included the collection of identifying data for those who are referred to community-based treatment (via a Re-entry Form) to track short- and long-term outcomes of those diverted from jail as well as those who were referred to treatment post-release (see below).

Additionally, some changes were made to align process indicators collected in Kalamazoo County with cross-site indicators collected at the other jail diversion pilot sites. The identified cross-site variables included: jail bookings, mental health screenings, mental health assessments, and individuals receiving services.

The final list of process indicators is included below and is reflected in the process map (Figure C5).

- # Jail Bookings
- # KCMSAS consumers booked to jail (from booking reports)
- # Referred to KCMHSAS Jail Clinicians
- Adjusted* # Screened by KCMHSAS Jail Clinicians (MH Assessments)
- # Referrals to Community-based Treatment by Jail Clinicians (Re-entry forms)
- % Occupancy of Housing Units
- Adjusted* Name, ID, M/F, Race, DOB of Inmates Diverted by Jail Clinicians or Referred to Community-based Treatment (from Re-entry Form)

The long-term outcome evaluation to be conducted by the Evaluation Team and reported in 2017 will follow those individuals served by the KCMHSAS jail team, including those diverted and those simply referred to treatment, to assess treatment engagement in the community and recidivism.

CIT-Y Pre/Post Training Indicators

Prior to the training, a pre-test was administered to all attending officers, followed by a post-test at the end of the training. The survey included 27 questions that inquired about the officers' knowledge of normal youth development, youth mental health, de-escalation techniques, and community resources and policies related to youth mental health. Each question had a Likert scale response that ranged from 1 (strongly disagree) to 5 (strongly agree). All 27 questions were then summed together to create a total score for knowledge in these areas¹. The total score could range from 27 to 135. To determine if the training had a positive impact on the attending officers, there should be a significant increase in score from pre to post test on average.

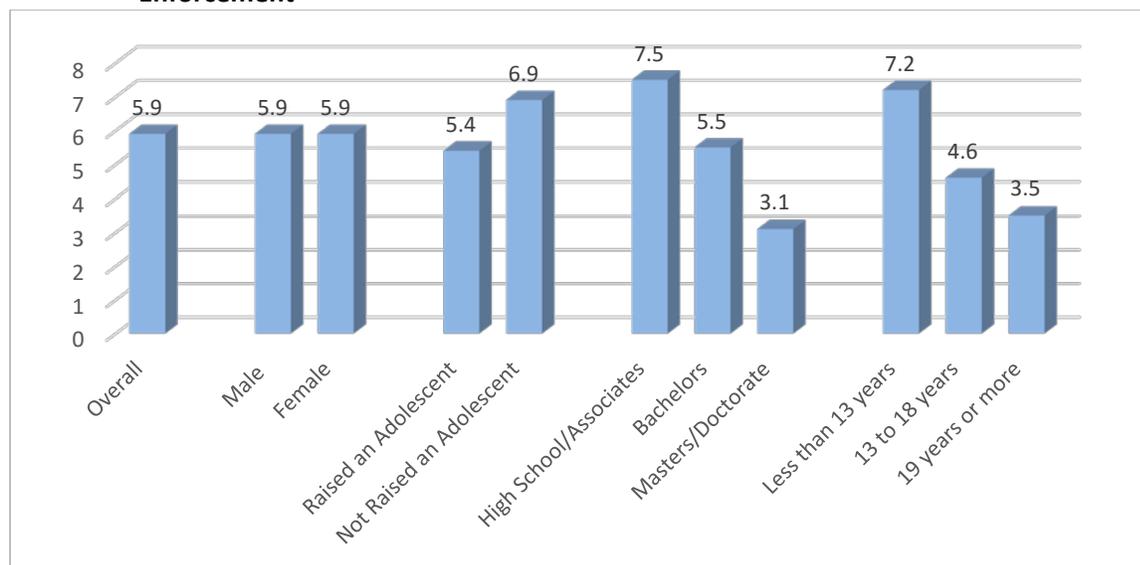
At pre-test, the scores ranged from 84 to 117, with an average score of 99. At post-test, the average score was 105, with a range from 84 to 126. Using paired t-tests to assess individual level change

¹ Some scale items are reversed scored so that all questions have a similar measurement metric.

between pre and post-tests, a significant increase in scores, averaging 5.9 points was found ($t(82)=7.44$, $p<.001$).

Examining change scores – or the differences between pre and post test scores – by various demographic characteristics as shown in Figure C1 below provides an indication of who may have learned more from the training. Analysis revealed that those who had not raised an adolescent learned more, on average, than those who had. Similarly, those with lower educational attainment and less time on the force learned more than those with a Bachelors or graduate degree and those who had been on the police force longer periods of time.

Figure C1. Change Score by Gender, Raising an Adolescent, Education Level, & Years in Law Enforcement



CIT Diversions and Closures (Adult and Juvenile)

The diversions associated with the adult CIT training are not technically part of this evaluation as they were funded under a 2014 grant. However, the tracking and system level changes are related and for that reason, data provided by project personnel is being reported.

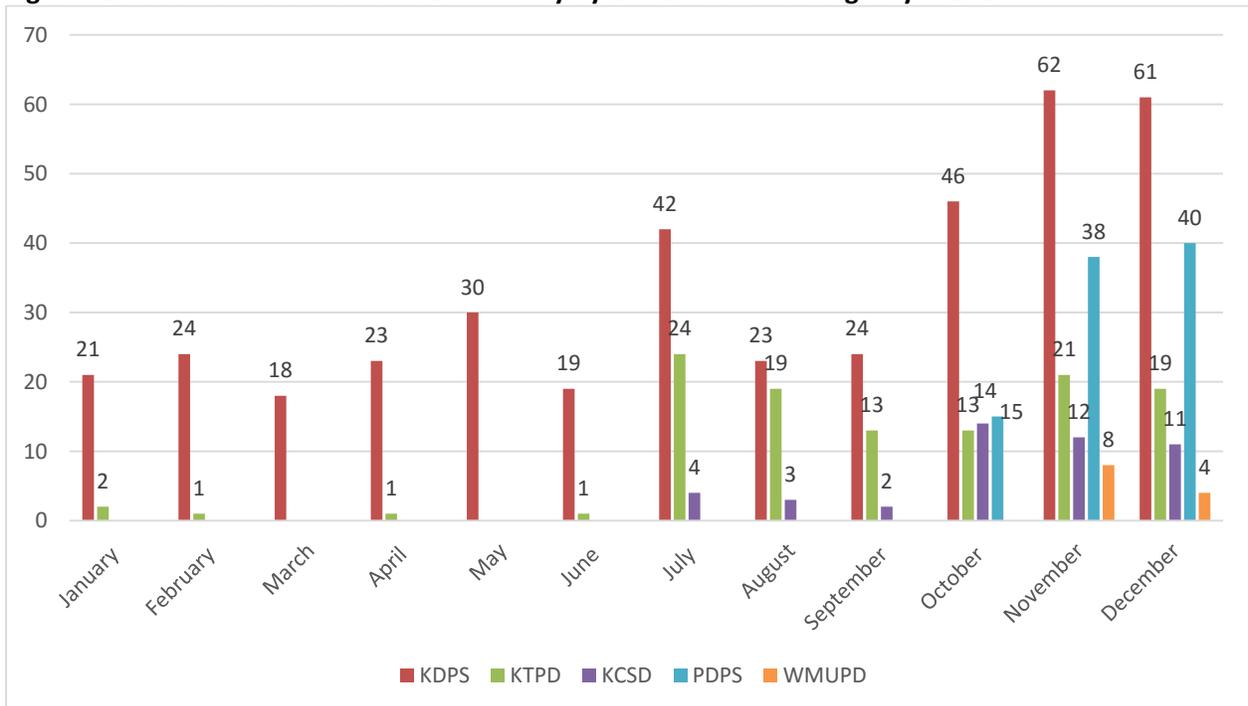
Table C1 shows that there were 33 individuals diverted from jail by law enforcement in Kalamazoo in 2015: 27 adults and 6 juveniles. As is true for the jail program, Kalamazoo differentiates current diversions from activities that might support future diversion. If an individual is involved in criminal activity that could result in arrest but law enforcement recognize a mental health issue and divert to a therapeutic solution, it is considered a **current** diversion.

| Table C1. CIT Current Diversions in 2015 | | |
|--|-----------|----------|
| 2015 | Adult | Juvenile |
| January | 0 | |
| February | 3 | |
| March | 3 | |
| April | 2 | |
| May | | 2 |
| June | 1 | |
| July | 6 | |
| August | 2 | |
| September | 1 | |
| October | 3 | 1 |
| November | 2 | 2 |
| December | 4 | 1 |
| TOTALS | 27 | 6 |

In addition to using CIT skills for current diversion, Kalamazoo law enforcement from several jurisdictions (i.e., city, township, sheriff) utilize CIT skills to defuse situations or refer individuals to community resources. When this occurs, the officers complete a five-question query that allows for the tracking of calls where CIT skills are used. Tracking of these ‘CIT closures’, as these calls are termed, is facilitated through a law enforcement liaison from KCMHSAS.

These numbers provide evidence of CIT skills being utilized even when no current diversion can be counted. Figure C2 below provides further evidence of CIT skill utilization across several law enforcement jurisdictions in Kalamazoo County. The coordination among five different law enforcement agencies (including one university police department) demonstrates the breadth of adoption of CIT in Kalamazoo County.

Figure C2. Crisis Closures in Kalamazoo County by Law Enforcement Agency in 2015



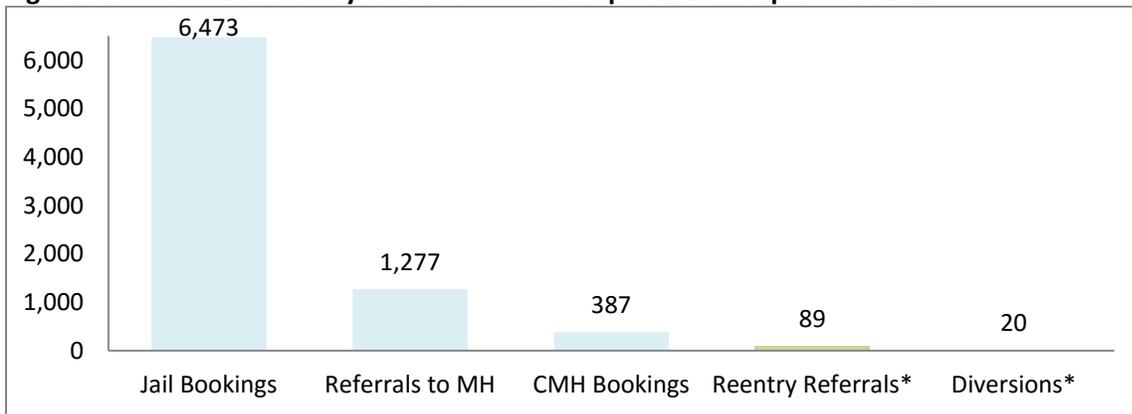
Note: KDPS-Kalamazoo Department of Public Safety, KTPD-Kalamazoo Township Police Department, KCSD-Kalamazoo County Sheriff Department, PDPS-Portage Department of Public Safety, WMUPD-Western Michigan University Police Department.

Note 2: Numbers for PDPS represent a low estimate as monthly totals were not available for some of their data.

Program Referral/Enrollment

As shown in Figure C3 on the following page, the proportion of individuals who were referred by jail staff for screening and/or services by the community mental health (CMH) jail treatment team was 20% of those booked (1,277 of 6,473).

Figure C3. Kalamazoo County Process Indicators April 2015 – September 2015



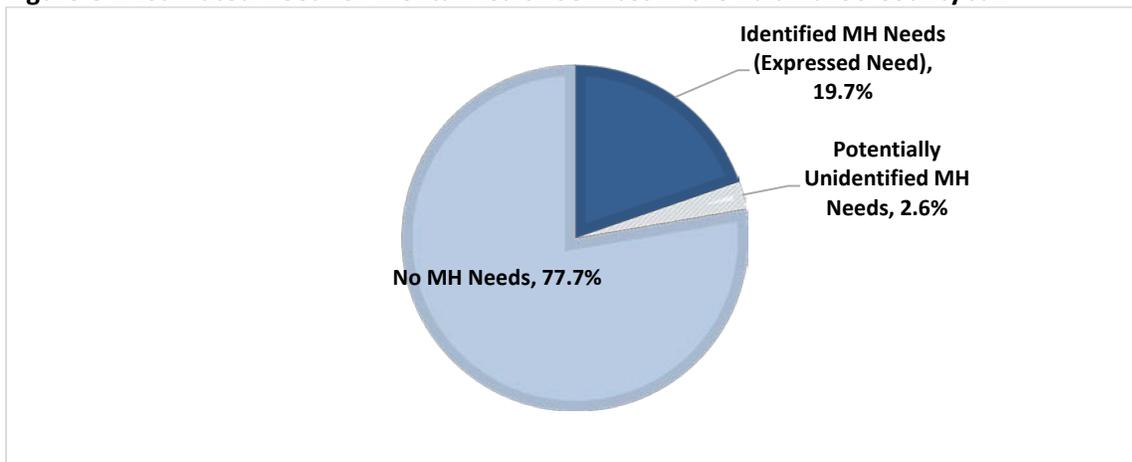
**A total of 109 individuals who received services from the mental health unit, including 20 who were diverted from jail and 89 who received a community referral, will be tracked for short- and long-term outcomes including jail recidivism and mental health treatment utilization.*

CMH consumers entering the jail represent about 6% of those booked (387 of 6,473). The KCMHSAS jail team provided reentry discharge planning to 89 individuals and ‘current diversion’ (defined as decreasing jail days during the current incarceration) to 20 individuals.

Need for Mental Health Services

Figure C4 below shows the need for mental health services in the Kalamazoo jail. Using the objective need estimate derived by the previous study using the K6 with all individuals booked into the jail, it is estimated that approximately 22% of individuals entering the jail might require mental health services. Because those referred to mental health screening was close to 20% (expressed need), it is possible that approximately 3% of individuals were unidentified, resulting in a potential ‘uncaptured’ need.

Figure C4. Estimated Need for Mental Health Services in the Kalamazoo County Jail



Progress on Year 1 Short-Term Objectives

The following short-term objectives were developed by the stakeholders during the proposal process as well as jointly between the Evaluation Team and stakeholders during the first site visit conducted in Kalamazoo County in March 2015. As such, the resulting short-term objectives address both the CIT and jail services programs. Progress associated with each stated objective is based on information and feedback generated during monthly data collection calls and the second site visit.

1. Strengthen the system to screen, assess, and coordinate care for those with active serious mental illness (SMI) symptoms during jail incarceration (CMH and non-CMH).

Progress: Goal partially met. As shown on the process map (Figure C5), individuals who are booked to the jail and flagged for mental health or substance abuse during the initial screening process are referred to the KCMHSAS jail team. Upon referral, the KCMHSAS jail team determines if the individual is symptomatic and, if so, determines their CMH status. Those who are not current CMH consumers are screened by the KCMHSAS clinician. As discussed earlier in this report (see Implementation of Jail Services in Kalamazoo County: Intercept 3), it is estimated that less than 3% of individuals identified as possibly needing mental health services are not being referred to the KCMHSAS jail team for services.

2. Strengthen the system to influence judicial decisions and reduce jail time for those booked at KCJ who are identified as having SMI (CMH and non-CMH).

Progress: Goal met. The KCMHSAS jail team actively advocates for diversion from jail to treatment on behalf of individuals identified as having SMI. As shown in the process map (Figure C5), the jail team diverted 20 individuals from jail to treatment during the implementation period.

3. Increase skills and resources available to law enforcement and CMH providers to benefit youth with potential mental health problems and to avoid arrest/incarceration and out of home placements through CIT-Y.

Progress: Goal met. Three CIT-Y training sessions were conducted in Kalamazoo County in September 2015. A total of 89 officers attended the training. Results of the pre-/post-tests administered at the trainings are earlier in this report (see Implementation of CIT-Y in Kalamazoo County: Intercept 1).

4. Improve relationships between community members and law enforcement related to troubled youth through CIT-Y.

Progress: Goal partially met. One primary resource to benefit youth in crisis within the Kalamazoo community is the Mobile Crisis Response Unit (MCRU), a 24-hour/7 days per week service focused on mental health or substance abuse crises among 10 -17 year olds. MCRU is a 'first responder' and also provide linkage and advocacy services. MCRU does not define what a crisis is; they allow the families to define it. During 2014, the MCRU received 902 crisis calls, with well over half (62%) of the calls initiated by parents. The second highest source was hospitals (17%). During the same time period, only 8 calls (.08%) were initiated by police. However, sometimes MCRU staff members call police or encourage family members to call police for assistance in volatile situations. It is reported that sometimes parents are reluctant to call police for fear their child will be taken to jail. Conversely, police officers interacting with youth in crisis can call MCRU for assistance. It was reported that some officers are unaware of the existence of MCRU or the resources that it offers in diffusing crisis situations. It is anticipated that CIT-Y training will increase the number of referrals to MCRU. The Evaluation Team will collect MCRU reports to monitor this relationship (see Next Steps).

Next Steps

The second site visit revealed a number of positive changes and initiatives for Kalamazoo County slated for the second year of the jail diversion pilot program.

- 1. Monitor relationship between community members and law enforcement related to troubled youth through CIT-Y.** One objective for Year One was the commitment to expand the relationship between the community and law enforcement. As noted earlier, CIT-Y training was provided to 89 officers in September 2015. One measure of the success of the CIT-Y training was the anticipated increase in police referrals to the MCRU. Through the end of November 2015, with just two months of MCRU data, no police referrals to MCRU were reported. The Evaluation Team will continue to collect monthly MCRU reports to monitor this relationship.
- 2. Track and assess CIT closure and diversion data.** Crisis call data, as illustrated above in C2, was provided by the CIT Coordinator (hired under this grant) to the Evaluation Team during the second site visit. CIT crisis closures and diversion call counts will continue to be reported by the CIT Coordinator to the Evaluation Team on a monthly basis beginning in January 2016.
- 3. Track treatment and recidivism outcomes for individuals diverted in the CIT program.** Stakeholders are interested in recidivism outcomes for adults diverted to treatment by law enforcement. For these individuals, tracking may include jail data (i.e., booking, release and offense type), similar to tracking for individuals diverted in the jail diversion program. However, tracking potentially could be expanded to include police contact/action and arrests as captured in the iLEADS system -- the records management system used by three of the five police agencies within the county including KDPS, KTPD, and KCSD -- and/or through MSP data. It is unknown if access to iLEADS for purposes of this evaluation would be granted. During the second year of the grant, the stakeholders and Evaluation Team will collaboratively identify short- and long-term objectives associated with the county's CIT program.
- 4. Track treatment and recidivism outcomes for individuals diverted to the hospital in the CIT program.** Stakeholders also expressed an interest in tracking those individuals diverted to Borgess Hospital ER (N=100) by local police agencies during the previous grant period (2014). Tracking of these individuals could include state-level mental health treatment, jail bookings/releases and offenses through KCJ, and, possibly, if access is granted, police contact through the iLEADS system. During the second year of the grant, the stakeholders and Evaluation Team will collaboratively identify short- and long-term objectives associated with the county's CIT program.

Appendix I-D: Kent County Site Summary

Introduction

The proposal put forth by Network 180, a community mental health agency (CMH), focused on the sustainment of jail mental health services provided within the Kent County Jail (KCJ) since 1994. Sustainment of the program included maintaining a total of 6.0 FTE (3.0 funded/contracted by Network 180 through this grant plus 3.0 funded by KCSD) to provide mental health services – including mental health assessment, individual/group therapy, and discharge planning – for all inmates (CMH and non-CMH) identified as having a mental health issue.

This report details the first year of grant activity. It includes:

- A description of the program being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team’s first site visit conducted in early 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the evaluation team’s second site visit in January 2016.

Description of Program in Kent County

Sustainment of Jail Mental Health Unit in Kent County: Intercept 3

Network 180, in partnership with its contracted jail mental health provider, Family Outreach Center, and the KCJ, proposed to sustain mental health services provided in the KCJ since 1994. The program includes maintaining a total of 6.0 FTE (3.0 funded/contracted by Network 180 through this grant plus 3.0 funded by the KCJ) to provide mental health services – including mental health assessment, individual/group therapy, and discharge planning and follow-up – for all inmates identified as having a mental health issue. Individuals are referred to the mental health unit by the jail corrections staff.

The process map, included as Figure D3 on the last page, illustrates the program operation as well as process counts for the implementation period.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to the collection and analysis of the K6 mental health screening conducted at the jail at the beginning of the grant period and one year later, the Evaluation Team worked in tandem with key stakeholders to identify and measure key process indicators associated with the jail mental health services in Kent County.

Based on the results of the initial consultation with the stakeholders, the following indicators were collected from Kent County beginning in April 2015.

- # Jail Bookings
- # Intake Screenings
- # Referrals/Notifications to Jail Mental Health
- # Assessments by Jail Mental Health

Network 180 Jail Treatment Plans Developed
 # Non-Network 180 Jail Treatment Plans Developed
 Name, booking ID, booking date, CMH ID, last-4 SSN, sex, race, DOB, county of residence, CMH status of all individuals provided with a Treatment Plan

One change was implemented in the collection of process data to more accurately reflect the process the jail mental health program follows in providing treatment plans as clarified during the second site visit. As noted during the site visit, while most individuals reflected in the Treatment and Comparison Groups do receive a treatment plan, some do not if their length of stay is anticipated to be less than 20 days. This is reflected in the process map (Figure D3).

Also, some changes were made to align process indicators collected in Kent County with cross-site indicators collected at the other jail diversion pilot sites. The identified cross-site variables include jail bookings, mental health screenings, mental health assessments and individuals receiving services. The final list of process indicators includes the following:

| | |
|-----------------|---|
| | # Jail Bookings |
| | # Intake Screenings |
| | # Referrals/Notifications to Jail Mental Health |
| | # Assessments by Jail Mental Health |
| <i>Adjusted</i> | # Network 180 Receiving Services |
| <i>Adjusted</i> | # Non-Network 180 Receiving Services |
| <i>Adjusted</i> | Name, booking ID, booking date, CMH ID, last-4 SSN, sex, race, DOB, county of residence, CMH status of all individuals receiving services from jail mental health |

The long-term outcome evaluation to be conducted by the Evaluation Team and reported in 2017 will follow individuals assembled in the Treatment and Comparison Groups who received services from the Jail Mental Health Unit to assess treatment engagement in the community and recidivism.

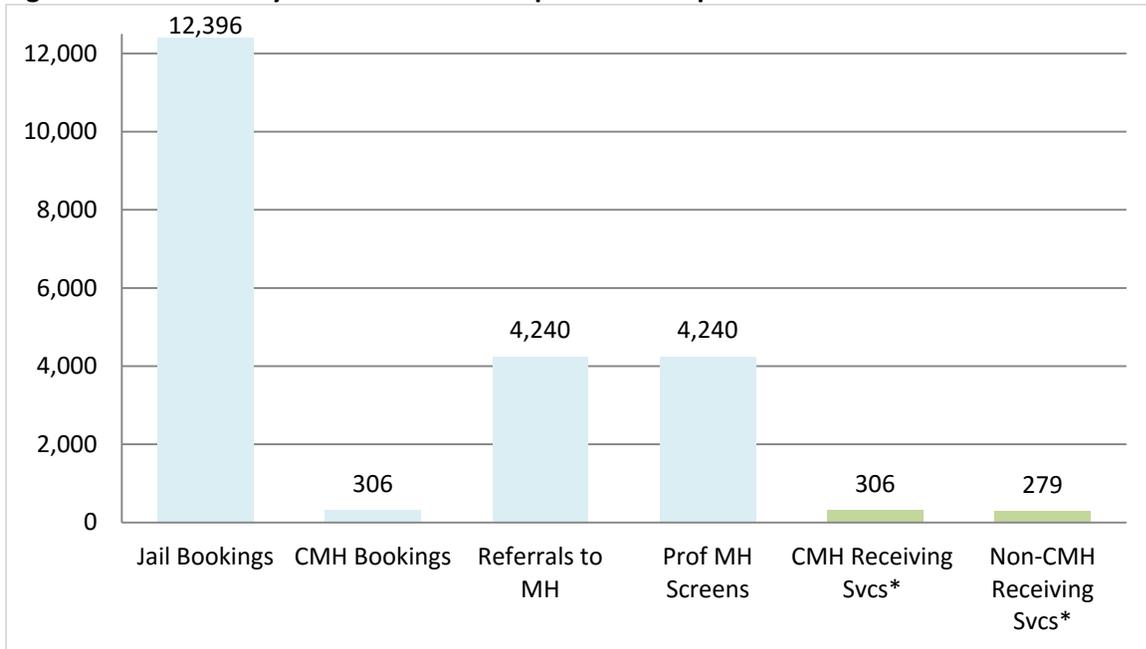
Program Referral/Enrollment

Figure D1 on the next page shows that during the six-month implementation period, there were over 12,000 individuals booked into the Kent County Jail.

The proportion of individuals referred for mental health screening/services during this time was 34% of those booked (4,240 of 12,396). All of those referred for screening were assessed by a jail mental health clinician (4,240 of 4,240). Of those assessed, 14% received treatment plans from the jail mental health unit.

Of the 585 individuals who received mental health treatment services within the jail, 52% were known to be CMH consumers and 48% were not. Those who are CMH consumers receive after-care services in the community to ensure that individuals receive medication and attend their next community appointment. Those who are not current consumers, but meet eligibility criteria, are enrolled in CMH community based services. In the evaluation of long term outcomes, both groups will be followed.

Figure D1. Kent County Process Indicators April 2015 – September 2015

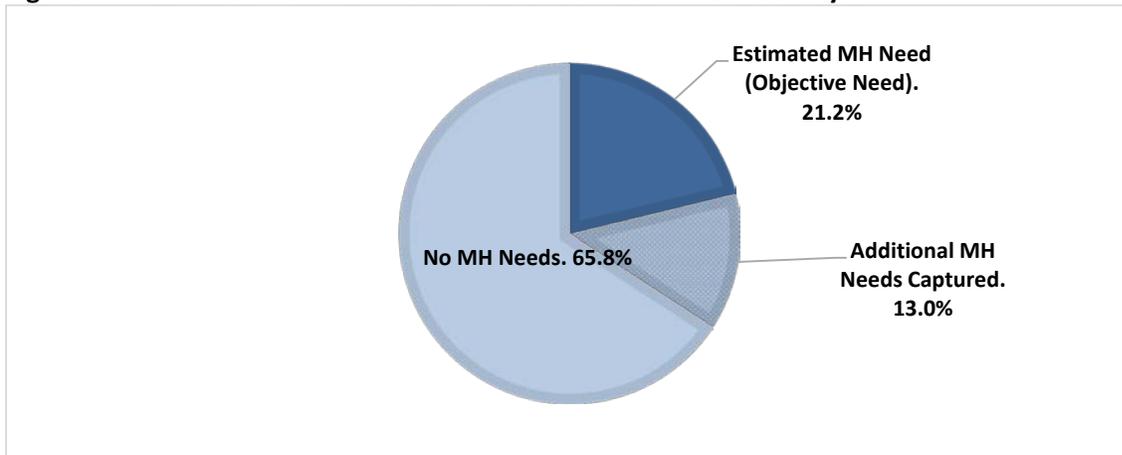


**A total of 585 individuals who received services from the jail diversion program, including 306 CMH and 279 Non-CMH, will be tracked for short- and long-term outcomes including jail recidivism and mental health treatment utilization.*

Need for Mental Health Services

Figure D2 below shows the need for mental health services in the Kent County jail. Using the ‘objective need’ estimate derived from the previous study using the K6 screening on those booked into the jail, it is estimated that approximately 21% of individuals might require mental health services. Based on this objective estimate, Figure D2 illustrates a higher ‘expressed need’ based upon the 34% of individuals referred for screening. In other words, an additional 13% of the jail population was referred to jail mental health than what might have been expected by the ‘objective measure’. This additional need captured in the KCJ was not uncovered in any other county.

Figure D2. Estimated Need for Mental Health Services in Kent County Jail



Proposed Evaluation Plan

Because the program proposed by Kent County was a program in existence within the jail for over 20 years and not a new program as the other jail diversion pilot programs are, short-term objectives were not established in Kent County. However, the Evaluation Team and Network 180 developed an evaluation plan to assess the effectiveness of the mental health intervention provided within the jail including a process and outcome evaluation.

The process evaluation focuses on the process indicators associated with the current intervention delivered within the jail and details the processes and protocols associated with the intervention as defined by the stakeholders. The outcome evaluation is intended to measure the efficacy, or outcomes, of the mental health services delivered within the jail.

For purposes of the outcome evaluation, treatment and comparison groups have been identified within the existing jail mental health treatment process. Individuals within the KCJ determined to have a serious mental illness (SMI) such as major depressive disorder, bipolar disorder, schizophrenia, but who are “non-Network 180” (i.e. are not enrolled/eligible for/in Network 180 services) will be identified as part of the Comparison Group. Those individuals within the KCJ determined to have an SMI and currently enrolled in CMH services are “Network 180” and will be identified as the Treatment Group. Both groups have equal access to the mental health services provided within the jail.

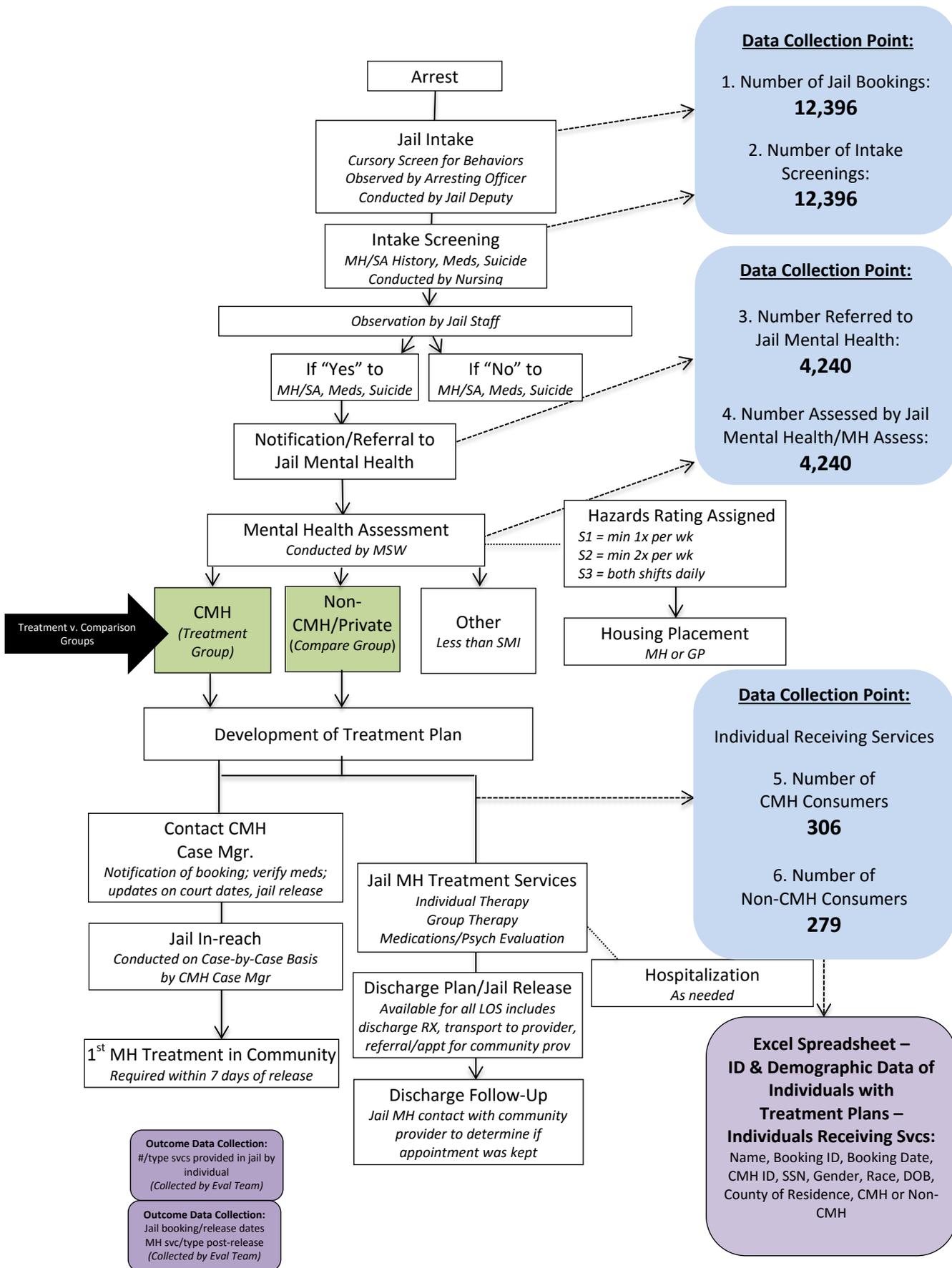
Next Steps

The second site visit revealed a number of positive changes and initiatives for Kent County slated for the second year of the jail diversion pilot program.

- 1. Identify CMH opens/reactivations after jail booking.** During the second site visit, it was noted that the jail mental health team actively enrolls individuals who qualify for CMH services into Network 180 during incarceration at the KCJ. This enrollment is facilitated by the jail mental health team. This change in CMH status will impact the composition of the Treatment and Compare Groups as initially assembled. Because CMH enrollment may be facilitated in other ways (e.g. probation) and/or beyond the first month of incarceration, CMH status may change beyond this point as well. Going forward, jail mental health will identify those who are known to enroll in CMH during the month in which they are booked to jail. The Evaluation Team will then work with Network 180 to flag additional opens/reactivations occurring after the booking month.
- 2. Track advocacy efforts resulting in current diversion.** Following the second site visit, it was revealed that the jail mental health team also regularly provides advocacy services which may result in early release for inmates. This advocacy is usually provided in the form of a letter of request to the judge/magistrate to issue a personal recognizance (PR) bond for the inmate to be released from jail to community-based treatment. In order to qualify for advocacy, the inmate must have a misdemeanor or non-violent felony charge and be SMI or developmental disabled. Beginning in January 2016, the jail mental health team will identify those individuals who received the benefit of advocacy effort and were successfully diverted (i.e., current diversion) from jail to community-based treatment. In addition, those who were diverted prior to January 2016 will be retroactively identified by the jail mental health team and considered to be current diversions by the Evaluation Team.

- 3. Explore opportunity for 24-hour drop-off.** Community stakeholders will consider exploring the opportunity to implement a 24-hour drop-off for individuals experiencing mental health crisis in the community. The implementation of such a resource would provide patrol officers with an additional treatment option other than the hospital emergency room or the jail. The drop-off would also provide the opportunity to increase pre-arrest and pre-booking diversion activities, both which could potentially reduce the number of individuals with mental health concerns booked to the jail.

Figure D3. Kent County Process Map



Appendix I-E: Marquette County Site Summary

Introduction

The proposal put forth by Pathways Community Mental Health (CMH) introduced a plan to expand access to Moral Reconciliation Therapy (MRT) provided in the jail and community as well as to implement a Crisis Intervention Team (CIT) training program across Marquette County.

This report details the implementation process of those services and programs during Year 1. It includes:

- A description of the programs being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team's first site visit conducted in early March 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the Evaluation Team's two site visits (March 2015 and March 2016).

Description of Program Implementation in Marquette County

Implementation of Crisis Intervention Team (CIT) Training in Marquette County: Intercept 1

In partnership with the Marquette County Sheriff's Office (MCSO) and the Marquette City Police Department (MCPD), Pathways proposed to train and implement CIT training among a total of up to 40 officers including patrol officers and dispatchers from Marquette County Central Dispatch across Marquette County including the MCSO and local police departments within Marquette County.

One 16-hour training was conducted by CIT-certified officers from MCSO at Northern Michigan University on July 16 – 17, 2015. The training curriculum included introductions to mental health and CIT, de-escalation techniques, legal issues, current topics (e.g. excited delirium, suicide by cop etc.) and scenario training using local actors to depict individuals in crisis. A total of 17 officers from across Marquette County volunteered to attend the training including three Marquette County Sheriff's deputies, two Alger County Sheriff's deputies, two Northern Michigan University (NMU) public safety officers and ten officers from local police departments including Marquette City (seven patrol, one dispatch), Houghton (one patrol), and Chocolay Township (one patrol).

Stakeholders in Marquette County continue to promote and expand CIT throughout the greater Marquette area. The Pathways Jail Liaison currently leads an advisory group comprised of representatives from NMU, MCSO, and MCPD. The group meets monthly to engage in problem-solving and monitoring related to the CIT program as well to identify potential training targets. This effort resulted in a CIT introductory training conducted in nearby Delta County, the second largest county within the Pathways CMH catchment area, in January 2016. This is described in more detail later in this report, in the section on Next Steps.

Implementation of Jail Services in Marquette County: Intercept 3

In partnership with the Marquette County Jail (MCJ) and the Marquette County Prosecutor's Office, Pathways also proposed to develop a more inclusive referral and delivery system for MRT groups within the jail and community. MRT groups initiated under a previous diversion grant were accessible to current or re-activated CMH consumers only. Under this grant, access to MRT groups was expanded to

include non-CMH individuals. Additionally, the number and target audience of MRT groups grew to include a group within the jail, at Pathways, at the court house, and at the detention center. The groups are facilitated by Pathways' Jail Liaison (community), a jail mental health professional (jail), and a probation or parole agent (court and detention center). The process map, included as Figure E6 on the last page, illustrates the program operation, as well as process counts during the six-month implementation period.

The plan put forth by Pathways, particularly as it related to CIT, was largely dependent on a strong collaboration with the various law enforcement agencies operating within Marquette County. Although cooperation and support among some of the law enforcement agencies was stronger than anticipated, the implementation process revealed resistance among others.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to the collection and analysis of the K6 mental health screening conducted at the jail during the implementation period, the Evaluation Team worked in tandem with stakeholders to identify and measure key process indicators within their implementation of Jail Services and CIT in Marquette County. Based on the results of the initial consultation with the stakeholders during the first site visit, the following process indicators for CIT and Jail Services were to be collected from Marquette County beginning in April 2015.

| | |
|----------------|---|
| CIT: | Name, title, agency affiliation of trainees Pre/Post-CIT Training survey Collection of 5 Questions (TBD in CIT call process) # Total Calls to Dispatch # Calls Cleared as MH at Dispatch Final Disposition of MH Coded Calls (jail, hosp/ER, Crisis Svcs/Jail Diversion, home/family/no action) |
| Jail Services: | # Jail Bookings # K6 Screenings # In-Jail Assessments by Pathways (Tami) # Cases Opened/Reactivated by Pathways by Crisis Services (Tami) # Referrals for MRT to Jail Mental Health # Enrolled in In-Jail MRT group(s) (Non-CMH only) # Enrolled in Community-based MRT (Non-CMH only) # Starting MRT (Non-CMH only) # Completing MRT (Non-CMH only) Name, ID, M/F, DOB of those enrolled in MRT (jail or community) |

As Pathways implemented and grew their jail diversion program, the evaluation of the pilot program was adapted as well. Specific changes were implemented in the collection of process data to appropriately reflect changes to the program as implemented. The primary change to data collection involved the expansion of process indicators to include CMH consumers in addition to non-CMH individuals. Initially, data collection focused only on non-CMH individuals as this was the primary focus of the proposal put forth by Pathways. Additionally, some changes were made to align process indicators collected in Marquette County with cross-site indicators collected at the other jail diversion

pilot sites. The identified cross-site variables included: jail bookings, mental health screenings, mental health assessments, and individuals receiving services.

The final list of process indicators was revised to include the following. These are indicated on the process map (Figure E6).

| | |
|----------------|--|
| CIT: | Name, title, agency affiliation of trainees Pre/Post-CIT Training survey Collection of 5 Questions (TBD in CIT call process) # Total Calls to Dispatch # Calls Cleared as MH at Dispatch Final Disposition of MH Coded Calls (jail, hosp/ER, Crisis Svcs/Jail Diversion, home/family/no action) |
| Jail Services: | # Jail Bookings |
| Removed | # K6 Screenings |
| Added | # Screens Conducted by Jail MH (Professional Screens) |
| Adjusted | # Assessed by Jail Liaison (MH Assessments) # Cases Opened/Reactivated by Pathways by Crisis Services (Tami) # Referrals for MRT to Jail Mental Health |
| Expanded | # Enrolled in In-Jail MRT (CMH + Non-CMH) # Starting In-Jail MRT # Completing In-Jail MRT |
| Added | # Individuals Receiving Services |
| Expanded | # Enrolled in Community MRT (CMH + Non-CMH) # Starting Community MRT # Completing Community MRT Name, ID, M/F, DOB of those enrolled in MRT (jail or community) |

The long-term outcome evaluation to be conducted by Evaluation Team and reported in 2017 will follow those individuals (both CMH and non-CMH) enrolled in MRT in the jail and community to assess treatment engagement in the community and recidivism.

CIT Pre/Post Training Indicators

A total of 13 officers who attended the training completed both pre- and post-test assessments. All were male, with an average of 13 years on the force (range from 3 to 22 years). Over two-thirds had a bachelor's degree (69%).

The pre- and post-tests were implemented immediately prior to (pre-) and following (post-) the training and are based on two instruments: the *Opinions of Psychiatric Treatment (OPT) Measure* and the *De-escalation Scale*. The 20-item validated OPT Measure assesses officers' attitudes and knowledge about psychiatric treatments within the community and attitudes about psycho-pharmacotherapy, psychotherapy, and psychosocial interventions. Responses are given a six-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The possible range of scores is 20–120. The 8-item De-Escalation Scale measures officers' de-escalation skills. Officers' opinions on the effectiveness of specific actions in various situations were rated on a four-point Likert scale ranging from 0 (very negative) to 3 (very positive). Total subscale scores range from 0 to 24.

As shown in Figure E1 below, there was an average change score from pre to post-test of 7.9 points on the OPT scale. Although the sample size is small, there was a statistically significant difference between the pre- and post-test¹. Based on this significant difference, it is likely that the training had a positive effect on the officer's knowledge of treatment and services for those with mental illness.

Figure E1. Differences in OPT Scale Pre- to Post-CIT Training in Marquette County

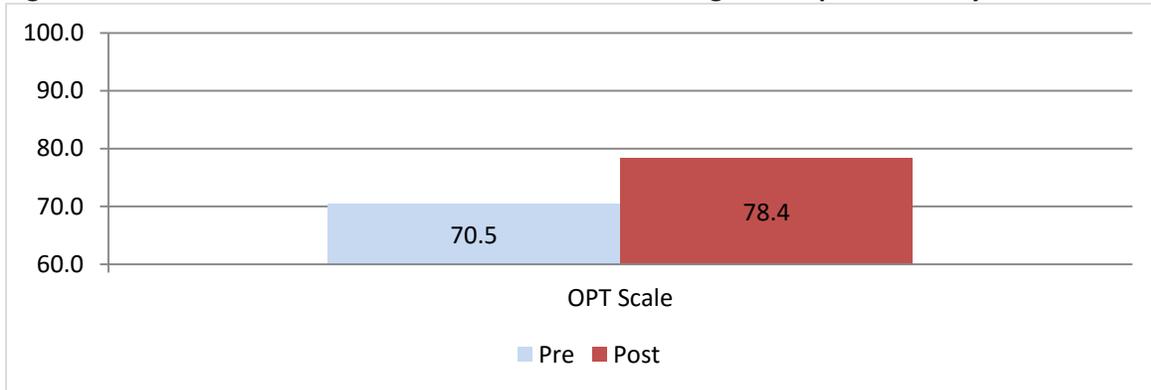
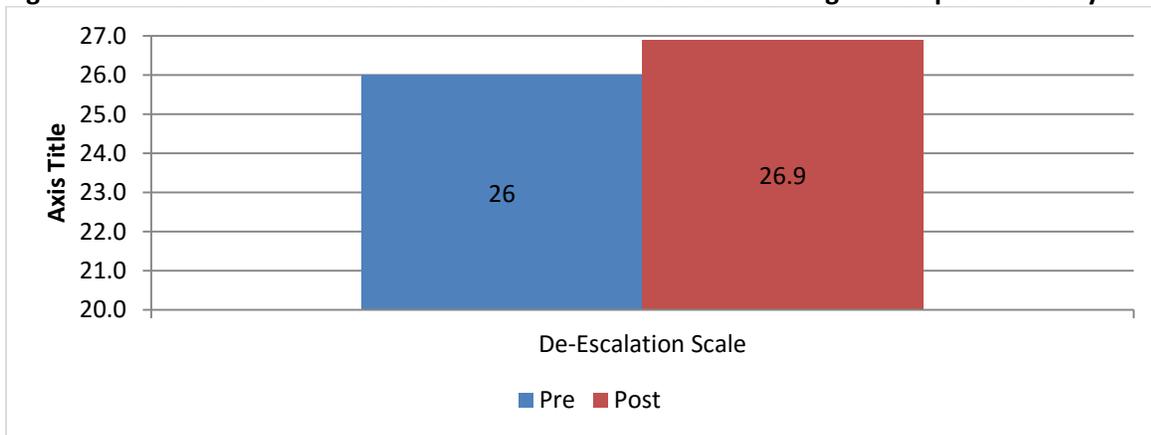


Figure E2 below shows that, on the de-escalation scale, there was an average of a 0.9 point increase in knowledge/skills regarding the de-escalation of an individual with mental illness. This change was not statistically significant (although a small sample), suggesting that the training had little effect on knowledge/skills of the officers attending.

Figure E2. Differences in De-escalation Scale Pre- to Post-CIT Training in Marquette County

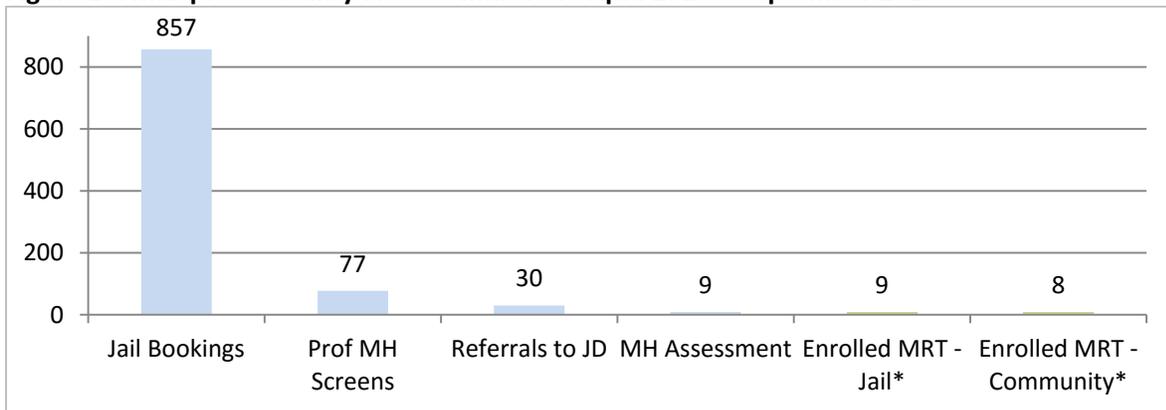


Program Referral/Enrollment

As shown in Figure E3 on the following page, the proportion of individuals referred for mental health screening conducted by the jail mental health clinician was 9% of those booked into the jail (77 of 857). Of those who were screened, 12% (9 of 77) were fully assessed by the Pathways jail liaison. Additionally, 30 individuals were referred to Pathways for MRT by a variety of referral sources including the jail clinician. Of those referred, 17 were ultimately enrolled in either a jail- or community-based MRT group.

¹ $t(12)=3.843, p<.01$

Figure E3. Marquette County Process Indicators April 2015 – September 2015

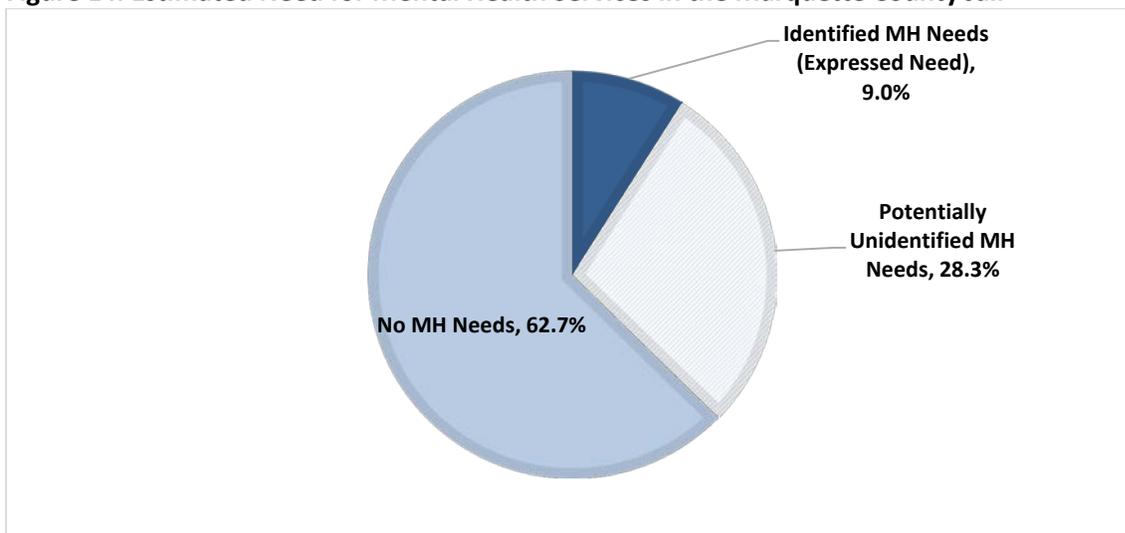


**A total of 17 individuals enrolled in MRT, including 9 in the jail and 8 in the community, will be tracked for short- and long-term outcomes including jail recidivism and mental health treatment utilization.*

Need for Mental Health Services

Figure E4 below shows the expressed need for mental health services in the Marquette County jail. Using the objective need estimate derived from a previous study that used the K6 to screen all individuals booked into the jail, it was estimated that 37% may require mental health screening/services. Based upon the expressed need of 9% (the 77 who were screened), there is potentially a 28% uncaptured need for mental health screening/services within the jail (28% of 857=243).

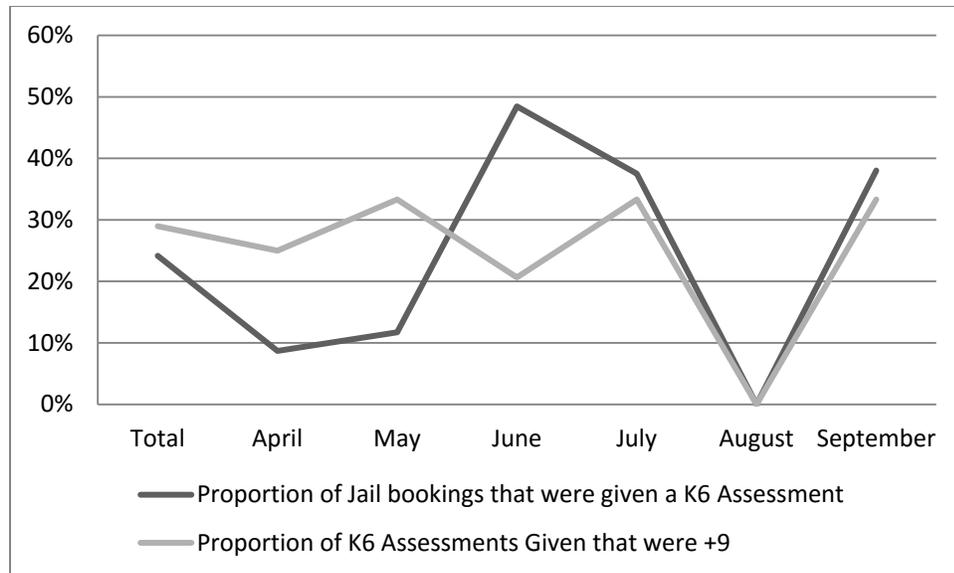
Figure E4. Estimated Need for Mental Health Services in the Marquette County Jail



However, it should be noted that the objective need estimate of 29% of those entering the jail having symptoms associated with serious mental illness (SMI) as determined by the K6 may require further confirmation. Due to the small number of individuals booked into the Marquette County Jail, screening with the K6 was requested for a full year. As Figure E5 on the next page indicates, at best less than half of individuals were screened when they entered the jail. Between April and September 2015 the range of individuals screened was 0% to 48%. Jail administrators report that there was no pattern of who was screened and who was not, but the fluctuation of proportion of those screened positive for an SMI

ranged from 21% to 35% of those booked. The 29% figure is the average proportion across that 6 month period.

Figure E5: Comparison Between Proportion of Those Booked Who Received K6 and Proportion with SMI



Progress on Year One Short-Term Objectives

The following short-term objectives were developed by the stakeholders during the proposal process as well as jointly between the Evaluation Team and stakeholders during the first site visit conducted in March 2015. Progress associated with each stated goal is based on information and feedback generated during monthly data collection calls and the second site visit. Overall, the program is on track to successfully meet most objectives related to MRT and CIT.

- 1. Develop a system and protocols to identify and code distress calls that possibly involve individuals experiencing a mental health crisis within the community.**

Progress: Goal partially met. Stakeholders successfully implemented a mental health dispatch code at the Marquette City Police Department (MCPD) in October 2015. This code provides the stakeholders with a mechanism to quantify the number of calls related to a mental health issue cleared/closed by MCPD Dispatch. To date, the mental health code has not been implemented at Central Dispatch operated by the Marquette County Sheriff's Office, which handles the majority of the 911/Emergency calls across the county. Stakeholders anticipate the mental health code can be implemented at Central Dispatch during the second year of the program.

- 2. Gain more directed information from disturbance calls at dispatch to determine if mental health is a factor.**

Progress: Goal partially met. As of the end of the implementation period, calls cleared/closed as mental health-related by MCPD Dispatch have not been provided to the Evaluation Team. It is anticipated that data collection will begin during the second year of the program.

3. Improve officers' skills in de-escalation techniques and improve attitudes in relation to persons with SMI and community treatment through CIT training.

Progress: Goal partially met. A total of 17 officers from across Marquette County received CIT training conducted in Marquette in July 2015. Details of the pre-/post-tests administered at the training are provided earlier in this report (see Implementation of CIT in Marquette County: Intercept 1).

4. Expand referral and delivery system for MRT to include individuals who do not qualify for CMH services (non-CMH).

Progress: Goal partially met. During the implementation period, MRT programming was expanded to include groups in the jail and community. Later in the year, groups were added at the court and detention center. Program eligibility is open to both CMH and non-CMH individuals.

5. Implement K6 mental health screening data collection at jail.

Progress: Goal not met. As indicated earlier, mental health screenings (K6) were to be conducted on all persons booked and classified into each county jail until a sample size of at least 200 completed screenings was achieved at each site. Due to the relatively low number of jail bookings into MCJ (average 147 bookings per month), collection was extended throughout Year One in order to achieve an appropriate sample pre- and post-intervention. Despite continued efforts by the Pathways Jail Liaison to encourage consistent screening practices within the jail, the overall collection produced screenings for just 24% of all bookings (207 screenings/857 bookings).

Next Steps

The second site visit in February 2016 revealed a number of positive changes and initiatives for Marquette County slated for the second year of the jail diversion pilot program.

- 1. Implement CIT training at Northern Michigan University police academy curriculum and block training.** The work of the CIT Advisory Committee has resulted in the addition of CIT training into Northern Michigan University's police academy curriculum beginning in 2016. The academy serves as a regional police academy for officers in the central and western sections of the Upper Peninsula. Stakeholders plan to implement a 12-hour CIT training into the academy's standard police academy training. Additionally, a 4-hour CIT training will be implemented into the academy's block training. This is a 3-day training held quarterly and based on Michigan Commission on Law Enforcement Standards (MCOLES) training requirements. Training curriculums for both the academy and block trainings are currently being worked out by the committee.
- 2. Expand CIT training to jail officers at MCJ.** In addition to the above training, stakeholders are tentatively planning to provide a 4-hour CIT introductory training to officers at MCJ. As discussed during the second site visit, jail officers face several obstacles in attempting to address the mental health needs of inmates. A major concern noted by one jail administrator is limited cell space, plus cells that are not configured for appropriate observation of individuals experiencing a mental health crisis. It was also noted that jail officers currently lack the skills necessary to properly de-escalate and better manage mental health crises. Crisis issues are referred to the jail mental health professional contracted by

the jail, but the clinician's hours are limited to just eight hours per week strategically spread over three days to provide as much coverage as possible. Similar to the approach stakeholders took in 2014 – 2015 when CIT was first introduced in Marquette, the stakeholders anticipate that the 4-hour training will provide the jail officers with an introduction to mental health signs and symptoms, and that this introductory training will then lead to the full 16-hour training model that was used in the community in 2015.

- 3. Expansion of CIT and MRT to Delta County.** As noted earlier, Delta County is the second largest county, after Marquette, in the Pathways CMH catchment area. Stakeholders are actively expanding both the CIT and MRT initiative into this county. In January 2016, a 4-hour introductory CIT training was held, with a total of 38 officers attended the training. It is anticipated that, similar to Marquette County and MCJ, this introduction may eventually lead to the full 16-hour training model within Delta County.

Stakeholders are also actively expanding MRT to Delta County. Two groups are tentatively planned at this time, including one at the court house and one at Pathways. As was the practice in the expansion of MRT within Marquette County in 2015, both staff members would attend MRT training provided under this grant.

- 4. Expansion of the CIT Advisory Committee to include representatives from MCJ.** It was noted that the CIT Advisory Committee currently does not include a representative from MCJ. Stakeholders hope to be able to engage jail administrators during 2016, both in terms of participation on the committee as well as around the implementation of CIT training for jail officers. It is anticipated that improved collaboration with the jail will strengthen diversion activities across the continuum.

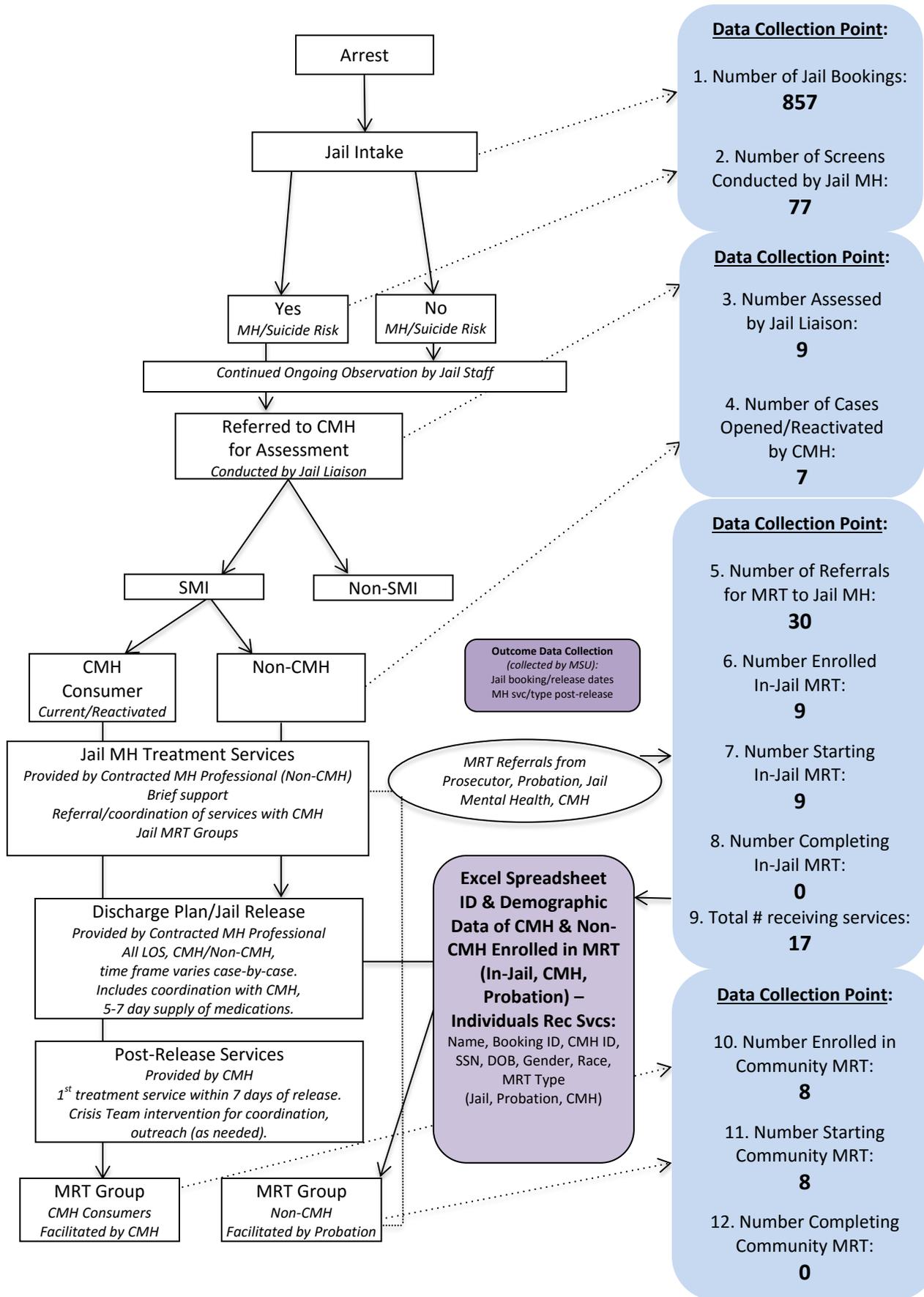
Evaluation Team Recommendations

In addition to the above initiatives, the Evaluation Team recommends the following.

- 1. Implement a second round of K6 mental health screening data collection at MCJ.** Due to the problems experienced with the K6 mental health screening data collection at the MCJ from February 2015 – January 2016, the Evaluation Team proposes to conduct a new two-month data collection at the jail in 2016. It is anticipated that consistent screening of all individuals booked to the jail over two months would yield an estimated 294 screenings, a sample at par with Michigan's other jail diversion pilot sites.
- 2. Expand data collection to include call and diversion data from MCPD Dispatch and Central Dispatch.** With the implementation of the mental health call code at MCPD Dispatch and in process at Central Dispatch, data collection efforts for both sites will be implemented in 2016. Dispatch and call data, as noted in the previous discussion of process indicators, will be collected retroactively to October 2015 for MCPD Dispatch and from implementation forward for Central Dispatch.
- 3. Expand data collection to accurately reflect services provided by Pathways' Jail Liaison.** During the second site visit, it was revealed that the number and scope of services routinely provided by Pathways' Jail Liaison were not reflected in current process indicators. In order to provide a more accurate reflection of the services provided by the Jail Liaison, many of

which could potentially lead to current or future diversion from jail, the Evaluation Team encourages the expansion of data collection to encompass these services. A follow-up meeting has been scheduled with stakeholders to develop and implement this expansion.

Figure E6. Marquette County Process Map



Appendix I-F: Monroe County Site Summary

Introduction

The proposal put forth by Monroe Community Mental Health Agency (MCMHA) focused on the enhancement of jail mental health services at the Monroe County Jail (MCJ). In partnership with the MCJ and the Monroe County Sheriff's Office (MCSO), MCMHA proposed to enhance mental health services provided in MCJ by increasing the Jail Diversion (JD) staff and enhancing treatment services. In addition, MCMHA proposed to provide Mental Health First Aid training to all MCJ corrections staff.

This report details the implementation process of those services and programs during Year 1. It includes:

- A description of the programs being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team's first site visit conducted in early March 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the Evaluation Team's two site visits (March 2015 and January 2016).

Description of Program Implementation in Monroe County

Implementation of Jail Services: Intercept 3

MCMHA, in partnership with MCJ and MCSO, proposed to enhance mental health services provided in the county jail through an expansion of the MCMHA's Jail Diversion (JD) staff within the jail. This was to include additional staffing (1.5 FTE) comprised of a full-time jail-based jail diversion specialist and a part-time certified peer support specialist (CPSS). The staff additions were to allow the expansion of jail mental health services including mental health screening, assessment, individual/group therapy, and discharge planning and follow-up for all inmates identified as having a mild/moderate to serious mental illness (SMI), irrespective of their involvement with or eligibility for community mental health (CMH) services. Inmates are referred to the jail diversion team by the jail's nursing unit. The process map, included as Figure F3 on the last page, illustrates the program operation as well as process counts achieved during the implementation period.

MCMHA also provided an 8-hour Mental Health First Aid Training to all MCJ corrections officers and sergeants.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to the collection and analysis of the K6 mental health screening conducted at the jail during program implementation, the Evaluation Team worked in tandem with stakeholders to identify and measure key process indicators within their implementation of jail services in Monroe County. Based on the results of the initial consultation with stakeholders during the first site visit, the following process indicators were to be collected from Monroe County beginning in April 2015.

- Name/Title/Date of Officers Participating in MHFA Training
- # Jail Bookings
- # Referrals to MCMHA

- # Assessments by MCMHA
- # MCMHA Consumers Receiving Individual or Group Therapy from JD in Jail
- # Non-MCMHA Individuals Receiving Individual or Group Therapy from JD in Jail
- # Activations/Re-activations for CMH services
- Case ID, CMH status, M/F, DOB of Inmates Treated by JD

As MCMHA implemented their jail diversion program, the evaluation of the pilot program was adapted as well. Specific changes were made in the collection of process data to appropriately reflect changes to the program as implemented. These changes included adjusting process indicators to match processes which can be quantified by MCMHA.

Additionally, some changes were made to align process indicators collected in Monroe County with cross-site indicators collected at the other jail diversion pilot sites. The identified cross-site variables include jail bookings, mental health screenings, mental health assessments, and individuals receiving services.

The final list of process indicators was revised to include the following.

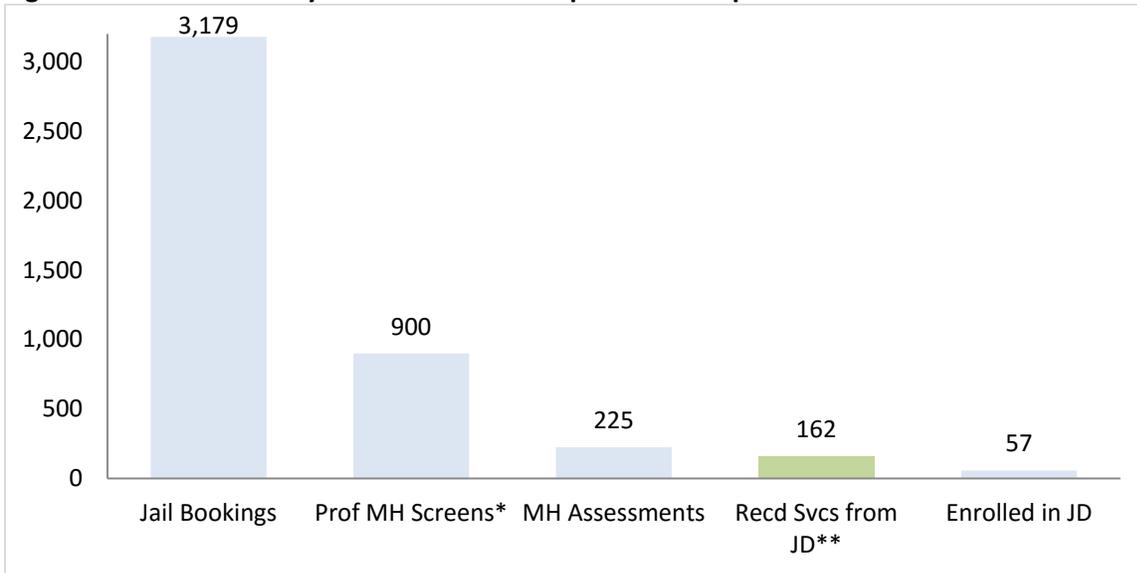
| | Name/Title/Date of Officers Participating in MHFA Training |
|-------------------|--|
| | # Jail Bookings |
| <i>Eliminated</i> | # Referrals to MCMHA |
| <i>Added</i> | # Screenings conducted by MCMHA |
| <i>Adjusted</i> | # Assessments conducted by MCMHA JD clinician |
| <i>Eliminated</i> | # MCMHA Consumers Receiving Individual or Group Therapy from JD in Jail |
| <i>Eliminated</i> | # Non-MCMHA Individuals Receiving Individual or Group Therapy from JD in Jail |
| <i>Added</i> | # Individuals receiving any mental health service from JD program |
| <i>Eliminated</i> | # Activations/Re-activations for CMH services |
| <i>Added</i> | # Individuals enrolled in JD program |
| <i>Adjusted</i> | Case ID, CMH status, M/F, DOB of individuals enrolled in JD program |

Initially, it was determined that the long-term outcome evaluation to be conducted by Evaluation Team and reported in 2017 would follow individuals enrolled into the jail diversion program to assess treatment engagement in the community and recidivism. However, during the second site visit, this group was expanded to also include individuals receiving any mental health service from the jail diversion team during first quarter of 2016. This is discussed in more detail below in the section on Next Steps.

Program Referral/Enrollment

As shown in Figure F1 on the next page, there were 3,179 bookings into the MCJ during the six-month implementation period. The proportion of individuals screened by the jail diversion team is estimated to be nearly 28% of those booked (900 of 3,179). Of those screened, 25% were assessed (225 of 900) for mental illness. A total of 162 individuals received services from the jail diversion team and of those, 57 individuals with mild to severe mental illness were enrolled into the jail diversion program.

Figure F1. Monroe County Process Indicators April 2015 – September 2015



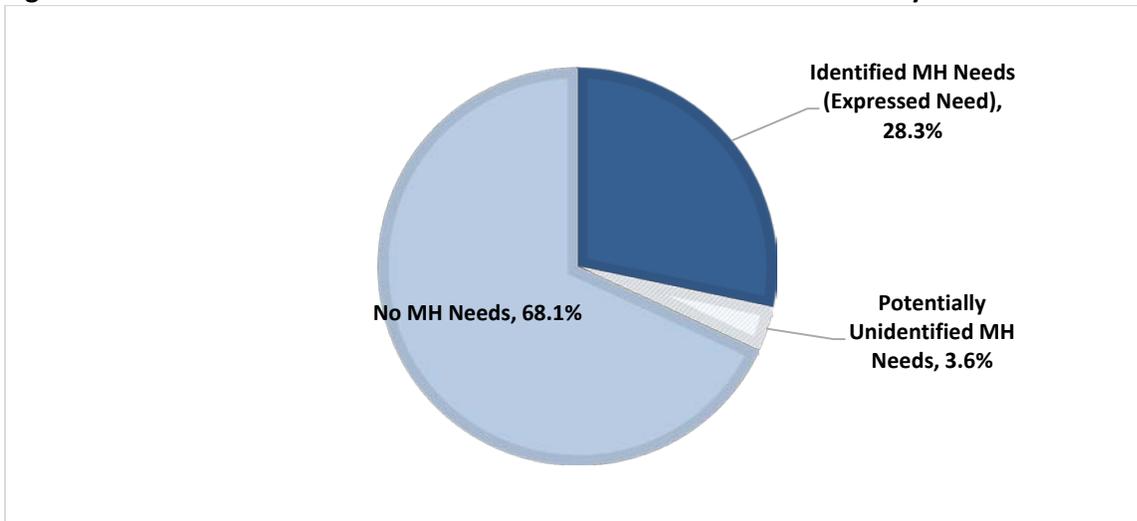
*At the time of this report, MCMHA administrators estimate that 900 mental health screenings were conducted by the JD team during six-month implementation period.

**A total of 162 individuals who received services from jail mental health, including 57 enrolled in the JD program, will be tracked for short- and long-term outcomes including jail recidivism and mental health treatment utilization.

Need for Mental Health Services

Figure F2 below shows the need for mental health services in the Monroe County jail. Using the ‘objective need’ estimate derived from the previous study using the K6 screening of all individuals booked into the jail, it is estimated that approximately 32% of individuals entering the jail might require mental health services. Because those referred to JD was 28% (expressed need), it is possible that approximately 4% of individuals were unidentified, resulting in a potential ‘uncaptured’ need.

Figure F2. Estimated Need for Mental Health Services in the Monroe County Jail



Progress on Year 1 Short-Term Objectives

The following short-term objectives were developed by the stakeholders during the proposal process as well as jointly between the Evaluation Team and stakeholders during the first site visit conducted at Monroe County Jail in March 2015 and address both the jail services and CIT programs. Progress associated with each stated goal is based on information and feedback generated during monthly data collection calls and the second site visit.

- 1. Provide counseling to first-time inmates experiencing mental health issues in order to help prevent entrée into the mental health system.**

Progress: Goal partially met. The certified peer support person (CPSS) has been an asset to jail staff and has provided crisis counseling to those in need – irrespective of their mental health diagnosis or classification – and has assisted staff navigate difficult situations. Because this is one person – who has several responsibilities within the jail as well as to the program, it has not been possible to speak to every ‘first time’ inmate.

- 2. Strengthen the system and protocols to identify current MCMHA consumers who are booked at the jail each day.**

Progress: Goal met. As shown in the process map (Figure F3), MCJ nursing staff and the certified peer support specialist (CPSS) on the JD team actively review the jail’s electronic booking sheets on a daily basis. On average, there are 16 bookings per day and individuals booked into the jail are manually matched by the CPSS in MCMHA’s data system. This process allows quick identification of MCMHA consumers booked into the jail.

- 3. Strengthen the system to identify, assess, open/reactivate, and provide an individualized plan of service for individuals within the jail assessed as having an SMI who are not current MCMHA consumers.**

Progress: Goal met. As shown in the process map (Figure F3), individuals booked into the jail who are identified to be at risk for suicide or to have a mental health concern are referred by the jail staff to MCMHA JD for a mental health screening. The screenings are conducted by the team’s CPSS. An estimated 900 screenings were conducted during the six-month implementation period. Those who screen positively for a mental health concern are then referred to the MCMHA JD clinician for a full assessment; a total of 225 assessments were conducted during the period. Individuals who are not current CMH consumers, but who qualify, are enrolled into CMH services at this time.

- 4. Strengthen system to notify MCMHA case managers of current consumers who are currently incarcerated in the jail.**

Progress: Goal met. During the process of reviewing the electronic booking sheet conducted by the CPSS, the CPSS is also to notify MCMHA case managers of current consumers who have been booked into the jail.

- 5. Increase jail mental health treatment services to include individual and group therapy and discharge planning for all mild/moderate and SMI inmates (CMH and non-CMH).**

Progress: Goal met. This is the focal point of this diversion grant. During Year One, the JD team implemented individual and group therapy for individuals experiencing longer stays in the jail. As shown in the process map (Figure F3), the JD team provided services to a total of

162 individuals during the six-month implementation period; 57 individuals assessed as having mild to severe mental illness were enrolled into the JD program. As outlined later in this report (see Next Steps), the JD team will continue to focus on the expansion of services provided in the jail during the second year of the program.

The program proposed by MCMHA was well considered and built upon a strong relationship the agency had already established with MCJ. The high degree of trust and collaboration between the two partners allowed for a quick implementation of the JD program, but the program was not without challenges during the first year of the grant period. The program's key staff position, the Jail Diversion Specialist, was filled during the first quarter of the year but vacated during the third and fourth quarters of the year when this staff member accepted a new position. Despite this turnover, the MCMHA team was able to sustain the JD program and continue to provide services within the jail. Overall, the program was highly successful in meeting the objectives set forth for the jail services program.

Next Steps

The second site visit revealed a number of positive changes and initiatives for Monroe County slated for the second year of the jail diversion pilot program.

- 1. Continue to expand jail mental health treatment services to include discharge services.**
The JD team will continue to focus on the expansion of services provided in the jail during the second year of the program. Efforts in Year Two will include the addition of a second CPSS as well as a JD supervisor to sustain current services as well as to enhance discharge services provided to individuals receiving mental health services.
- 2. Implement a new Jail Management System report to gather daily and aggregate data on mental health concerns.** In order to produce statistics as needed for funding and quantification of the issue of mental illness within the MCJ, stakeholders will implement the production of a daily report to identify individuals booked into the jail who may potentially have serious mental health concerns based on how questions pertaining mental health and suicide are answered during the initial booking interview. These reports will be used to generate a new data indicator for the evaluation – as well as alert jail mental health staff about the potential needs of detainees. The new report, to be titled the Mental Health Daily Log, will be used to proactively identify inmates with mental health concerns. This report will supplement current processes already utilized within the jail including referrals from the jail staff and kites from inmates. This process will also augment the practice of reviewing the daily booking list conducted by the CPSS in which the daily booking report is manually cross-referenced in the CMH system to identify current consumers.

Evaluation Team Recommendations

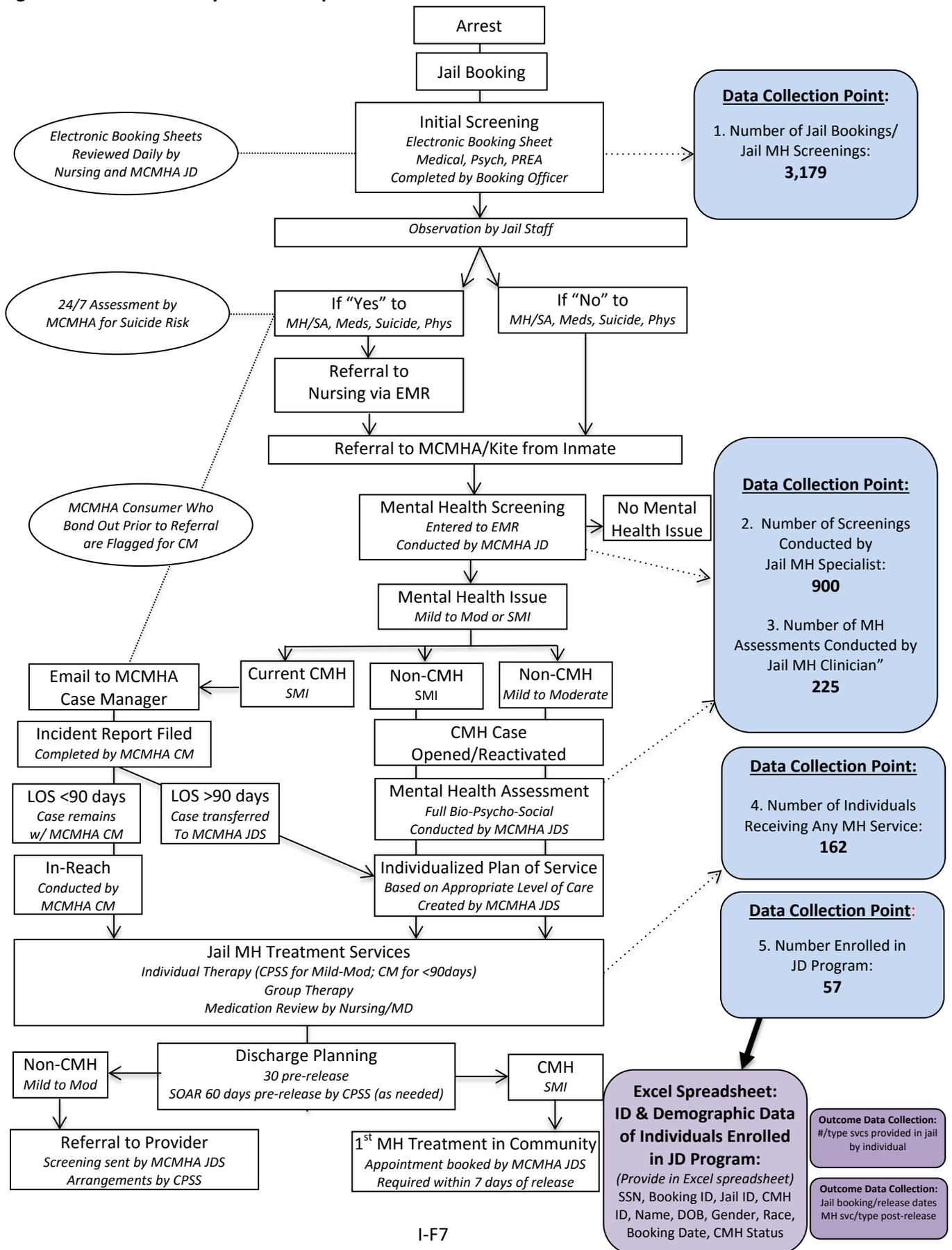
In addition to the above initiatives, the Evaluation Team recommends the following.

- 1. Define the diversion program model and eligibility criteria.** A key item to be addressed by the JD team during the second year of the program is the jail diversion program model. Specifically, the team should define the standard services provided to those individuals enrolled into the JD program (e.g. individual/group therapy, crisis care, community referrals, discharge planning, discharge follow-up, etc.).

- 2. Expand the long-term outcome evaluation to include individuals enrolled in the jail diversion program plus those receiving any mental health service from the jail diversion team.** Due to the high number of individuals receiving services from the jail diversion team (N=162 during six-month implementation period), the Evaluation Team will expand the long-term evaluation to include tracking mental health and recidivism outcomes for those who are enrolled in the JD program (N=57 during six-month implementation period) plus those receiving any service during the first quarter of 2016 (estimated to be approximately 80 individuals). It is anticipated that the addition to the evaluation of those receiving any mental health service will more accurately assess the impact of the JD program versus treatment as usual.

- 3. Assess advocacy efforts by the jail diversion team resulting in current diversion.** During the second site visit, it was revealed that the CPSS provides advocacy service to individuals which can result in a current diversion (i.e., experienced fewer jail days due to an action or advocacy taken by a team member). During the second year of the program, the JD team will identify those individuals who are diverted from jail to treatment going forward, as well as retroactively identifying those who received a current diversion during year one.

Figure F3. Monroe County Process Map



Appendix I-G: Oakland County

Introduction

The diversion program proposed by Oakland County Community Mental Health Association (OCCMHA) encompassed one key objective prioritized by MDCH, the training and implementation of Crisis Intervention Team (CIT) training. OCCMHA, in partnership with the Oakland County Sheriff's Office (OCSO), proposed to train and implement a CIT among a total of up to 80 OSCO officers. These 80 officers represent a significant proportion of the total work force and provide primary services to many of the municipalities within Oakland County.

This report details the implementation process of the CIT programs during Year 1. It includes:

- A description of the program being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team's first site visit conducted in early March 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the Evaluation Team's two site visits (March 2015 and February 2016).

Description of Program Implementation in Oakland County

Implementation of CIT in Oakland County: Intercept 1

The implementation of CIT in Oakland County focused on providing a 40-hour training for up to 80 deputies and sergeants as well as officers of local police departments across the county. Two 40-hour training sessions were conducted during the weeks of May 4 and May 18, 2015. All officers volunteered for the training. Of the 79 participants, 60 were deputies or sergeants from the Oakland County Sheriff's Office and 19 were officers from local police departments including Auburn Hills (one), Bloomfield Township (one), Farmington Hills (two), Novi (four), Rochester Hills (one), Southfield (two), West Bloomfield (seven), and White Lake Township (one). Changes as a result of the training were measured using standardized instruments. Significant pre/post changes were found in officer's knowledge of mental health resources and de-escalation skills. More details of these findings are included below.

A second round of training was added later in the year consisting of an abbreviated 8-hour training for up to 32 dispatch officers from the county's centralized dispatch center. Four 8-hour training sessions were conducted from September 23 – October 14, 2015, attracting 32 dispatch officers. The abbreviated training was tailored to meet the specific needs of dispatch officers and included the history of CIT training, an introduction to mental health issues, a review of the mental health system and community resources, suicide awareness and prevention and a 4-hour section of advanced verbal de-escalation techniques.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to the collection and analysis of the K6 mental health screening conducted at the jail pre- and post-program implementation, the Evaluation Team worked in tandem with key stakeholders to identify and measure key process indicators associated with the implementation of CIT within Oakland County.

Based on the results of an initial consultation with stakeholders, the following indicators were collected from Oakland County beginning in April 2015.

- Name, title, agency of all trainees
- Pre/Post-CIT Training survey
- # Total Calls to Dispatch
- # Calls Coded as Jail Diversion/CIT (L3545) in CLEMIS
- Narrative for Calls Coded L3545 (to determine final disposition)
- Name, DOB, M/F, race, and last-4 (if available) of L3545 Calls
- Common Ground Resource and Crisis Center Log Book

No changes were made to the process indicators or the data collection process set forth in Oakland County in April 2015.

CIT Pre/Post Training Indicators

The goal of the CIT training is to create change in knowledge and attitudes of law enforcement regarding responding to individuals with mental illness and community treatments for this population. For officers who participate in the training, significant changes from pre- to post test for both the OPT and the De-escalation Scales to show that the CIT training had a positive impact on the officers is desired. Due to the differences in training (40 hours vs. 8 hours) and roles (patrol versus dispatch), training outcomes were evaluated by group using the same measures.

For both groups (patrol and dispatch), pre- and post-tests were implemented immediately prior to (pre-) and following (post-) the training and were based on two instruments: the *Opinions of Psychiatric Treatment (OPT) Measure* and the *De-escalation Scale*. The 20-item validated OPT Measure assesses officers' attitudes and knowledge about psychiatric treatments within the community and attitudes about psycho-pharmacotherapy, psychotherapy, and psychosocial interventions. Responses are given a six-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The possible range of scores is 20–120. The 8-item De-Escalation Scale measures officers' de-escalation skills. Officers' opinions on the effectiveness of specific actions in the situation were rated on a four-point Likert scale ranging from 0 (very negative) to 3 (very positive). Total subscale scores range from 0 to 24.

Pre/Post CIT Scores for Patrol Officers

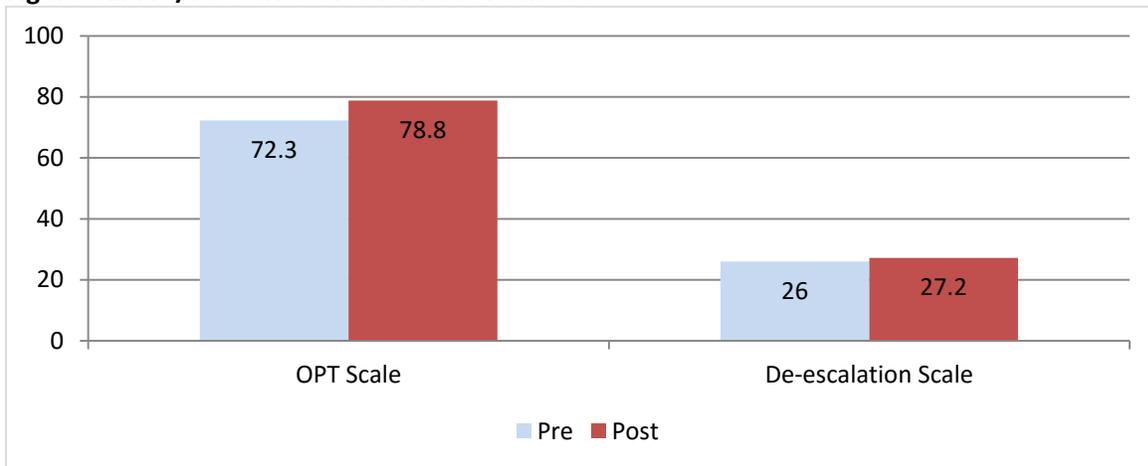
A total of 67 of the 79 officers who attended the 40-hour CIT training completed both a pre- and post-test assessment. As shown in Figure G1 on the next page, there was an average change score from pre- to post-test of 6.6 points on the OPT Scale. This change was a statistically significant difference¹ indicating that the training improved the officers' knowledge of treatments in the community. There were no significant differences in change scores by gender, education level, or number of years in law enforcement.

There was an average increase of 1.3 points from pre- to post-test on the De-escalation Scale. This seemingly small average increase was statistically significant² indicating that the training improved the officers' knowledge of what behaviors are best to help de-escalate someone with a mental illness. There were no significant differences in change scores by gender, education level, or number of years in law enforcement.

¹ Paired t-tests were used to assess the individual differences on the OPT scale ($t(66)=8.722, p<.001$). The statistical significance implies that it is improbable to believe the results were due to 'chance'.

² Paired t-tests were used to test individual level change scores on the de-escalation scale ($t(66)=4.199, p<.001$).

Figure G1. Pre/Post CIT Scores for Patrol Officers

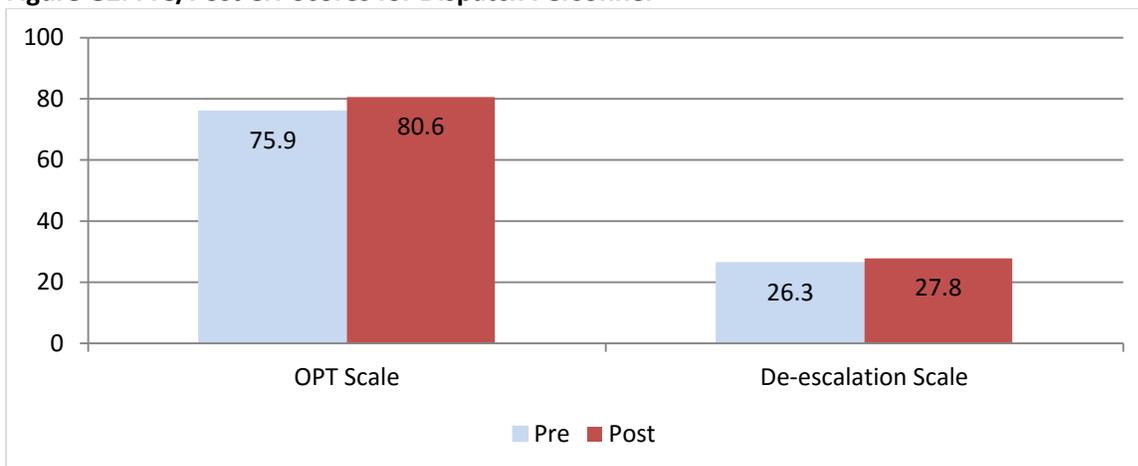


Pre/Post Scores for Dispatch Officers

A total of 16 of the 32 dispatch officers who attended the 8-hour CIT training completed both a pre- and post-test assessment. As shown in Figure G2 below, there was an average change score from pre- to post-test of 4.7 points on the OPT Scale. This change was statistically significant indicating that the training improved the officers' knowledge of treatments in the community.³ There were no significant differences in change scores by gender, education level, or number of years in law enforcement.

There was an average increase of 1.4 points on the De-escalation Scale. This change was statistically significant indicating that the training improved the dispatch officers' knowledge of what behaviors are best to help de-escalate someone with a mental illness⁴. There were no significant differences in change scores by gender, education level, or number of years in law enforcement.

Figure G2. Pre/Post CIT Scores for Dispatch Personnel



³ Note: Paired t-tests were used to test individual level change scores on the OPT scale ($t(15)=4.858, p<.001$). The statistical significance of this finding and the one below suggest that these results are highly unlikely to occur due to chance.

⁴ Note: Paired were used to test individual level change scores on the de-escalation scale ($t(15)=2.626, p<.05$).

Other Process and Outcome Indicators Related to CIT Implementation

Call Report Data

In an attempt to assess the change in officer behavior after completion of the training, the Evaluation Team examined call reports provided by the OCSO. These are the officers' documentation of the calls they were sent via dispatch.

These calls have been divided into three categories: 1) Mental Health, 2) Suicide and 3) CIT/Jail Diversion. Each category is based on the verified code entered by the officer in the dispatch system at the opening/closing of the call. It is noted that the code affixed by the dispatcher when the call is opened may vary from that used by the officer to close the call. Because of this, all calls opened or closed as Mental Health, Suicide, or CIT/Jail Diversion were provided to the Evaluation Team.

It is noted that the Mental Health code is designated for mental health crises, which includes suicide ideation. The Suicide code is designated for actions taken toward suicide or attempted suicide and completed suicide. This Suicide code is differentiated from the Mental Health code by the action or self-harm taken towards suicide. The CIT/Jail Diversion code was created by OSCO to represent when a CIT-trained officer has actually diverted an individual with a mental health problem involved in criminal behavior from jail to treatment.

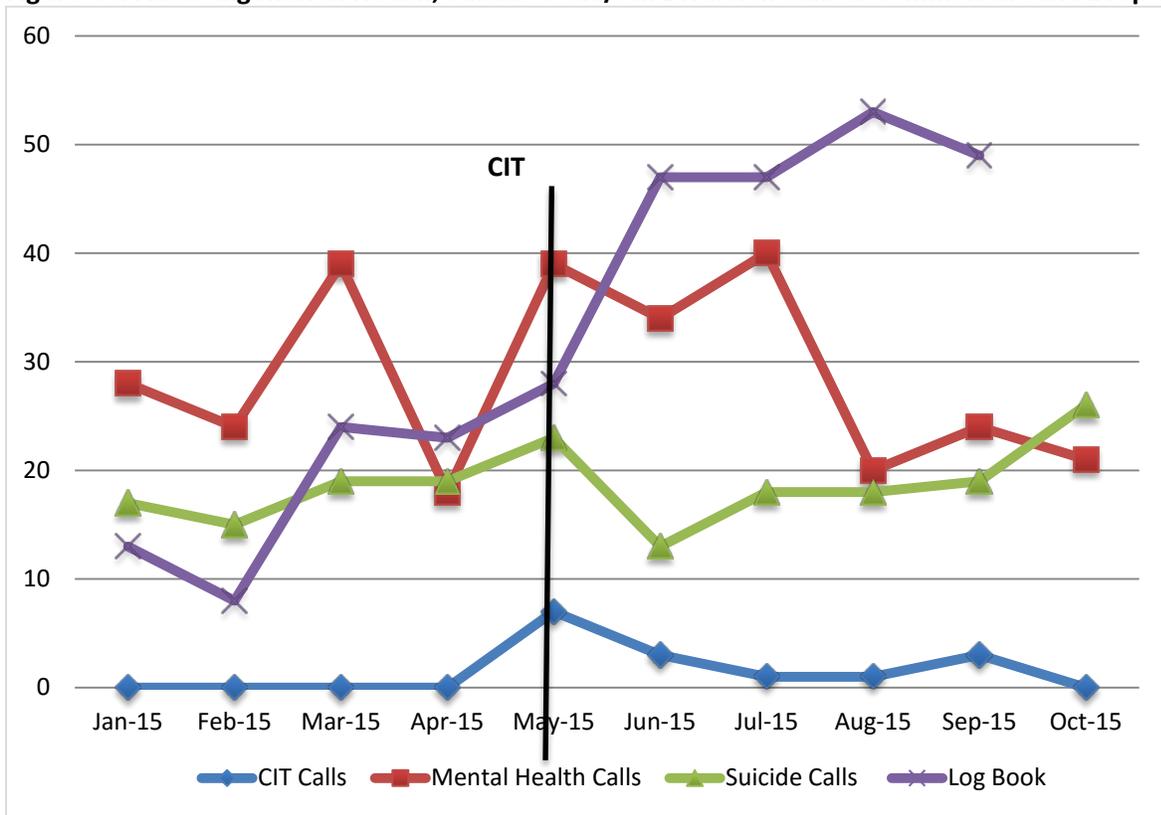
Common Ground Drop-Off Logs

An additional attempt to assess the change in officer behavior after completion of the training was the collection of drop-off logs from Common Ground, a 24-hour mental health crisis center operated in Oakland County. The drop-off logs, or Police Contact Logs, were provided by OCCMHA on a monthly basis as collected from Common Ground. The logs provide the name of each individual dropped off by a member of law enforcement at Common Ground as well as the date and the officer's name and police agency affiliation.

Call reports from January 2015 – October 2015 were analyzed by the Evaluation Team. Common Ground logs were also analyzed for the same period as well as the year prior to the implementation of CIT (January 2014 – December 2014). Mental Health and Suicide calls represent no particular pattern for the 2015 calendar year as shown in Figure G3 on the following page. In contrast, there is an obvious increase in drop-offs at Common Ground immediately following the CIT training in May.

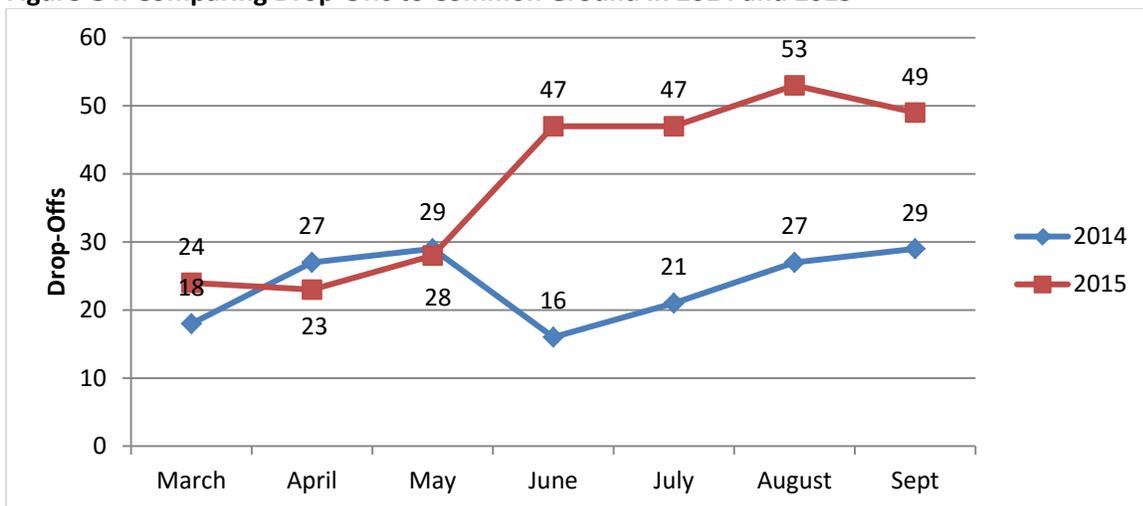
One possible explanation for the increase in drop-offs to Common Ground is that the CIT training helped inform officers of the available resources including Common Ground and, as a result, officers began to utilize Common Ground more than before the training.

Figure G3. Assessing Mental Health, Suicide & CIT/Jail Diversion Calls & Common Ground Drop-offs



To further assess if CIT training was the catalyst for the increase in drop-offs to Common Ground, drop-offs in 2014 were analyzed to compare the number of drop-offs to Common Ground from 2014 to 2015. As shown in Figure G4 below, the average number of drop-offs in 2014 was 21.9 individuals per month; the average in 2015 grew to 32.8 per month. The highest number of drop-offs to Common Ground prior to the CIT training in May 2015 was 29; after the CIT training, drop-offs increased to over 50 per month and have remained at this higher level.

Figure G4. Comparing Drop-Offs to Common Ground in 2014 and 2015



Progress on Year 1 Short-Term Objectives

The following short-term objectives were developed by the stakeholders during the proposal process as well as jointly between the Evaluation Team and stakeholders during the first site visit conducted in Oakland County in March 2015. Progress associated with each stated goal is based on information and feedback generated during monthly data collection calls and the second site visit.

1. Utilize a new CIT/Jail Diversion code in CLEAR report in CLEMIS for calls involving a mental health issue.

Progress: Goal met. Prior to the completion of the first CIT training sessions in May, the Sheriff's Operation Center implemented a new code within the CLEMIS dispatch system for responding officers to close or verify a call as CIT/Diversion. The system was already equipped for responding officers to close/verify a call as mental health- or suicide-related. Use of the new CIT/Diversion code was included in the CIT training provided to the officers in May. Use of the new CIT/Diversion code would indicate the officer's use of diversion (i.e., placement at a hospital, crisis center) in lieu of jail as appropriate when an individual committing an offense is determined by a CIT-trained officer to be experiencing a mental health crisis. This new code was one of the three call codes – including Mental Health, Suicide, and CIT/Jail Diversion – currently collected from OCSO and analyzed by the Evaluation Team.

2. Develop a process to integrate the use of five diversion questions regarding the decision to 'arrest' or 'charge' individuals that CIT officers interact with (as developed by Officer Raphael Diaz, Kalamazoo Department of Public Safety).

Progress: Goal met. The five diversion questions defined by Sgt. Diaz are triggered when officers select the CIT/Jail Diversion dispatch code (see above). This data is included in the call reports provided by OCSO to the Evaluation Team.

3. Increase de-escalation skills and familiarity with community-based treatment as a result of CIT training.

Progress: Goal met. A total of 79 patrol officers and 32 dispatch officers attended the CIT trainings conducted in the county during May and September – October respectively. Details of the pre-/post-tests administered at the training are provided in this report (see Implementation of CIT: Intercept 1) but pre/post scores indicate that officers improved their knowledge of community-based treatment and de-escalation techniques. Going forward, stakeholders plan to provide CIT training to the remaining dispatchers, as well as OCJ officers, in 2016 (see Next Steps).

Next Steps

The second site visit revealed a number of positive changes and initiatives for Oakland County slated for the second year of the jail diversion pilot program.

- 1. Provide CIT training to additional patrol officers throughout Oakland County.** Under this grant, stakeholders plan to provide CIT training to an additional 40 officers in 2016. At the time of the second site visit, one training session utilizing the 40-hour training model was planned for June. An estimated 40 officers from throughout Oakland County including OCSO and local police departments are expected to attend the training. Going forward, trainings will be conducted by Sgt. Todd Hill from the OCSO Training Unit or an equally qualified

designee; trainings were previously conducted by Sgt. Diaz from Kalamazoo Public Safety Department. Additional CIT training for OCSO dispatchers and corrections staff and CIT-Youth training are planned for 2016, but these trainings will be covered in a separate jail diversion grant funded by the Michigan Department of Health and Human Services for 2016 – 2017.

- 2. Add a CIT Coordinator position within the OCSO.** Stakeholders in Oakland County have addressed CIT implementation issues on a case-by-case basis; however, during the first year of operation, there was no mechanism in place to formally address issues on a regular, ongoing basis. CIT-related issues (e.g. difficulties experienced by officers when dropping individuals to the county's 24-hour crisis center) are addressed as they occur by the key personnel from the OCSO Training Unit and OCCMHA assigned to the development and implementation of this grant. This level of collaboration, while so far effective in removing obstacles in the implementation of CIT, was taxing on the key personnel assigned to the grant because these duties fall outside of the realm of their normal, day-to-day responsibilities. During the second year of the grant, stakeholders plan to develop and implement a CIT coordinator position. The primary purpose of this position will be to manage CIT data issues, as well as to serve as a liaison between the officers and OCCMHA. At the time of the second site visit it was anticipated that, due to lack of long-term funding for this position, the role would be assumed by the key stakeholder from the OCSO Training Unit.

Evaluation Team Recommendations

In addition to the above initiatives, the Evaluation Team recommends the following.

- 1. Implement a community advisory council.** The presence of an ongoing advisory council comprised of criminal/legal professionals, mental health professionals, mental health advocates, and law enforcement that can engage in problem-solving and monitoring of CIT data is highly recommended to properly sustain the CIT program. The power of collaboration between agencies was clearly demonstrated during the tour of Common Ground when representatives from OCSO, OCCMHA, and Common Ground staff candidly discussed and problem-solved a number of questions and concerns regarding OCSO drop-offs. Additionally, elevating CIT to the county level will improve awareness of the program among the county's criminal, legal, law enforcement, and mental health stakeholders and properly place the program among the variety of other diversion programs currently operating within the county including mental health and sobriety courts.
- 2. Enhance data coding to include CIT skill utilization.** In reviewing the call data provided by OCSO, it is recognized that, while the number of calls in which a true jail diversion occurs are low, there are a high number of calls in which CIT skills are utilized by officers. In order to account for the utilization of CIT skills, in addition to CIT/Jail Diversions, the Evaluation Team will continue to review the narrative of all Mental Health and Suicide call reports. Those calls in which use of de-escalation skills are described within the narrative and in which the resolution is either 1) drop-off at Common Ground, 2) drop-off or resolved at home, or 3) drop-off at the hospital/ER, will be coded and quantified as such.

Appendix I-H: Wayne County Site Summary

Introduction

The proposal put forth by Detroit Central City (DCC) Community Mental Health Agency in Wayne County -- the Intensive Jail Diversion Pilot (IJDP) -- focused on two targeted intercepts: a pre-arrest diversion program developed in partnership with the Detroit Police Department (DPD) and a post-booking jail services program at Wayne County Jail based on the Forensic Assertive Community Treatment (FACT) Model. Due to difficulties in gaining the engagement of the DPD, the initial plan was adjusted during the first quarter of the grant. The result was a 'phase' strategy in which the post-booking jail services program would be considered Phase 1 and addressed first. The pre-arrest diversion program with DPD would be considered Phase 2 and phased in later in the year once Phase 1 was implemented.

This report details the implementation process during Year 1. It includes:

- A description of the program being implemented.
- Short-term (Year 1) objectives, process indicators, and the process map agreed upon during the Evaluation Team's first site visit conducted in early March 2015.
- Information yielded from the process indicators generated during the six-month implementation period of April – September 2015.
- Evaluation Team observations and stakeholder feedback regarding program implementation generated during stakeholder interviews, monthly data collection calls, and the Evaluation Team's two site visits (March 2015 and February 2016).

Description of Program Implementation in Wayne County

Implementation of Jail Services in Wayne County: Intercept 3

DCC's new jail diversion program, developed in partnership with the Wayne County Jail (WCJ), was designed to supplement two existing diversion programs currently operated by DCC's Community Reentry Division: Diversion I and the Mental Health Court (MHC). Specifically, the new diversion opportunity targeted current and/or previous DCC consumers with serious mental illness jailed for a low felony or misdemeanor offense.

The program focuses on the implementation of a jail diversion team located within the county jail. Inmates are referred to IJDP in three ways: by social workers in the jail's mental health unit; through Director Heard, Director of Jail Populations, as part of the jail's administrative jail release effort; and from other existing diversion programs within the community including MHC and Veteran's Court. Services provided by the IJDP team, originally intended to follow the Forensic Assertive Community Treatment (FACT) Model, include jail in-reach, individual and group therapy, discharge planning and follow-up, and housing placement. The process map, included as Figure H3 on the last page, illustrates the program operation as well as process numbers during the implementation period.

It was anticipated that consumers enrolling into IJDP would likely have different needs based on their stability, functionality, and length of sentence. The initial plan was to provide all clinically-eligible individuals enrolled into the program with the services prescribed under the FACT Model beginning during incarceration and continuing upon release. Services would include direct contact with IJDP team members (i.e., the case manager, peer support specialist, nurse, or psychiatrist) three times weekly, in-reach by the assigned IJDP case manager during incarceration at WCJ, and housing assistance and placement. Others, outside of the DCC network, would receive less intensive services such as

transportation, depending on individual need. Due to a higher clinician-to-staff ratio than prescribed by FACT, the IJDP team has adjusted the above listed services to meet the needs of the consumer and not necessarily in fidelity with the model.

During the first six months, the IJDP team identified a number of issues that hampered implementation of the model. Team members identified a lag time of up to 30 days from the time an individual is identified for the IJDP program until they are able to be enrolled into the program and, ultimately, released from jail. This lag can result in lengthened jail time for someone with a qualifying mental health problem and potential exacerbation of symptoms. It is anticipated that Director Heard's new role focused on jail population will enhance communication within the jail system, ultimately increasing the number of jail diversions and further decreasing jail days.

Additionally, team members identified that delayed access to a psychiatrist also hampered implementation. It was reported during the second site visit that individuals were waiting 30-45 days for an appointment with a psychiatrist for medication review/renewal. This was particularly problematic given that consumers are provided with just a two-week supply of medication upon release from jail. During the second year of the program, an additional psychiatrist has been hired to provide services to DCC's jail services and reentry division three days per week. It is anticipated that the addition of the psychiatrist will improve time to treatment within the community.

Identification and Measurement of Process Indicators

Key Process Indicators

In addition to attempting to collect and analyze the K6 mental health screenings conducted at the jail pre- and post-program implementation, the Evaluation Team worked in tandem with stakeholders to identify and measure key process indicators within the implementation of jail services in Wayne County. Based on the results of the initial consultation with the stakeholders during the first site visit, the following process indicators were to be collected from Wayne County beginning in April 2015:

- # DCC Consumers Booked (per Daily Booking Reports)
- # DCC Consumers Referred to Chief Heard for Consideration of AJR
- # Referrals to IJDP from WCJ MHU Jail Clinician
- # Referrals from Dickerson Facility staff
- # Referrals/Approvals to IJDP from AJR
- # Enrolled in IJDP
- # IJDP Enrollees Receiving Early Release
- # In-reach Sessions Conducted by IJDP Staff
- # Individuals Receiving In-reach by IJDP Staff
- # Phone Calls or Meetings Regarding Phase 2 Implementation

As DCC refocused its diversion activities on the post-booking component of its jail diversion program, the evaluation of the pilot program was adapted as well. Specific changes were implemented in the collection of process data to appropriately reflect changes to the program as implemented. These changes include the examination of referral sources for individuals referred to and ultimately in the IJDP, as well as the elimination of indicators that were not feasibly quantifiable including the number of DCC consumers booked to the jail and advocated for/referred to Director Heard for early release. Additionally, some changes were made to align process indicators collected in Wayne County with cross-site indicators collected at the other jail diversion pilot sites. The identified cross-site variables include jail bookings, mental health screenings, mental health assessments, and individuals receiving services.

The final list of process indicators was revised to include the following. These are indicated on the process map (Figure H3).

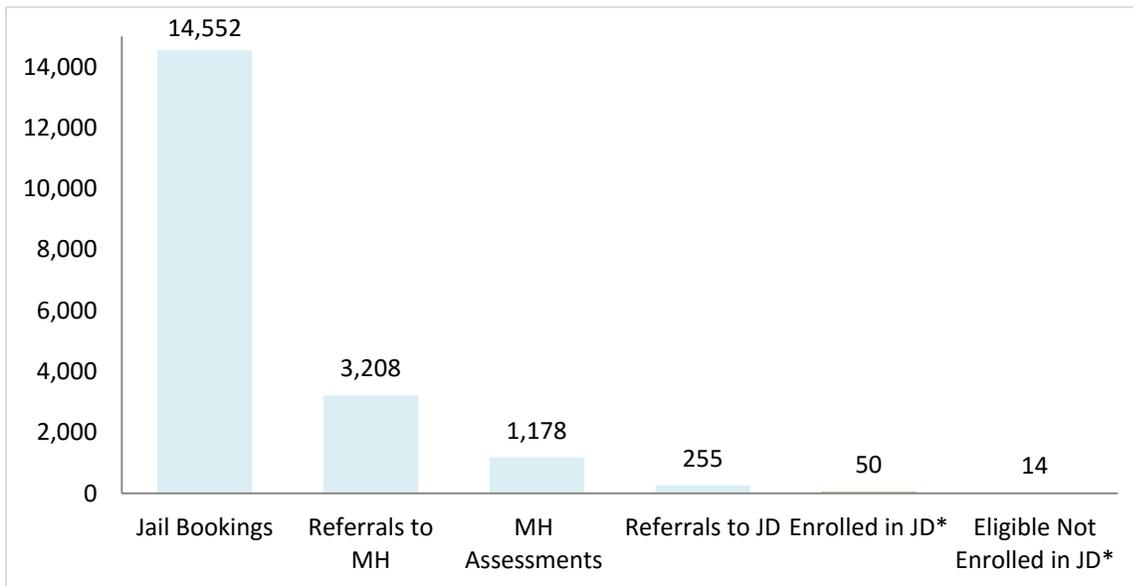
| | |
|---------|---|
| Removed | # DCC Consumers Booked (per Daily Booking Reports) |
| Removed | # DCC Consumers Referred to Chief Heard for Consideration of AJR |
| Added | # Jail Bookings into WCJ |
| Added | # Mental Health Status Exams conducted by Jail MH Social Worker |
| Added | # Referred to MHU Psychologist by RDC for MH Assessment |
| | # Referrals to IJDP from WCJ MHU Jail Clinician |
| | # Referrals from Dickerson Facility staff |
| | # Referrals/Approvals to IJDP from AJR |
| | # Enrolled in IJDP |
| Added | # Eligible but Not Enrolled in IJDP |
| | # IJDP Enrollees Receiving Early Release |
| Removed | # In-reach Sessions Conducted by IJDP Staff |
| Removed | # Individuals Receiving In-reach by IJDP Staff |
| Added | # Services Provided in Jail |
| Removed | # Phone Calls or Meetings Regarding |

The long-term outcome evaluation to be conducted by the Evaluation Team and reported in 2017 will follow individuals enrolled in IJDP to assess treatment engagement in the community and recidivism.

Program Referral/Enrollment

Figure H1 below shows that approximately 22% (3,208 of 14,552) of those booked to Wayne County Jail were referred for mental health services when screened for mental health problems by the jail’s social worker.

Figure H1. Wayne County Process Indicators: April 2015 – September 2015



**A total of 64 individuals, including 50 who enrolled in the JD program and 14 who were eligible for the program, but did not enroll, will be tracked for short- and long-term outcomes including jail recidivism and mental health treatment utilization.*

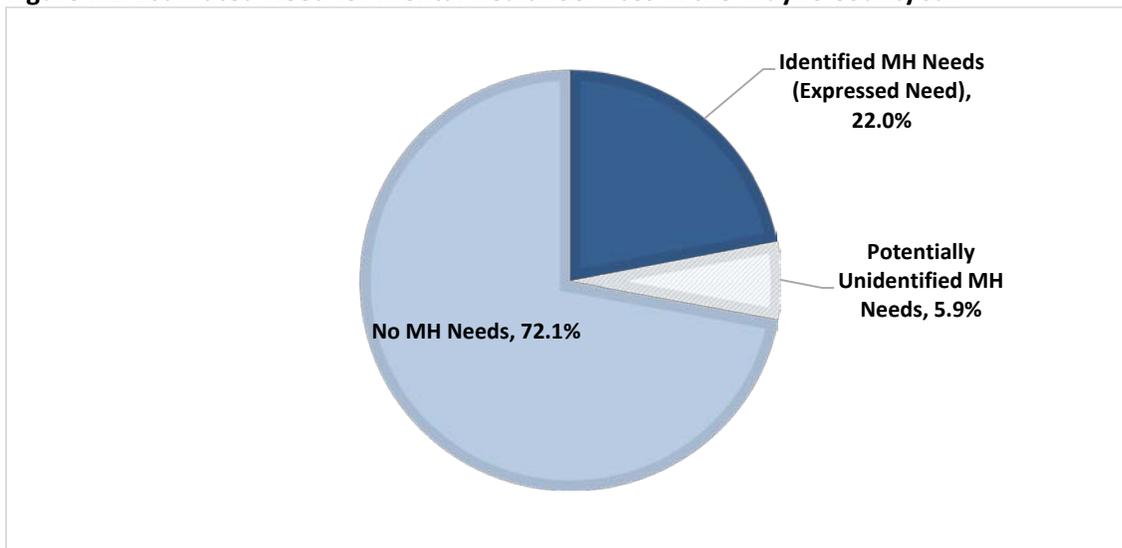
Of these, 38% (n=1,178) were referred for comprehensive mental health assessments by the jail’s

psychologist. The new jail diversion program, IJDP, received 255 referrals and enrolled 50 individuals into the program during the first six months of implementation. This enrollment number indicates that DCC is on track to meet enrollment of 100 individuals to IJDP in its first year.

Need for Mental Health Services

Figure H2 below shows the expressed need for mental health services in the Wayne County jail. Although a precise estimate of objective need is not available for Wayne County due to issues with the implementation of the K6 study, a state average of 28% is used as a proxy to assess estimated need. Since the number of mental health screenings (3,208) is 22% of the booked population, it is possible that approximately 6% of individuals were unidentified, resulting in a potential ‘uncaptured’ need.

Figure H2. Estimated Need for Mental Health Services in the Wayne County Jail



Progress on Year 1 Short-Term Objectives

The following short-term objectives were developed by stakeholders during the proposal process as well as jointly between the Evaluation Team and stakeholders during the first site visit and address both the pre-arrest and post-booking programs. Progress associated with each stated goal is based on information and feedback generated during monthly data collection calls and the second site visit. Overall, the program successfully met goals related to implementation of the post-booking program within the jail.

- 1. Develop and implement a system and protocol to identify current/previous DCC consumers who are booked at the jail each day.**

Progress: Goal partially met. The process of gaining referrals through review of the daily booking report from the jail was not implemented because of the high number of bookings (563 per week). Because the IJDP team found the review of the daily booking report to be too resource intensive to implement, the process was amended to rely upon referrals from other sources to feed the program.

- 2. Develop a system to identify, assess, and open/reactivate individuals within the jail who meet IJDP eligibility and are not current DCC consumers.**

Progress: Goal met. As illustrated in the process map developed during the first site visit (Figure H3), the system designed and implemented for IJDP encompassed referrals from the Wayne County Jail's Mental Health Unit and Director Heard, Director of Jail Population, who oversees the jail's Administrative Jail Release initiative. Both of these referrals sources include current CMH and non-CMH individuals who meet legal and clinical program eligibility.

3. Develop a process to advocate on behalf of eligible DCC consumers for participation the jail's early release program.

Progress: Goal partially met. The ability of IJDP team members to advocate on behalf of known DCC consumers for early release was hampered when review of the daily booking report was not able to be implemented. Instead, as noted above, the program primarily relies upon referrals to the program rather than proactively identifying consumers within the system. However, the jail social work staff is identifying DCC consumers during the jail's mental health screening process. IJDP team members report a highly collaborative and accessible relationship between IJDP and Director Heard, creating a foundation for such advocacy during this grant period.

4. Implement components of FACT Model as necessary to provide recommended treatment "dosage" to IJDP enrollees.

Progress: Goal modified and in process. Strict fidelity to the FACT Model has reportedly been problematic due to the high clinician to consumer ratio of 1:10 required of the model and absence of key components (i.e. swift access to psychiatrist). Operating at an estimated ratio of 1:20, the IJDP team has loosely followed the FACT Model and is actively adding components of FACT (i.e., psychiatrist, individual therapy). The team expressed some 'goal conflict' with strict adherence to FACT with their enrollment goals (i.e., 100 enrollees to IJDP during Year 1) and is considering transitioning to a modified model more aligned with the existing staff-to-consumer level.

5. Initiate at least two meetings per month with community leaders and/or DPD officials related to Phase 2 objectives.

Progress: Goal partially met. Efforts to initiate Phase 2, the development of the pre-arrest program with DPD, were unsuccessful throughout the first year of the grant period. As a result, this goal was not met. It was reported at the second site visit that that the plan will be amended and the pre-arrest program will be implemented during the second year of the grant period. There is a mental health/criminal justice advisory council in place in Wayne County and the pre-arrest project with DPD remains on the agenda at the advisory council level, although representatives from DPD have been elusive.

Next Steps

The second site visit revealed a number of positive changes and initiatives for Wayne County slated for Year 2 of their program and are included here as next steps. As the first four steps listed below were discussed earlier in this report, they are listed in summary form only.

- 1. Enhance communication with within the jail to increase the number of jail diversions and further decrease jail days** by reducing the lag time between identification of an eligible consumer and their enrollment in IJDP.

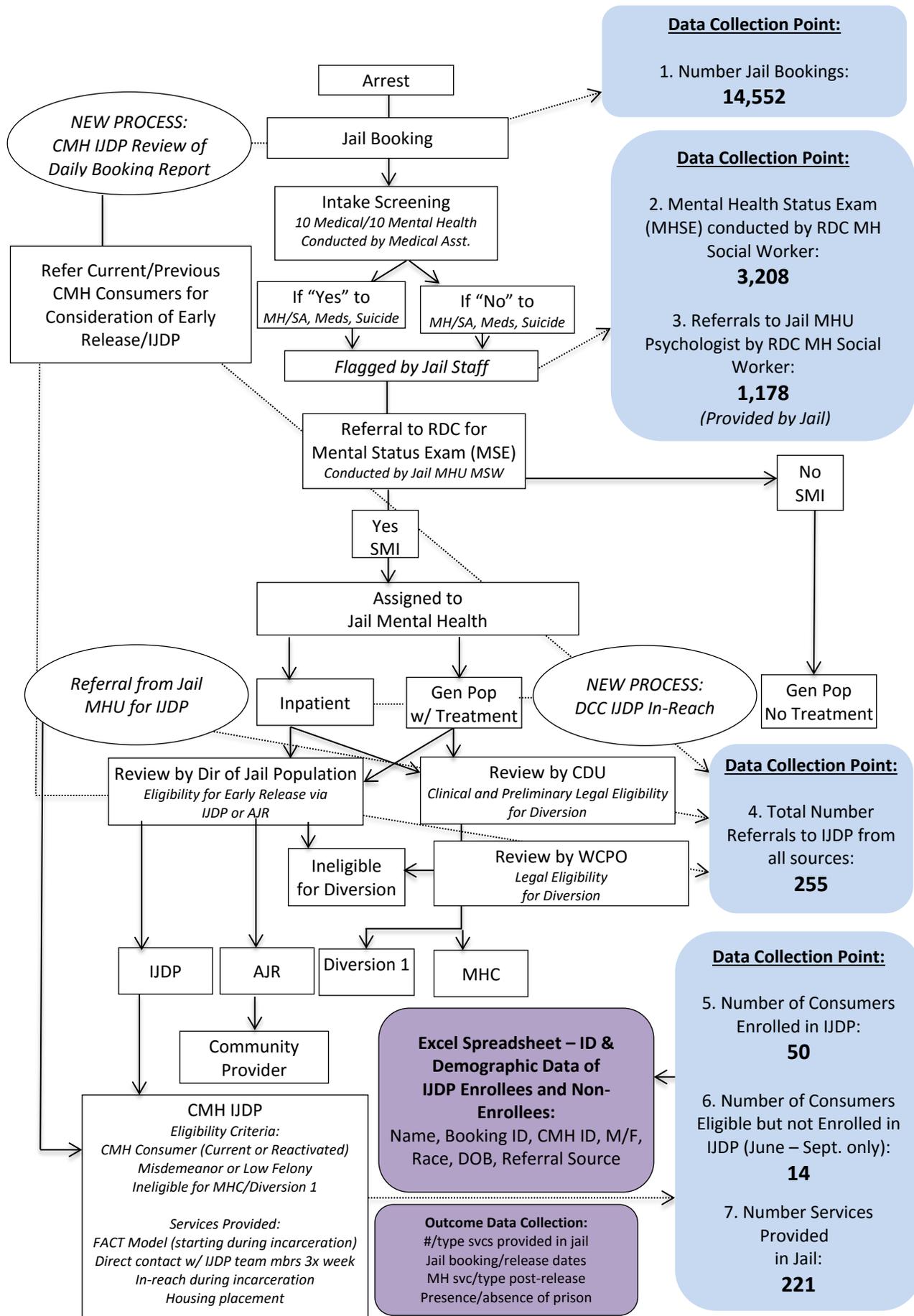
2. **Improve time to community-based treatment** by ensuring that consumers have access to a psychiatrist for medication review/renewal before their two-week supply of medications ends.
3. **Continue engagement post-jail release** to retain individuals in treatment.
4. **Address staffing issues** in order to maintain the forward momentum of the program.
5. **Service expansion to include individuals discharged from the jail to Detroit Receiving.** A memorandum of understanding was recently signed between DCC, the jail, and Detroit Receiving Hospital to facilitate services and housing for individuals who are discharged from the jail directly to Detroit Receiving. Previously these individuals were not followed into the community and engaged in treatment services by DCC. It is anticipated that this agreement will result in improved community-based treatment engagement for these individuals.

Evaluation Team Recommendations

In addition to the above initiatives, the Evaluation Team recommends the following:

1. **Continue to provide follow-up information for individuals who are eligible but not enrolled in IJDP.** Team members currently provide identifying data for individuals who are referred to and eligible for IJDP, but who choose to not enroll into the program. While it was noted during the second site visit that this practice is time-consuming, we encourage team members to continue efforts to provide this information to bolster the evaluation of the jail diversion program.
2. **Establish clear program guidelines for discharge and continuity of care from IJDP.** Although the FACT model individualizes discharge based on attainment of goals, there is no current demarcation between the IJDP/FACT program services and continuity of care as practiced in the 'treatment as usual' community mental health. Stakeholders are encouraged to establish and document clear guidelines for discharge (i.e., objectives to meet for completion or discharge from program) and continuity of care (i.e., how the consumer will be transferred out of IJDP caseload to community case manager) from IJDP.

Figure H3. Wayne County Process Map



Appendix II: Process Data Collection Methodology

This evaluation relies on multiple sources of data to assess the implementation and processes of the eight pilot programs.

Process Methods

Process methods employed during this evaluation period included K6 jail screenings, site visits, process mapping, and data collection. For those sites implementing CIT, pre- and post-tests were conducted across all officers participating in the training. Each of these methods is described in greater detail below.

K6 Jail Screenings

The eight pilot programs represent diverse communities: different geographically, in population size and density, and in the size and scope of the problem. The uniqueness of the pilot programs limits the state's ability to assess the cumulative impact of the projects statewide. One way to collect consistent data across sites is to measure the diversion of individuals with SMI from the local jails. In an effort to measure the impact of the jail diversion programs on all eight jails, the Evaluation Team collected data reflecting the number of individuals with a SMI booked into each jail before the intervention is implemented (February 2015) and one year later (February 2016).

The data collected from each jail consists of a single sheet screening including: characteristics (e.g., DOB, sex, ethnicity), six questions related to current mental health issues (last two weeks), prior jail and/or treatment. The screening was conducted by the Booking Officer(s) with every individual booked into the jail (with the exception of INS/immigration /ICE detainees) during the two collection periods. The goal was to collect at least 200 completed screenings from each site during both collection periods. If 200 screenings were achieved during the 1-week period, collection was ceased. If 200 screenings are not achieved during the initial 1-week period, collection continued until least 200 completed surveys were achieved. At two sites where booking numbers were low (Barry and Marquette), the collection period was extended from February 2015 – December 2015 to provide a sample size suitable for analysis.

The collected data was forwarded by the jails to the Evaluation Team by either email or hardcopy through the mail at the conclusion of both collection periods. In the two cases where collection was extended through December, completed hardcopies of the screenings were forwarded to Evaluation Team on a monthly basis. Screenings were then labeled and numbered by a member of the Evaluation Team. Screening data was then coded and entered into a database by a member of the Evaluation Team.

Site Visits

Initial site visits were conducted at all eight sites in March 2015. All site visits were conducted in person and lasted approximately four hours. The purpose of the site visit was to familiarize members of the evaluation team with key stakeholders, to understand program eligibility and scope, to document the flow of program activities from initial intercept to diversion, and to develop data collection processes and mechanisms. In addition, short-term objectives for the program were identified. Stakeholders representing mental health and criminal justice (i.e., jail, sheriff's department, local police department) were present during each site visit.

Second site visits were conducted with all eight sites during the first quarter of 2016. Of these, six were conducted face-to-face (Berrien, Kalamazoo, Kent, Monroe, Oakland, and Wayne) and two were conducted by phone (Barry and Marquette). All site visits lasted approximately two hours. The purpose of the second site visit was to review short-term objectives identified during the site visit; review any changes to the program during year one; and to highlight any challenges and successes. In addition, objectives for the second year of operation were identified.

Process Mapping

Process mapping was conducted in conjunction with each site visit. A process map was created to illustrate jail services and CIT in those cases where CIT was implemented within the community. The process map illustrates the intercept of individuals pre- (i.e., CIT) or post-booking (i.e., jail services) and follows the individual through the various processes and services associated with the pilot program within the context of existing jail- and community-based processes. The process map was used to assess the flow of the pilot program at both the individual and systems level to answer the following questions: When and where are individuals intercepted? How are individuals diverted from the criminal justice system to treatment? What services are provided via the pilot program? What data indicators are available for measurement throughout the process? In addition, the process maps illustrate similarities and differences across the eight pilot programs. Process maps for all eight sites are presented in Appendix III.

Process Data Collection

Based on the process map(s) established, a unique data collection plan was developed and implemented for each site. Data collection forms were created for each site to guide key stakeholders in the collection of specific process indicators on a monthly basis. The process indicators included both existing processes (i.e., jail bookings and calls to dispatch) and the development of new processes related to the pilot program (i.e., referrals to the program and number of individuals receiving services). Data was provided by the key stakeholder to the evaluation team each month in advance of the monthly conference call (see below).

CIT Pre- and Post-Tests

Immediately prior to the start of the CIT training, a pre-test was administered to all attending officers. A post-test was administered immediately following the training. Two instruments, validated in other research on CIT training, were used in the pre/post-tests. The first instrument was used to assess officers' knowledge regarding psychiatric treatments for individuals with mental illness (OPT Scale); the second instrument was used to assess officers' understanding of how to de-escalate aggressive behavior from an individual suffering from mental illness (De-escalation Scale, see below). A pre/post-test design was utilized to assess changes in knowledge and understanding as a result of the training.

Opinions about Psychiatric Treatments (OPT) Scale. The first instrument included questions about the officers' knowledge regarding psychiatric treatments for individuals with mental illness. The questions about medication, psychotherapy, day and residential treatment programs, and case management services asked for the respondent's agreement with the statement using a 5-point scale (i.e., strongly agree to strongly disagree). The scale was summed to provide an overall score for each officer.

De-escalation Scale. The second instrument included questions about the officers' understanding of how best to de-escalate the behavior of an individual suffering from mental illness. A vignette was provided concerning an individual who presented signs of mental illness. Officers were then asked if specific verbal and behavioral responses would be positive or negative (4-point scale) in the situation. A scale

was created with a possible score of 32; higher scores indicate the officer had more helpful responses towards the person with mental illness.

Implementation Monitoring Methods

Implementation monitoring methods employed during this evaluation period included monthly conference calls and implementation interviews. Each of these methods is described in greater detail below.

Monthly Conference Calls

Monthly data collection calls were conducted with each site beginning in April 2015. The purpose of the call was two-fold: 1) to collect process indicators based on the process map (see above), and 2) to monitor the implementation of the pilot program. The conference calls were held between members of the evaluation team and key stakeholders from each site as identified by each pilot program. The 30-minute conference calls included a review of the previous month's data provided by the site, modification and finalization of process map(s), discussion of implementation accomplishments and challenges, and an update on the current state of the evaluation provided by the evaluation team.

Implementation Interviews

Implementation interviews were conducted with key criminal justice and/or community mental health stakeholders in August 2015. The interviews were conducted by phone with seven of the eight sites including Barry, Berrien, Kalamazoo, Marquette, Oakland, and Wayne Counties. The purpose of the implementation interview was to learn more about the process undertaken at each site to implement pilot program. An implementation interview was not conducted with Kent County where the pilot program was actually the sustainment of an existing jail services program.

Each interview took approximately 60 minutes and focused on the primary objective of each site – either jail services or CIT. Questions were asked about the following:

- Highlights of the project to date.
- Aspects of the project which were unanticipated or surprising.
- Problems or barriers to implementation.
- The level and kinds of collaboration that have been achieved to date.
- Additional supports that would benefit implementation of the pilot.
- Any advice sites would offer to others who are considering implementing a diversion project.