Baseline Activity Across Sequential Intercepts by Diversion Pilot Programs:
Using a Cohort Sample to Evaluate Diversion
Report on Stage 2 Activities from March 2017 – April 2018

Mental Health Jail Diversion

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EXECUTIVE SUMMARY

Over the past four years, 10 counties in Michigan have demonstrated that collaborative projects between mental health (MH) providers and the criminal/legal system can improve responses to individuals with serious mental illness (SMI). During this time, over 7,000 jail-based MH services have been provided through these collaborations. Through the support of the Governor’s Diversion Council and the Michigan Department of Health and Human Services (MDHHS), these projects were expanded in 2017 to county-wide efforts to enhance interventions across all five points in the Sequential Intercept Model (i.e., law enforcement, courts, jail detention, jail services and re-entry into the community). Therefore, evaluation efforts transformed from project-based evaluation to system-based evaluation in an effort to assess the impact of interventions across the sequential intercepts.

The first stage of the system evaluation began in March 2017. The Stage 1 reported in January 2018 detailed how individuals booked into these 10 county jails (Intercept 2) were identified with SMI and what MH services they received during the jail stay (Intercept 3). The Stage 1 report also compared standard jail processes for identifying SMI with the K6 MH Screen results and then followed the individuals in the cohort through the jail for follow-up referral, assessment, and the provision of services to those with SMI.

This Stage 2 report provides a ‘baseline’ of how counties functioned as interventions were developing across all intercepts. For the first time, this report provides comparisons between the SMI and Non-SMI populations by following a sample (n=1,160) of individuals initially identified at jail intake in Stage 1. This report begins at Intercept 2 (Initial Detention), comparing length of jail stay, associated with the target booking, by SMI status. The sample is then followed to Intercept 3 (Jails/Courts) to examine traditional and specialty court processing; Intercept 4 (Reentry) to examine discharge planning and treatment received during the reentry process; Intercept 5 (Community Corrections) to examine the impact of probation and parole violations on jail diversion efforts; Intercept 0 (Community Services) to examine barriers to accessing services within the community; and, Intercept 1 (Law Enforcement) to assess jail recidivism as a proxy for involvement with police. Figure 1 below illustrates the data collected and sample size at each intercept.

Figure 1: Data Points Across the Sequential Intercept Model for Longitudinal Analysis
Findings

As with each report, county specific data will be provided to each pilot as a mechanism to improve prevention and intervention. The primary focus of this aggregate report is on system-wide issues that state-level policy might address through the Diversion Council’s efforts. To illuminate those policy issues, similarities and differences between those identified as SMI and Non-SMI are detailed across the intercepts. Figure 2 summarizes the findings.

Figure 2: Outcomes by SMI/Non-SMI Populations

*For the purposes of this report, divertable offenses are defined as misdemeanor, civil ordinance, and/or violation offenses.
Recommendations

Figure 3: Recommendations by Sequential Intercept

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<td>Community Services</td>
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<td>Increase accessibility of cooccurring mental health and substance abuse treatment</td>
<td>Identify and reduce barriers to data collection</td>
<td>Implement standardized mental health screening in jails to augment current identification processes</td>
<td>Explore length of stay differences between individuals with and without SMI, including uniform risk assessment, implications of CIT training, and behavioral indicators such as tickets and incident reports</td>
<td>Reduce after-hours releases for individuals identified with SMI</td>
<td>Build and enhance relationships with Probation and Parole to decrease violations that result in incarceration through strategies including specialized caseloads, formal collaboration between CMH and Probation and Parole, and mental health training.</td>
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<td>Explore policy recommendations to attain effective transition of Medicaid coverage post jail release</td>
<td>Explore how to effectively define “diversion” for dispatch and law enforcement systems</td>
<td>Explore resources to support incorporation of screening instruments into jail management systems</td>
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Next Steps

- Replicate this study after development and implementation of a multi-intercept intervention strategy within each county. This requires data collection in 2019 (two years post multi-intercept interventions) that uses the same methods and data collection.
- WSU Center for Behavioral Health and Justice will work with Diversion Council members to develop and initiate statewide strategies to improve system barriers.
- WSU Center for Behavioral Health and Justice will develop policy briefs in an effort to inform legislators and state administrators.

REPORT ON THE SECOND STAGE OF SYSTEM EVALUATION

Intercept 2: Initial Detention and Initial Court Hearings

As summarized in the Stage 1 report (January 2018), identification of SMI – and referral to and receipt of MH services – varied across jails. Data collection for that study began in March 2017 with the collection of a MH screen conducted at booking at all 10 jail diversion pilot county jails. In total, 2,972 usable screens were collected1.

The combination of the K6 screening tool and jail staff identification offered insight into who was referred for assessment (or other service) by a MH professional. Because the K6 was used as a data collection tool only, and jail staff did not know the results of the scoring at the time of booking, it was not anticipated that those identified as SMI by only the K6 would receive a referral, assessment/services, or diversion services in the jail. However, it was anticipated that individuals identified by jail staff would receive a referral and/or MH assessment or service.

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1 Two counties were unable to systematically collect jail-based data at booking and were not included in the sampling for this study.
In this report, we drew a subsample of 1,160 individuals to examine the characteristics of the offense and jail stay associated with the target booking in 2017. A subsample was selected to provide similar populations across counties and to select a comparison group of Non-SMI individuals to compare. This subsample was purposefully selected to include a larger proportion of individuals with SMI (K6 ID and Jail ID) and represents a larger proportion of SMI (44%) than identified at booking and reported in Stage 1 (20%). Based on sample size at each jail site, this subsample is not equally distributed: All individuals identified by jail staff as having a SMI are included and vary by site. However, an equal distribution of K6 ID and Non-SMI are included across all sites (except one where a K6 ID group is not available).

Of the 1,160 individuals included in this subsample:
- 280 (24%) individuals are ‘Non-SMI’ – they were not identified by jail staff or the K6 as having a MH issue.
- 880 (76%) individuals were identified as ‘SMI’. Of this 76% of individuals:
  o 637 (72%) individuals were identified by jail staff as having a MH issue and could also have scored positive on the K6 instrument (Jail SMI)
  o 243 (28%) individuals were identified by only the K6, but were not identified by jail staff as having a MH issue (K6 SMI)

![Figure 4: Subsample (n=1,160) by Mental Health Identification Type](image)

Data Source: jail intake, K6 survey and jail-based service records. Sample Size 1,160

![Figure 5: Jail-Based Mental Health Services Received by Identification Type](image)

Data Source: Jail-Based Services; Sample Size 1,160

2 Because of our interest in following those with SMI into the community, those with SMI are over sampled (44%), which differs from the population estimate of 20% in the Stage 1 report.
Figure 6: Days in Jail for Target Jail Stay by Mental Health Identification Type

- After controlling for offense type, individuals with SMI spent 14 more days in jail than Non-SMI.

Data Source: County Jails; Sample Size 1,160

Figure 7: Days in Jail for Target Jail Stay by Mental Health Identification Type by County

Two counties were omitted from this analysis due to insufficient sample collection.
*Days in Jail differed by Non-SMI/SMI

Data Source: County Jails; Sample Size 1,160
**Intercept 3: Jails and Courts**

This Stage 2 report returns to Intercept 3 to examine court processing for those in the cohort sample. Using individual-level data collected from the State Court Administrative Office (SCAO) and the Judicial Data Warehouse (JDW), traditional and specialty court processing is examined.

**Specialty Court Processing**

The examination of specialty courts is the first attempt to track enrollment of individuals within the cohort sample in specialty courts. All eight counties had specialty courts operating during the evaluation period. The types of specialty courts included Drug Court, Veterans Court, Mental Health Court, Swift & Sure Sanctions Probation Program, and Family Dependency Court.

**Figure 8: Specialty Courts Across Jail Diversion Pilot Sites**

- Over the course of the 14-month evaluation period, 3,688 individuals participated in a specialty court in the eight counties.
- A total of 57 individuals from the cohort sample participated in the specialty courts. It is important to note that our sample was collected during a shorter window (6 weeks) and proportion may differ if the collection period was longer.

**Figure 9: Individuals in Specialty Court by Mental Health Identification Type**

The Non-SMI group primarily participated in Drug Courts and Swift & Sure Sanction Courts, while the SMI group (Jail ID and K6 ID) participated in MH Courts and Drug Courts.

*Data Source: SCAO; Sample Size 57*
Traditional Court Processing
Continuing the examination of courts, traditional court processing was also examined. There are a total of 45 courts across the eight counties. Of those courts, 39 report court data to the JDW and six do not. Of the eight counties examined for court processing, seven counties had at least two courts reporting to JDW; one county had no courts reporting to JDW. Due to these non-reporting communities, the JDW contained only 59% of the cohort sample (n=684).

Of the closed cases (n=584), 486 individuals were found guilty (83%) and 98 cases were completely dismissed before trial or found not guilty (17%). No significant differences were found by SMI and Non-SMI groups.

Figure 10: Traditional Court Case Outcome

![Pie chart showing case outcomes: Guilty/Convicted, 83%; Dismissed/Not Guilty, 17%]

Data Source: JDW; Sample Size 1160 (41% of cases missing, resulting in data on 684)

Figure 11: Sentencing Outcome (a) by SMI status (b)

![Bar chart showing proportion of individuals sentenced to prison or jail by SMI status: 57% for SMI, 43% for Non-SMI]

Data Source: JDW; Sample Size 1160 (41% of cases missing, resulting in data on 684)

- Individuals with SMI were more likely to be sentenced to jail or prison (57%) than Non-SMI (43%)³.
- There was a significant difference in the proportion of individuals sentenced to jail or prison by county⁴: County G (31%), County C (47%), County A (52%), and County E (57%) sentenced fewer individuals to jail or prison compared to the remaining six counties. This was likely related to county size, as urban jails sentenced fewer individuals to jail/prison (42%) compared to rural (64%) and metropolitan (69%) jails⁵.
- Examples of Alternative Sentence include fines, community service, and probation.

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³ χ²(1, N=466)=4.4, p<.05
⁴ χ²(7, N=466)=48.016, p<.001
⁵ χ²(2, N=455)=30.7, p<.001
Intercept 4: Reentry
For purposes of this report, reentry includes discharge planning within the jail and at jail release, as well as MH and substance abuse treatment engagement upon the individuals’ reentry to the community. Conversely, this reentry intercept does not examine those individuals who were sentenced to prison and did not reenter the community.

Time of Jail Release
Time of jail release was examined to determine what time of day individuals are released from jail and if this release time coincides with standard business hours for treatment providers – and thus easier access to services for those re-entering. It is noted that jail release time is often unexpected and can be impacted by the results of court hearings and/or payment of bond.

Figure 13: Jail Release Time During Non-Business Hours Across Counties by SMI Status

- The proportion of those released during non-business hours differed significantly by county\(^6\), but did not differ based upon SMI/Non-SMI status.

\(^6\) \(\chi^2(7, N=1,108)=60.3, p<.001\)
Mental Health Treatment Engagement
The sample cohort was then followed into the community to determine if those identified as SMI accessed MH treatment services post-jail release. Data was obtained from state-level Medicaid ‘encounters’. Of the 1,160 individuals in the subsample, 803 individuals (69%) were found in Medicaid data.

Figure 14: Community Mental Health Status by Mental Health Identification Type

\[ \chi^2(2) = 22.3, \ p < .001 \]
Data Source: Medicaid; Sample 1,160; 31% of sample not found in medicaid; 803 individuals included

Figure 15: Mental Health Treatment Engagement in the 14-Month Post-Release Period by CMH Status

\[ \chi^2(1) = 169.5, \ p < .001 \]
Data Source: Medicaid; Sample 1,160; 31% of sample not found in medicaid; 803 individuals included

Figure 16: Mental Health Treatment Engagement Post-Release and by Recipients of Jail-Based Diversion Program Services

\[ \chi^2(1, \ N=802) = 27.8, \ p < .001 \]
Data Source: Medicaid; Sample 1,160; 31% of sample not found in Medicaid; 803 individuals included.

- Of those with an existing or historical relationship with the CMH, there is a significant difference in the proportion of individuals by SMI identification type.

- Individuals with a CMH relationship (current or history) were more likely to engage in MH treatment in the 14-month post-release period (60%) than those with no CMH relationship (15%).

- Individuals who received jail-based diversion services were more likely to engage in treatment (64%) compared to those who did not receive jail-based diversion services (31%).

\[ \chi^2(1, \ N=802) = 27.8, \ p < .001 \]
Overall, 53% of SMI and Non-SMI individuals did not receive treatment in the post-release period. Of those who did receive treatment, 91 (11%) received substance abuse treatment only; 105 (13%) received mental health treatment only; and 180 (23%) received both MH and substance abuse treatment.

Figure 17: Type of Treatment Received Post-Release by SMI Status

- Type of services received significantly differed by SMI: 26% of individuals with SMI received treatment for a COD compared to 10% Non-SMI.
- Though individuals were not identified in the jail, 9% of the Non-SMI group received MH services within the community compared to 14% of those identified within the jail (SMI).

Discharge Planning Among a Random Subsample of those with Serious Mental Illness

In addition, a random subsample of those with SMI was evaluated to determine if any discharge planning services were received leading up to and at jail release. In this section, discharge planning, as well as substance abuse referral, housing referral, and medication at jail release are examined.

Discharge Planning Services

Discharge planning services were broadly defined to encompass a wide range of services being provided within the jails by jail or treatment staff including distribution of community resource guides, individual or group discharge meetings, written discharge plans, treatment referrals, or scheduling intake or MH appointments. This represents the first attempt at defining and documenting discharge planning services within these counties. This process revealed several factors that facilitate or inhibit discharge planning and documentation, including jail size, identification of MH issues at booking, the role of the jail MH provider, and whether or not a MH assessment is conducted.

Figure 18: Proportion of SMI Sample Who Received Discharge Planning Service

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8 Sampling and Methods for this Analysis: Of the individuals identified in the jail as having SMI (by both the jail staff and K6 screening tool), a random selection of 20 cases from eight counties were chosen (n=160). In-depth review of jail and CMH case files was conducted to determine if any type of discharge planning occurred prior to jail release. For purposes of this report, discharge services were broadly defined to encompass the wide range and scope of services being provided within the jails.
Figure 19: Proportion of SMI Sample Who Received Discharge Planning Service

The proportion of individuals who received discharge services differed by county\(^9\), and documentation of services also varied. In some counties, services may be under-reported as it was reported that some discharge services were delivered but not documented.

Data Source: Discharge Services; Sample Size 160

*It is noted that a change in data systems used to track services & the largesse of jail population to sample size (N=20) may have contributed to this result.

Substance Use Disorder Identification and Substance Abuse Treatment Referral

The identification and subsequent referral for substance abuse treatment at discharge was also assessed.

Figure 20: Substance Use Disorder Identification and Substance Abuse Referral by County

There is a difference in the proportion of individuals identified with SUD who received a corresponding service by county\(^10\): A higher proportion of individuals in County A (30%), and County I (45%) counties received substance abuse referrals for community-based treatment.

Data Source: Discharge Services; Sample Size 160; *UKN= unknown, no available data.

**A change in data systems used to track services & the largesse of jail population to sample size may have contributed to this result.

\(^9\) \(\chi^2(7, N=160)=26.7, p<.001\)

\(^10\) \(\chi^2(7, N=140)=18.9, p<.01\)
**Housing Insecurity Identification and Referral**

The identification of housing insecurity and referral for housing services was also examined due to the high prevalence of homelessness reported by individuals with SMI.

**Figure 21: Housing Insecurity Identification and Referral**

Housing insecurity was identified in two ways: by the K6 MH screen conducted at booking or through evidence of such in the individual’s case file. In cases where housing insecurity was reported on the K6 MH screen, jail or treatment staff response was not anticipated. However, in cases where evidence of housing insecurity was documented in the individual’s case file, a corresponding referral could be expected. **Of those identified with housing insecurity in the case file, only 14% (n=2) were given a referral for housing during discharge planning.** For many treatment providers, the lack of an available housing solutions inhibits the ability to make appropriate referrals.

**Data Source:** jail intake, K6 survey and jail-based service records. **Sample Size:** 160.

**Medication at Jail Release**

This section examines if those identified with SMI were provided with a supply of psychotropic medications or a prescription at jail release.

**Figure 22: Medication(s) or Prescription (℞) at Jail Release**

K6 mental health screens conducted at booking were analyzed to identify those individuals who self-reported current use of medications at booking. **Of the subsample, 7% (n=7) received a medication supply or prescription at jail release.**

**Data Source:** K6 Collection at Jail Booking & Discharge Services; **Sample Size** 100
Intercept 5: Community Corrections

This Stage 2 report now moves to community corrections (Intercept 5). The impact of probation and parole violations on the target offense, as well as collaboration between Community Corrections with CMH treatment providers is examined.

Impact of Probation and Parole Violations on Target Offense

Target offenses were examined to determine the effect of violations on the target jail offense.

Figure 23: Target Violation Charge (a) by SMI Status (b)

- 63% of individuals were charged with a divertable offense: 47% with a misdemeanor, civil, or ordinance offense and 16% with a probation or parole violation.
- A larger proportion of Non-SMI individuals were charged with a violation (23%) compared to individuals with SMI (14%)\(^\text{11}\).

Level of Collaboration with Probation and Parole

Interviews were conducted with jail and CMH stakeholders to assess collaboration with Probation and Parole in each county.

Figure 24: Collaboration between CMH and Probation/Parole by County

Across all ten counties, the level of involvement of probation and parole in jail diversion efforts varies. Three counties reported specific programs partnering the CMH or jail diversion program with probation or parole. In only two counties, stakeholders were aware of specialty MH caseloads within probation or parole. None of the stakeholders in any of the ten counties were aware of specialized MH training being provided to probation or parole officers.

\[^{11}\] \(\chi^2\) (2, N=1,107)=15.3, p<.001
Intercept 0: Community Services

Community-based services that might prevent involvement in the criminal/legal system are Intercept 0. For purposes of this report, we are interested in accessibility to integrated MH and substance abuse treatment services, as well as the effects of the suspension and/or reactivation of Medicaid benefits for individuals transitioning in and out of jail.

Integrated Mental Health and Substance Abuse Treatment Services

In our efforts to examine the receipt of integrated substance abuse and MH treatment for individuals with COD, systemic barriers to integrated treatment were identified. With the consolidation of the substance abuse and MH systems of care, there seems to be an unintended consequence that often results in a bifurcation of service delivery at the PIHP level.

- Funding is currently provided through separate streams. As a result, different treatment structures have emerged including those in which treatment is provided by separate MH and substance abuse providers or through a truly co-occurring provider.
- The separate treatment MH and substance abuse tracks result from:
  o Separate funding streams due to Medicaid billing codes and treatment authorization.
  o Separate treatment data due to broad interpretations of Health Insurance Portability and Accountability Act (HIPAA) and/or 42 Code of Federal Regulations (CFR) Part 2 patient protections.
- When treatment is delivered in systems with separate MH and substance abuse treatment tracks, MH clinicians cannot bill for IDDT or access substance abuse treatment history without a signed CFR Part 2 release.

Suspension and Reactivation of Medicaid Benefits

Another issue that emerged in discussions with jail and treatment staff across nearly every county was the interruption in treatment resulting from the “suspension” of Medicaid benefits during jail incarceration and sporadic “reactivation” upon release. Federal policy dictates that Medicaid benefits are limited to offsite services during incarceration. Therefore, individuals convicted of a crime and incarcerated are not eligible for Medicaid coverage within jails/prisons. At the state level, Michigan Department of Corrections has an automated system with MDHHS to remove codes that restrict Medicaid eligibility (PET code) once an individual is released. However, the procedures related to jail and county-level incarceration lack consistency across counties and transparency in terms of how/when PET codes are applied and removed. Following jail release, the PET code must be removed before the individual’s Medicaid status returns to full coverage.

- Seven counties indicated that “suspension” of benefits was inconsistent. The remaining three counties indicated specific practices or policies for suspension based either on the number of days incarcerated or when reported by the jail.
- In nine counties, assistance in reactivation of Medicaid was provided by CMH staff. As a result, in six counties, only CMH consumers were assisted in reactiving Medicaid. Non-CMH individuals within those counties would only receive assistance by visiting the local DHHS office.
- MDHHS & MDOC have clear processes for applying & removing PET codes, but this is more difficult at the jail level due to unknown or unplanned release dates and variation in jail organization and staffing.

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12 The description of Medicaid suspension and reactivation is specific to county level jail incarceration and may not apply to state-level incarceration.
**Intercept 1: Law Enforcement**

Due to the lack of data, we were unable to systematically measure when or how often officers made decisions to divert an individual from the criminal/legal system. However, because our sample included both SMI and Non-SMI, we were interested in looking at return to jail as a proxy for law enforcement involvement across the samples.

**Figure 25: Recidivism Post Target Jail Stay (a), by Group (b)**

- 54 individuals (5%) went directly to prison after their target jail stay.
- 491 individuals (43%) returned to the county jail in the 14-month follow-up period after their target jail stay.
- MH identification type was not associated with jail recidivism: 47% of Jail SMI, 43% of K6 SMI, and 41% of Non-SMI returned to jail.

**Conclusion**

This report represents a baseline look at how the jail diversion pilot counties functioned as interventions were developing across all intercepts and provides an initial comparison between the SMI and Non-SMI populations. This study will be replicated beginning in March 2019 using the same methods and data collection. In upcoming reports in 2019 and 2020, we anticipate improvements across the intercepts in each county based on stakeholder response and engagement in improving data collection and documentation and identifying and rectifying service gaps in the two years since the start of this baseline study.