DIVERSION PILOTS: LONG TERM OUTCOMES

Aggregate Findings across sites for those served between April 1, 2015 and March 31, 2016

Michigan State University
Sheryl Kubiak, Ph.D., Principal Investigator
Liz Tillander, LMSW
Celeste Rabaut, MSW
Heidi Bisson

Wayne State University
Erin Comartin, Ph.D.
Lester Kern, MSW
Laine Putans, MSW
## DIVERSION PILOTS: LONG TERM OUTCOMES
### APRIL 1, 2015 – MARCH 31, 2016

### TABLE OF CONTENTS

<p>| Section |
|-----------------|-----------------|
| EXECUTIVE SUMMARY | 1 |
| SECTION 1: Jail Diversion Services | 5 |
| A. Program Overview | 7 |
| B. Did Individuals Receive Mental Health Treatment Post-Intervention and Did It Meet Continuity of Care Standards? | 9 |
| Pre- &amp; Post-Intervention Mental Health Service Utilization | 10 |
| Continuity of Care | 11 |
| C. How Do Recidivism Outcomes Change? | 14 |
| Prison &amp; Jail Stays in the Post-Intervention Period | 14 |
| Pre- &amp; Post-Intervention Recidivism | 14 |
| Pre- &amp; Post-Intervention Days Spent in Jail | 15 |
| Post-Intervention Charges | 17 |
| D. Who Is Successful in Both Treatment Engagement and Absence of Recidivism? | 19 |
| E. Across Outcome Indicators What County Programs Are Exemplars? | 20 |
| SECTION 2: Crisis Intervention Team Training Outcomes | 21 |
| A. Do Officers Change Behavior in the Field Post CIT Training? | 22 |
| B. What Factors Predict Deputies’ Decisions To Transport to the Crisis Center? | 25 |
| C. Does CIT Training of Jail-Based Officers Reduce the Need for Cell Extractions? | 26 |</p>
<table>
<thead>
<tr>
<th>SECTION 3: Considerations and Next Steps</th>
<th>27</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. What Needs to be Considered When Reviewing This Data?</td>
<td>27</td>
</tr>
<tr>
<td>Jail-Based Interventions</td>
<td>27</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>29</td>
</tr>
<tr>
<td>B. What Are the Next Steps for the Evaluation?</td>
<td>29</td>
</tr>
<tr>
<td>System-level Evaluation</td>
<td>29</td>
</tr>
<tr>
<td>Monitoring Program Processes</td>
<td>29</td>
</tr>
<tr>
<td>CIT Outcomes</td>
<td>30</td>
</tr>
<tr>
<td>APPENDIX</td>
<td>31</td>
</tr>
<tr>
<td>Appendix A: Definitions</td>
<td>33</td>
</tr>
</tbody>
</table>
Diversion Pilots
Long-Term Outcomes Report

Executive Summary

Background
The Jail Diversion Pilot Program consists of pilot programs funded in eight counties in 2015 through the Governor’s Diversion Council. One of the counties focused exclusively on Crisis Intervention Team (CIT) while the other seven offered exclusively jail-based interventions or a combination of jail-based interventions and law enforcement training. In March of 2017, a baseline data report presented the prevalence of serious mental illness among those entering jail, recidivism among persons with serious mental illness, and officer’s perception of CIT training and behavior post-training. This report is an extension of the baseline data report, and presents the long-term outcomes of individuals within these jail diversion programs and results of the county-wide implementation of the CIT intervention.

Focus of Report

SECTION 1. Jail Diversion Services
This section focuses on 1,267 individuals enrolled in jail diversion programs between April 1, 2015, and March 31, 2016, to assess their outcomes in the 1-year post-intervention period. This report explores the following questions:

- Did individuals receive mental health treatment services post intervention and did this treatment meet continuity of care standards?
- Is there a change in recidivism after receiving the intervention?
- What proportion of participants are successful in both treatment engagement and absence of recidivism, post intervention?
- Across outcome indicators what county programs are exemplars?

SECTION 2. Crisis Intervention Team (CIT) Training
This section focuses on the outcomes of CIT training in one county that had high fidelity to the CIT model, the greatest number of officers trained, a high number of dispatch call reports related to mental health, and allowed researchers access to relevant data. This section examines the following questions:

- Do officers change behavior in the field post-CIT training?
- What factors predict deputies’ decisions to transport to the crisis center?
- Does CIT training of jail-based officers reduce the need for cell extractions?

1 One county, funded in 2016, was included in the analysis for a 6 month period pre- and post-intervention (April 1, 2016 to September 30, 2016).
SECTION 3. **Considerations and Next Steps**

This section looks at considerations and next steps as they relate to this report and future evaluation activities. It examines the following two questions:

- What needs to be considered when reviewing this data?
- How can programs and policy improve going forward?
- What are the next steps for the evaluation?

### Highlights

**Jail Diversion Program Outcomes**

- More than 3,500 individuals have received at least one jail diversion service from the pilot programs since 2015. For purposes of this evaluation, we focus on 1,267 individuals enrolled in the first year of the pilot program (April 1, 2015 – March 31, 2016).
- The numbers served in each county varied, ranging from 35 to 701, depending on the type of program, existing services, and individual county objectives. Aggregate analyses of the data were often ‘pulled’ by the size of the largest county, where the sample of 701 individuals was over half of the total sample. Analyses were adjusted accordingly. Below are outcomes related to this group of 1,267.
- Assessing programs across outcome indicators, some counties demonstrated exemplary outcomes in three or more of the six indicators. Practices within these counties focused more heavily on intensive case management, inreach/outreach, and continuity of care.

### Examining Indicators of Success by County

<table>
<thead>
<tr>
<th>County</th>
<th>% increase in MH treatment engagement pre- to post-</th>
<th>% receiving continuity of care post-jail release</th>
<th>% reduction in # individuals recidivating</th>
<th>Total number of jail days pre- to post-</th>
<th>% of those returning to jail for misd or PV</th>
<th>% successful on both recidivism and treatment engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>17%↑</td>
<td>29%</td>
<td>4%↓</td>
<td>↑</td>
<td>89%</td>
<td>29%</td>
</tr>
<tr>
<td>B</td>
<td>18%↑</td>
<td>48%</td>
<td>6%↑</td>
<td>↑</td>
<td>79%</td>
<td>26%</td>
</tr>
<tr>
<td>C</td>
<td>9%↑</td>
<td>71%</td>
<td>16%↑</td>
<td>↑</td>
<td>47%</td>
<td>31%</td>
</tr>
<tr>
<td>D</td>
<td>6%↓</td>
<td>42%</td>
<td>6%↑</td>
<td>↑</td>
<td>65%</td>
<td>34%</td>
</tr>
<tr>
<td>E</td>
<td>8%↑</td>
<td>28%</td>
<td>10%↓</td>
<td>↓</td>
<td>80%</td>
<td>41%</td>
</tr>
<tr>
<td>F</td>
<td>2%↑</td>
<td>10%</td>
<td>19%↓</td>
<td>↓</td>
<td>75%</td>
<td>30%</td>
</tr>
<tr>
<td>G</td>
<td>12%↑</td>
<td>29%</td>
<td>10%↓</td>
<td>↑</td>
<td>44%</td>
<td>24%</td>
</tr>
<tr>
<td>J</td>
<td>13%↑</td>
<td>33%</td>
<td>14%↓</td>
<td>↓</td>
<td>60%</td>
<td>48%</td>
</tr>
</tbody>
</table>
Mental Health Treatment and Continuity of Care

- Mental health treatment outcomes were obtained for 1,048 individuals who were present in state-level Medicaid data.
- In 7 of 8 programs, jail-involved individuals were more likely to receive a mental health service in the year after the pilot intervention than in the year before; increases range from 2% to 17%.
- Across counties, CMH consumers were 2.5 times more likely to receive mental health services post-intervention than Non-CMH Medicaid individuals.
- Overall, CMH consumers were also 3 times more likely to experience continuity of care (service within 14 days of jail release) than Non-CMH. (Note: adjusting for the county size difference, we found that in six of the seven counties, CMH consumers were 21 times more likely to receive continuity of care).
- Individuals who received a high dose of intervention services were more likely to receive mental health services post-intervention than those who received low or medium dosages.

Recidivism

- A total of 1,267 individuals were assessed for jail and prison recidivism outcomes; 84 were sent directly to prison and 1,183 were assessed for jail recidivism outcomes.
- In 5 of the 8 programs, reductions in recidivism were achieved, ranging from 4% to 19% (4 programs experienced 10% or greater reduction in jail recidivism).
- Programs with greater than 10% reduction in recidivism focused on continuity of services between the jail and community through activities such as outreach and intensive case management.
- In 3 of the 8 programs, a decrease in the number of jail bed days was achieved ranging in reductions from 193 to 461 days.
- Across counties, post-intervention jail confinement was often associated with misdemeanors or violations of the court, ranging from 44% to 89% of of those who recidivated.
- At least 25% of individuals across all counties were successful in treatment and recidivism following the intervention.

CIT Outcomes

- A total of 665 officers were trained since 2015 including 384 patrol, 306 corrections, and 33 dispatchers. For purposes of this evaluation, we focus on one county where 462 officers have been trained including 123 patrol, 306 corrections, and 33 dispatchers.
- In this county, less than 1% of mental health calls were transported to jail before or after CIT training.
Diversion Pilots: Long-Term Outcomes

- Transports to the crisis center increased 22%; the increase was sustained 20 months post-training and equates to 10 drop-offs per month.
- CIT-trained deputies are 3 times more likely to transport individuals to the crisis center than untrained deputies.
- For every 1-mile away the deputy is from the crisis center, they are 1% less likely to transport to the crisis center.
- An initial review of calls for the Cell Extraction Team within the jail indicates a 49% reduction in CET calls when comparing the 3-month period before corrections CIT training to the 3-month period following the training.

Future Considerations

- Across all counties, address the number of individuals returning to jail for misdemeanor or ordinance offenses by initiating a cross-agency community dialogue involving the courts, law enforcement, CMH, and the county jail to identify alternatives to arrest and jail for those with mental illness who are charged with low-level offenses.
- Address the number of individuals returning to jail for probation and parole violations, in part, by extending mental health training to probation and parole officers.
- Greater emphasis on the existence and treatment of co-occurring substance use disorders (SUD). Substance misuse was a major predictor of recidivism and treatment silos remain in the community in respect to integrated treatment and access to data.
- Explore the relationship between CMH enrollment and service access and availability. As CMH enrollment was a predictor of continuity of care, determine eligibility and access for those identified within the jail.
- Enhance Medicaid reinstatement practices and CMH enrollment at jail release.

Next Steps for Evaluation

- **System-level Evaluation:** MSU will engage in exploration of jail discharge activities, warm hand-off, community-based law enforcement interactions and the continuum of care from jail to the community for individuals identified with a mental health concerns within the jail.
- **Monitoring Program Processes:** MSU will continue to collect monthly process indicators for jail diversion programs and CIT trainings from the ten current pilot sites.
- **CIT Outcomes:** MSU will continue to evaluate the impact of CIT in the jail through the collection of cell extraction reports to track and monitor the impact of CIT training on the number of incident requiring cell extraction team involvement.
Diversion Pilots

1 Year- Long-Term Outcomes

Full Report

SECTION 1: Jail Diversion Services

This section looks at individual-level mental health treatment and recidivism outcomes for persons with serious mental illness across programs in eight counties that offered jail diversion interventions during the first year of the pilot program (April 1, 2015 – March 31, 2016). County identifies are blinded in this report, but it is important to note that the variation across the intervention programs is immense, encompassing jail- and/or community-based groups, treatment, discharge services, and advocacy to divert those with SMI from jail to treatment. As a result, the number of individuals enrolled in each program varies.

![Figure 1: NUMBER OF INDIVIDUALS BY COUNTY (N=1267)](image)

Outcomes for the intervention are measured one year post-intervention. In an effort to assess the outcomes in the year after the intervention, we use the year before the intervention as a ‘control’ to determine if this is a behavioral change for the individual. Therefore, this evaluation design examines three specific time periods:

- **Pre-Intervention** – 1 year prior to the intervention.
- **Intervention/Target** – point between 4/1/15 - 3/31/16 when intervention was received.
- **Post-Intervention** – 1 year after the intervention.

---

2 Due to the size disparities by county, logistic regression and general estimating equation models were used to confirm findings; the most conservative estimates are reported

3 Note: One county joining in 2016 uses 6 month pre/post intervention outcomes, and not one year.
Based upon this data collection strategy, data was collected from several sources: 1) jail records from each county; 2) Michigan Department of Corrections Offender Tracking and Information System; and 3) State of Michigan Medicaid behavioral health billing data. Data was merged using unique identifiers and analyzed to assess treatment continuity and recidivism across the time periods.\(^4\)

\(^4\) In addition to descriptive data, analyses included both regression and general equation estimating (GEE). GEE was used to verify regression models due to the variation in the size of the counties.
A. Program Overview
As described in the Implementation Report (MSU 2016), jail diversion programs varied by county. The following chart illustrates variation across counties.

<table>
<thead>
<tr>
<th>County</th>
<th>Diversion Type</th>
<th>New Program</th>
<th>Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current</td>
<td>Future</td>
<td>Advocacy</td>
</tr>
<tr>
<td>County A</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>County B</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>County C</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>County D</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>County E</td>
<td>X</td>
<td>X*</td>
<td>X</td>
</tr>
<tr>
<td>County F</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>County G</td>
<td>X</td>
<td>X*</td>
<td>X</td>
</tr>
<tr>
<td>County J</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

For purposes of the evaluation, some of service variations were used to assess differences in program and individual outcomes:

- **Diversion Type**: Of the 1,267 individuals enrolled in jail diversion programs, 7% (92 individuals) were classified as a ‘current’ diversion from jail: the individual received a reduction in jail days due to advocacy efforts. The majority (93%, 1,173 individuals) received services that may lead to future diversion, but did involve a reduction in jail days (i.e., groups, support services, jail-based treatment).

- **CMH Status**: Involvement with Community Mental Health (CMH) was reported by program sites and is used as a program characteristic to assess outcomes. All programs offered diversion services to CMH consumers, and most provided services to those who were not current CMH consumers (Non-CMH) or those who were CMH consumers of another county, as well (Other). In addition, some programs actively enrolled or reactivated individuals into CMH services. Medicaid data revealed that some Non-CMH individuals were Medicaid eligible, yet others were not found in Medicaid data and are assumed to be privately insured, covered in another state, or veterans served by the Veterans Administration (see Figure 7). At program enrollment, program staff reported that 6% (794 individuals) were current CMH consumers; the remaining 37% (473 individuals) were Non-CMH.

- **Models/Dosage**: Programs were asked to describe their program model (i.e., what service delivery consisted of) and how much service was received per individual. Based
on their information and program model, dosage was divided into high, medium, and low.

Figure 4: **PROGRAM DOSAGE**

- 50% (1,175 individuals) received a low dose of services, 16% receive a medium dose, and 34% receive a high dosage across the six counties that reported program dosage.
- The average length of stay (or the number of days services were offered under the program models) was 73 days (SD=108), with the median being 22 days. Stays ranged from 0 to 718 days.

Demographic and offense characteristics were also added into analytic models to determine if they created variation in outcomes.

Figure 5: **DEMOGRAPHIC CHARACTERISTICS**  
Figure 6: **TARGET OFFENSE CHARACTERISTICS**

- Age ranged from 17 to 71 years old, average of 37; half (50%) were age 35 or younger.
- 70% (886 individuals) were male.
- 47% (587 individuals) were of individuals of color.
- 79% (1,003 individuals) showed evidence of a co-occurring mental health (MH) and substance use disorder (SUD).

---

5 See Appendix A for definition of Program Dosage
6 Two 16 year olds were removed from the analyses.
47% (539 individuals) had a felony target offense; 44% (515 individuals) had a misdemeanor, civil or ordinance target offense; and 9% (104 individuals) had a probation, parole or court violation from a prior offense as the target offense.

B. Did Individuals Receive Mental Health Treatment Post-Intervention and did it Meet Continuity of Care Standards?

Treatment engagement in the pre- and post-intervention periods was determined through state-level Medicaid behavioral health encounter data. In determining treatment interface post-incarceration, Medicaid data was thought to be the most robust choice of data for two reasons: 1) individuals with serious and persistent mental illness (SPMI) qualify for Medicaid through CMH involvement; and 2) a greater number of low income individuals are eligible for physical and mental health services through Medicaid expansion.

Figure 7. CMH AND NON-CMH MEDICAID STATUS OF PARTICIPANTS

Using a composite variable based upon CMH status reported by the programs and those found in Medicaid data, we found:

- 53% (623 individuals) were current CMH consumers at enrollment in the jail diversion program.
- 29% (337 individuals) were Medicaid enrolled, but not affiliated with CMH (Non-CMH).
- 11% (135 individuals) were not found, or were “Unknown” in Medicaid/CMH service eligibility. In some cases individuals were known to be veterans; others are assumed to be privately insured or covered within another state.
- 6% (72 individuals) were newly enrolled or reactivated in CMH during the jail diversion program; 1% were from an out-county CMH (16 individuals).

---

7 109 individuals were classified as pre-booking diversion as they were referred to the diversion program from outside of the jail (i.e., court, police etc.); thus they did not have a target offense.

8 A total of 1,183 individuals were considered for mental health treatment outcomes after removing those individuals who went to prison.
Pre- & Post-Intervention Mental Health Service Utilization

Of the 1,048 individuals located in Medicaid data, mental health treatment engagement was assessed for the pre- and post-intervention periods.

Figure 8. PROPORTION RECEIVING ANY MENTAL HEALTH TREATMENT IN PRE- & POST-INTERVENTION PERIODS - BY COUNTY (n=1,048)

- 7 of 8 programs saw increases in individuals’ receipt of mental health services from the pre- to post-intervention period; increases range from 2% to 17%.
- Aggregate analysis across counties found that 75% (784 individuals) received at least one mental health treatment service in the post-intervention period, up from 73% (764 individuals) in the pre-intervention period. However, this change varies across counties.
- In four counties, 75% or greater of enrolled diversion participants received mental health services in the year after the target intervention.
- Individual-level indicators associated with post-intervention mental health service utilization:
  - Females were more likely to receive services in the post-intervention period (79%), than males (73%)\(^9\).
  - Individuals between the ages of 17 - 25 were less likely to receive services in the post-intervention period (66%) than those 26 - 35 years old (78%) or those 36 and older (76%)\(^10\).

\(^9\) \(\chi^2(1, n=1,048)= 4.579, p<.05\)
\(^10\) \(\chi^2(2, n=1,048)= 11.731, p<.01\)
Individuals with a co-occurring MH and SUD were more likely to receive services in the post-intervention period (78%) than those who did not have a co-occurring disorder (61%)\(^{11}\). In fact statistical models\(^{12}\) show they were 1.8 times more likely\(^{13}\) to receive services.

Individuals who had a felony target offense were less likely to receive services in the post-intervention period (71%) than those with a misdemeanor, civil, ordinance offense or those with a violation of the court (77%)\(^{15}\).

- Program/service indicators associated with post-intervention mental health service utilization:
  - Individuals who received a high dose of jail diversion program services were more likely to receive mental health services in the post-intervention period (80%), than those who received a low or medium dose of services (72%)\(^{16}\).
  - Individuals who were CMH consumers were more likely to receive services in the post-intervention period (82%), compared to those who were non-CMH Medicaid (60%)\(^{17}\). In fact statistical models\(^{12}\) show they were 2.5 times more likely\(^{18}\) to receive any service post intervention.
  - Individuals who received a current diversion (reduction in jail days) were more likely to receive mental health services in the post-intervention period (85%) than those who received a future diversion service (74%)\(^{19}\).

### Continuity of Care

**Continuity of care is achieved when the individual receives the first mental health treatment service in the community within 14 days of release from jail.**

Generally, those released from jail and on medication are given a 2-week supply and instructed to see their CMH case manager within that time period. In assessing the time between jail release and first mental health treatment, jail release dates were juxtaposed with Medicaid mental health service dates. A limitation of this method is that all services may not be available in the Medicaid data. For example, outreach services funded from diversion pilot funds would likely not be found in Medicaid. Conversely, we would expect that services such as medication

---

\(^{11}\) \(\chi^2(1, n=1,048)= 23.295, \ p<.001\)

\(^{12}\) \(\chi^2(8, n=915)= 156.035, p<.001, \) predicted by: gender, age, co-occurring status, target offense charge, CMH status, high dose JD program services, current diversion, receipt of mental health services in the pre-intervention period. Variance explained (Nagelkerke \(R^2\)) = 23%, cases predicted = 79%.

\(^{13}\) Wald=7.212, \(p<.01, \) CI: 1.180 – 1.262.

\(^{14}\) Although those with a COD were more likely to receive services, it is not clear if they received MH only services or some form of integrated MH SUD treatment.

\(^{15}\) \(\chi^2(1, n=981)= 4.387, \ p<.05\)

\(^{16}\) \(\chi^2(1, n=970)= 6.414, p<.05\)

\(^{17}\) \(\chi^2(1, n=1,048)= 57.598, p<.001\)

\(^{18}\) Wald= 26.676, \(p<.001, \) CI: 1.749 – 3.464

\(^{19}\) \(\chi^2(1, n=1,047)= 4.793, p<.05\)
39% (378 individuals) enrolled in the jail diversion programs received their first mental health treatment service in the community within 14 days from their release from jail. There were no individual-level indicators predicting continuity of care.

Aggregate analysis across counties demonstrated that CMH consumers were more likely to receive continuity of care (47%) than non-CMH individuals (20%)\(^{21}\). In fact statistical models\(^{22}\) show they were 2.8 times more likely to receive continuity of care.

Given the weight of the number of participants in one county, analysis removing that county found that, across the remaining counties, individuals enrolled in CMH were 22 times more likely to engage in continuity of care if they were CMH-enrolled.

Individuals who received a high dose of program services were more likely to receive continuity of care (45%) than those who received a low or medium dose (34%)\(^{23}\).

Individuals who received current diversion (reduction in jail days) were more likely to receive continuity of care (58%) than those who received a future diversion service (37%)\(^{24}\).

---

\(^{20}\) After removing individuals who went directly to prison, those who were not found in the Medicaid data, and those who did not have a target jail stay, 983 individuals were assessed continuity of care.

\(^{21}\) \(\chi^2(1, n=983)=64.423, p<.001\)

\(^{22}\) \(\chi^2(4, n=915)=131.919, p<.001, \) predictors: CMH status, high dosage of JD services, current diversion, and community-based services in the pre-intervention period, variance explained (Nagelkerke R2)=18%, predicted cases=66%. Wald= 35.777, p<.001, CI: 1.996 – 3.916

\(^{23}\) \(\chi^2(1, n=916)=11.046, p<.01\)

\(^{24}\) \(\chi^2(1, n=982)=11.893, p<.01\)
Continuity of care ranged from a high of 71% to a low of 10% across counties.

One-third or more of individuals enrolled in the jail diversion programs received continuity of care in 4 of 8 counties; less than one-third of individuals received continuity of care in the remaining four counties.

The program achieving continuity of care for 71% of individuals focused on advocacy and current diversions (reduction in jail days), so individuals were diverted from jail to treatment.
C. How Do Recidivism Outcomes Change?
Data was obtained from two sources to determine recidivism: 1) records from each county jail; and 2) Michigan Department of Corrections Offender Tracking and Information System.

Recidivism is based on confinement in state prison or return to jail in the county where the diversion intervention was administered.

Prison & Jail Stays in the Post-Intervention Period
All 1,267 individuals enrolled in the program were assessed for post-intervention recidivism.

Figure 11. PRISON AND JAIL RECIDIVISM IN THE POST-INTERVENTION PERIOD

Pre- & Post-Intervention Recidivism
After removing 84 individuals who went directly to prison from their target jail stay, the remaining 1,183 individuals were assessed for jail recidivism in the pre- and post-intervention periods.

- Aggregating all of the data across counties, there were no differences in the proportion of individuals who had a jail stay in the pre-and post-intervention periods (51%); however this aggregate number is largely driven by the number of participants in one county and suppresses the stories of individual counties.
- Aggregate data does indicate that Individuals with a co-occurring substance use disorder were more likely to recidivate (56%) than those without a co-occurring disorder (31%)\(^{25}\). In fact statistical models\(^{26}\) show they were 2.6 times more likely to recidivate.

\(^{25}\)\(\chi^2(1, n=1,181)= 46.175, p<.001\)

\(^{26}\)\(\chi^2(2, n=1,181)= 75.057, p<.001,\) predictors: co-occurring disorder and a jail stay in the pre-period. Variance explained (Nagelkerke R\(^2\))=8%, predicted cases=61%. Wald=37.814, p<.001, CI: 1.919 – 3.532.
Figure 12. PROPORTION OF INDIVIDUALS IN JAIL IN THE PRE- & POST-INTERVENTION PERIODS – BY COUNTY (n=1,181)

- 5 of 8 programs saw a reduction in recidivism from the pre-intervention period to the post-intervention period, ranging from a 4% to a 19% reduction.
- Four counties had a 10% or greater reduction in recidivism. These counties were located in each of the geographic regions (metropolitan, urban, and rural) and focused heavily on continuity of services between jail and community (i.e., mandated treatment, intensive case management, and outreach services upon jail discharge).
- Conversely, the county with the greatest increase in recidivism is reflective of only 35 cases, most of whom were diverted from jail at intake due to need for intensive treatment.

**Pre- & Post-Intervention Days Spent in Jail**

After removing 84 individuals who went directly to prison from their target jail stay, the remaining 1,181 individuals were assessed for the number of days spent in jail in the pre- and post-intervention periods.

Reducing the number of individuals returning to jail in the five of eight counties did not always result in a decrease in the overall number of jail days in the post-intervention period. In fact, there were substantial increases in the number of days individuals spent in jail.
The average number of days in jail increased from 35 days in the pre-intervention period (range 1 to 365 days; median 8 days) to 60 days in the post-intervention period (range 1 to 365; median 28 days).

In comparing pre- and post-intervention day jails, days in jail increased across offense types an average of 24 days. Increase in jail days for those with a felony was 47 days, compared to 13 days for misdemeanors, and 19 days for violations.

Aggregating data across jails, the total number of jail days increased from 20,625 (597 individuals) in the pre-intervention period to 35,629 (596 individuals) in the post-intervention period. Again, this total number is reflective of the large number of individuals in County D.
Assessing change across individual counties, three programs achieved a decrease in the number of jail bed days from pre to post-intervention, with reductions of 193 days (County F) to 461 days (County E). These three programs also experienced 10% or greater drop in recidivism.

**Post-Intervention Charges**
Charge type was assessed for the 596 individuals who recidivated in the post-intervention period.

**Figure 15. POST-INTERVENTION CHARGES**

- 32% (184 individuals) were charged with a felony offense.
- 49% (281 individuals) were charged with a misdemeanor, ordinance, or civil offense.
- 19% (109 individuals) were charged with a violation of a court order.
- Taken together, **68% of those incarcerated in the post-intervention period could have potentially been diverted** from jail for misdemeanor or violation offenses.

Keeping in mind the proportion that recidivated from each county (from 29% to 64% as illustrated above in Figure 12), Figure 16 below provides an overview of the charge type for ONLY those individuals who returned to jail for in the post-intervention period.
44% (County G) to 89% (County A) of individuals who recidivated were charged with misdemeanor/civil/ordinance offenses or violations of the court.

- Jail capacity may have some bearing on the ability of some jurisdictions to have greater number of persons with misdemeanors or court violations confined. However, geographic size of the county did not seem to be a predictor of the proportion of who were confined for lower level offenses.

- For purposes of jail diversion, returns for misdemeanor or civil offenses may be avoidable and one strategy towards reducing jail bed days and maintaining community-based treatment continuity.
D. Who is Successful in Both Treatment Engagement and Absence of Recidivism?

Success is defined as engagement in low- or medium-intensity mental health treatment services AND no recidivism in the post-intervention period.

Successful diversion implies more than an absence of recidivism since treatment engagement is important in maintaining stability and optimal functioning within the community. Therefore, this analysis combines both jail and treatment outcomes to determine success.

Figure 17: PROPORTION WITH SUCCESSFUL TREATMENT AND RECIDIVISM OUTCOMES IN THE POST-INTERVENTION PERIOD

- In aggregate, across all counties, 34% (356 individuals) were successful on measures of both recidivism and treatment engagement in the post-intervention period.
- Individual-level indicators associated with success:
  - Across all counties, CMH consumers were more likely to be successful in the post-intervention period (38%) than Non-CMH individuals (27%)\(^{27}\).
  - Younger individuals, aged 17 to 25, were less likely to be successful in the post-intervention period (27%) than those aged 26 to 35 (34%) or 36 and older (37%)\(^{28}\).

\(^{27}\) \(\chi^2(1, n=1048)= 11.991, p<.01\)
\(^{28}\) \(\chi^2(2, n=1048)= 6.096, p<.05\)
Across all programs, at least one quarter of individuals were successful in both treatment and recidivism outcomes in the post-intervention period.

The county with the highest success rate (County J) provides intensive case management services which begin in jail and continue post-jail release in the community.

E. Across outcome indicators what county programs are exemplars?

The variation in program models – as well as the variation in the size, geographic location, and resource availability of counties – makes comparison of programs difficult. However, when looking across indicators and counties we can determine which programs are excelling in certain outcomes and how those successes cluster. Table 2 below provides a snapshot of various outcomes; exemplars within each outcome indicators are highlighted.

The first conclusion is that all programs/counties excel in at least one outcome area and that no one program/county excels on all. There are three counties that are positive in three or more indicators (Counties E, G and J) and two counties that excel in one area (Counties A and D). The program with the highest number of positive indicators (County J) is one in which there is intensive case management and outreach post-jail release while those with the lowest number of indicators were focused primarily on jail-based treatment and/or services with less emphasis on discharge planning from jail to community during the intervention period.

It is recognized that several programs have evolved and expanded during the second and third years of the pilot program. Subsequent evaluation studies will be in a better position to assess these modifications and enhancements across programs.
### Table 2: EXAMINING INDICATORS OF SUCCESS BY COUNTY

<table>
<thead>
<tr>
<th>County</th>
<th>% increase in MH treatment engagement pre-to post-</th>
<th>% receiving continuity of care post-jail release</th>
<th>% reduction in # individuals recidivating</th>
<th>Total number of jail days pre-to post-jail release</th>
<th>% of those returning to jail for misd or PV</th>
<th>% successful on both recidivism and treatment engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>17%↑</td>
<td>29%</td>
<td>4%↓</td>
<td>↑</td>
<td>89%</td>
<td>29%</td>
</tr>
<tr>
<td>B</td>
<td>18%↑</td>
<td>48%</td>
<td>6%↑</td>
<td>↑</td>
<td>79%</td>
<td>26%</td>
</tr>
<tr>
<td>C</td>
<td>9%↑</td>
<td>71%</td>
<td>16%↑</td>
<td>↑</td>
<td>47%</td>
<td>31%</td>
</tr>
<tr>
<td>D</td>
<td>6%↓</td>
<td>42%</td>
<td>6%↑</td>
<td>↑</td>
<td>65%</td>
<td>34%</td>
</tr>
<tr>
<td>E</td>
<td>8%↑</td>
<td>28%</td>
<td>10%↓</td>
<td>↓</td>
<td>80%</td>
<td>41%</td>
</tr>
<tr>
<td>F</td>
<td>2%↑</td>
<td>10%</td>
<td>19%↓</td>
<td>↓</td>
<td>75%</td>
<td>30%</td>
</tr>
<tr>
<td>G</td>
<td>12%↑</td>
<td>29%</td>
<td>10%↓</td>
<td>↑</td>
<td>44%</td>
<td>24%</td>
</tr>
<tr>
<td>J</td>
<td>13%↑</td>
<td>33%</td>
<td>14%↓</td>
<td>↓</td>
<td>60%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Note: The green shading within each column provides the exemplars within each outcome area. For those where there is an assessment of the % change (Increase or decrease), counties that experience a 10% or greater change in a positive direction are highlighted.

### SECTION 2: Crisis Intervention Team Training Outcomes

Crisis Intervention Team (CIT) Training is part of the diversion activities within five counties. In total, 723 officers have been trained since 2015 including 384 patrol, 306 corrections, and 33 dispatchers. Short-term outcomes related to the change in officers’ knowledge and skills in these five counties were reported in a previous report (see the March 2016 Diversion Implementation Process Report). This report focuses on the outcomes of CIT training and is limited to one county that had high fidelity to the CIT model, the greatest number of officers’ trained, a high number of dispatch call reports related to mental health, and allowed researchers access to relevant data.

**CIT Model and Trainings within the County**

Although the main focus of the CIT training is to enhance officers’ knowledge of mental illness, resources within the community, and de-escalation skills, trainings are only part of the CIT model. Other aspects of CIT include the presence of a problem-solving community advisory board and the officer access to a 24 hour drop-off center. Variation in the CIT training component for dispatch personnel and officers situated within the jail reduces the 40 hour training to eight hours.
Within this county, a 24-hour crisis center is available and the advisory council is currently constituted by the CMH and law enforcement team involved with the diversion grant. In this county, a total of 462 officers have been trained since the inception of the grant in 2015 including 123 patrol officers (2015 and 2017), 33 dispatchers (2015), and 306 corrections officers (2017). The officers trained were primarily sheriff’s deputies, but a limited number of officers from local police departments within the county were also included in the training. In addition, 58 officers received CIT-Youth training (2016), a specialized training for officers already certified in CIT.

A. Do officers change behavior in the field post CIT training?

The goal of CIT training is to promote changes in officer behavior when encountering an individual experiencing a mental health crisis. Pre/post-training assessments demonstrated officers’ enhanced knowledge following the 40-hour training (see Baseline Report, 2016), but it was unclear if this knowledge would translate into behavioral change in every day practice.

In an effort to assess behavioral changes in the field, all officer call reports flagged by dispatchers or patrol officers as ‘mental health’ or ‘suicide’ were collected from the county’s dispatch system from January 2014 to December 2016 (1,617 call reports). CIT training began in May 2015, so 16 months of call reports (639 call reports) documented calls occurring before CIT training and 20 months of call reports (978 call reports) documented calls occurring after CIT training. In addition to the call reports, rosters of officers who completed CIT training were provided by the county.

Figure 19: TRANSPORTATION DECISIONS OF MENTAL HEALTH CRISIS CALLS, JANUARY 2014 – DECEMBER 2016 (N=1617)

- 91% of calls (1,475) were transported to either the emergency room (74%, 1,196 calls) or the crisis center (17%, 279 calls) before and after CIT training.
- Less than 1% (0.5%, 8 calls) were transported to jail before or after the CIT training.
- 9% of calls (134) were either completed suicides, individuals transported to other destinations (i.e., friend/family), those refusing transportation, or the disposition was unresolved at the time of data collection.

Although transport to the hospital ER is an alternative to jail incarceration for officers, there have historically been complaints across the state of the wait times involved in processing individuals through emergency rooms. Officers also stated frustration with hospital drop-offs because individuals who were dropped at the hospital were often quickly released from the hospital, sometimes during the same shift. Transport to the crisis center was deemed a better solution for officers, as well as for the individuals in crisis. The crisis center provides officers with an expedited check-in process, including a special law enforcement entrance and simple sign-in procedure, to enable officers to quickly drop-off the individual and return to the road. In addition, the crisis center is designed to appropriately assess and link individuals with mental health services immediately. This resource minimizes officer time and protects public safety in the short-term and provides individuals with appropriate mental health treatment with a goal of stabilization over the long-term.

Figure 20. **PROPORTION OF MENTAL HEALTH AND SUICIDE CALL REPORTS WITH CRISIS CENTER OR EMERGENCY ROOM DISPOSITION**

- Before training, 9% (43 calls) were transported to the crisis center and 91% (416 calls) were transported to an ER.
- After training, 31% (235 calls) were transported to the crisis center and 69% (521 calls) were transported to an ER.

A more sophisticated analytic technique (Interrupted Time Series Analysis) was used to determine if the behavioral change in transportation decisions to the crisis center was statistically significant and if the post-CIT training behavioral changes were sustained over time.
Figure 21 shows that there was an immediate increase in transport decisions to the crisis center following training.

**Figure 21. TRENDS IN TRANSPORT DECISIONS TO CRISIS CENTER**

- Call dispositions indicate that there was an increase of 10 drop offs per month to the crisis center.
- In the month after CIT, a person was 38 times more likely to be brought to the crisis center. The increase in drop-offs to the crisis center has been sustained for 20 months following training.

In addition, we analyzed the trends in transport decisions to the ER. Figure 22 shows a decrease in transport decisions to the ER immediately following CIT training.
There were 11 fewer transports to ER per month immediately following CIT training.

Transports to the ER continue to decline following training: there were 14 fewer transports per month to ER 5-months post-training and 21 fewer transports per month 20-months post-training.

B. What factors predict deputies’ decisions to transport to the crisis center?

After analyzing transport decisions, we used other information from the call reports to understand what predicts a deputy’s decision to transport an individual to the crisis center versus ER. After removing cases where there was evidence of physical injury\textsuperscript{29} we used a statistical model to examine the type of call (suicide attempt vs. mental health), intoxication status of the individual, and distance from the crisis center:\textsuperscript{30}

- Non-intoxicated individuals\textsuperscript{31} were 2.6 times more likely to be transported to the crisis center than those who were intoxicated.
- For every 1-mile increase in the distance between the call location and the crisis center, officers were 1% less likely\textsuperscript{32} to take the individual to the crisis center.

\textsuperscript{29} A total of 905 call reports depict transports to the crisis center or ER in the post CIT-training period. After removing calls where physical injuries were severe and required emergency medical attention (15%, 146 individuals), there were 759 total transports. Of the 759 transports, 31% (236 individuals) were taken to the crisis center and 69% (523 individuals) were taken to an ER.

\textsuperscript{30} \chi^2(8, N=663)=91.950, p<.001

\textsuperscript{31} Wald=12.486, p<.001

\textsuperscript{32} Wald=6.087, p<.05
- CIT officers\textsuperscript{33} were 3 times more likely to transport to the crisis center than non-CIT officers.
- Calls coded as mental health\textsuperscript{34} were 4.5 times more likely to be transported to the crisis center than those coded as suicide.

C. Does CIT training of jail-based officers reduce the need for cell extractions?

The Cell Extraction Team (CET) is a highly trained group of corrections officers who are called to defuse escalating incidents within the jail. This xx member team responds to incidents when inmates inflict or threaten harm to others or themselves and/or when inmates refuse movement to other locations within the jail. Per strict protocol, CET members debrief after each call to author reports detailing the incident. With the addition of CIT training for all corrections officers in 2017, including CET officers, it was anticipated that CIT training may reduce the need for CET response within the jail. Corrections CIT training was conducted from May to July 2017. A total of 306 corrections officers were trained during this period.

CET reports were collected for the 1-year period before corrections CIT training and will continue to be collected for the 1-year period following the training. A cursory review of the CET reports to date indicates that in the three months prior to corrections CIT training (February – April, 2017), there were 108 CET calls within the jail. In comparison, there were 53 CET calls in the three month following the training (July – September, 2017). Ongoing data collection and future analyses will explore this finding in greater depth, but this preliminary data suggests an initial 49% drop in need for the services of the CET team.

Figure 23. NUMBER OF CELL EXTRACTIONS W/IN JAIL THREE MONTHS PRE AND POST CIT TRAINING

\begin{figure}
\begin{center}
\begin{tikzpicture}
\begin{axis}[
    ybar, bnear, xmax=120, ymax=120, width=\textwidth, height=\textwidth,]
    \addplot coordinates{(3 mon pre CIT, 108) (3 mon post CIT, 53)};
\end{axis}
\end{tikzpicture}
\end{center}
\end{figure}

\textsuperscript{33} Wald=24.305, p<.001
\textsuperscript{34} Wald=23.091, p<.001
A. What needs to be considered when reviewing this data?
This report focuses on three primary analyses: prison and jail recidivism among those receiving jail-based interventions; mental health treatment engagement and continuity of care among those receiving the jail-based interventions; and changes in officers’ behavior, factors predicting decisions to transport to the crisis center, and, preliminarily, the impact of CIT on the need for cell extraction within the jail. This section outlines recommendations and considerations based on each analytic area.

Jail-Based Interventions
Assessing outcomes of jail-based services programs across counties is reliant on the variation in location, size, and resource availability within the county. This report finds variation in outcomes, with all counties experiencing improvements in at least one area and some counties improving in three to four areas. Intensive case management post jail results in better treatment engagement and less recidivism in the post intervention period. There are some issues that arise from this analysis that deserve greater attention and clarification going forward.

Treatment Access and Treatment Funding
Accessing mental health and substance abuse treatment post-jail incarceration is incumbent on many factors (outlined below):

CMH Affiliation
CMH enrolled individuals were more likely to receive post-confinement mental health services than those who were receiving Medicaid, but not CMH-enrolled. CMH eligibility for services in most counties is dependent upon meeting criteria for serious and persistent mental illness (SPMI). However, CMH organizations in counties may provide service to those without SPMI. Programs identified, and differentiated from CMH and Medicaid eligibility, but there may be nuances in the level of mental health severity that were not captured within our distinction between groups.

Medicaid enrollment
Medicaid eligibility for those who have MH problems but are not considered to meet severity levels for SPMI, provides limited access to services. At the time under review, those services were for 20 sessions by a MH professional. Perhaps more pertinent to our study is Medicaid enrollment after release from jail. Stops and starts in Medicaid coverage during and after a jail stay vary greatly across counties and many CMH providers discussed issues with Medicaid eligibility post-jail.
Services absent from our data collection
As discussed earlier, a limitation of our analysis is that the Medicaid data was the only source of treatment data. **It is likely that all services received by individuals are not found in the Medicaid data, and thus the report cannot claim comprehensive reporting of services.** Examples of services that may not be included are those that individuals may have received as a result of grant funding or perhaps substance abuse treatment provided through Community Corrections.

SUD treatment
Although Medicaid covers treatment of substance use disorders, it was difficult to determine if an individual received substance abuse treatment. There was an absence of any ‘dual diagnosis’ or integrated substance abuse and MH treatment within the data and CMH providers discussed the division of SUD treatment data from MH data. **Overall, the absence of SUD or integrated dual diagnosis treatment was a major concern as COD MH and SUD was a strong predictor of recidivism.**

Post-intervention jail confinement
In assessing criminal sanctions post intervention there are indicators that interventions involving law enforcement and courts are needed across the criminal/legal systems. If assumptions can be drawn regarding the need for confinement being tied to public safety, there were nearly 68% of those serving jail time in the post intervention period on misdemeanors or violations of court orders (i.e. PV).

Misdemeanor offenses in post intervention period
The proportion of individuals returning to jail post intervention on misdemeanor charges varied across counties, but averaged 48%. **If diversion to treatment and reduction in jail beds days is the goal that there are additional strategies needed:** 1) enhancing law officer training (i.e., CIT) and 2) availability of crisis center of 24 hour drop off facilities that officers can access.

Violations of court orders
Jail confinement when an individual is in violation of a court order or probation/parole order occurred in 19% of the recidivism events (note: in one county we were unable to obtain data on violations). In the case of probation/parole violations this could be for positive drug screens, failure to obtain treatment, or any other disorderly conduct that is occurring within the community. In these instances, it may be helpful to train probation and parole agents in recognizing signs/symptoms of mental health so that alternative decisions can be made.

Increase in the number of days in jail post-intervention
Even though most counties saw a reduction in the number of individuals returning to jail – an overall increase in the number of bed days between pre/and post intervention is indicative of frustration with repeat offenses or in non-compliance. It is thought that these increases are
occurring through court interactions and sentences. In subsequent evaluation studies it will be interesting to determine if individuals were involved in specialty courts within their counties (or if in fact a specialty court exists). Education of court personnel (i.e., judges, probation officers) could be helpful in diverting such individuals. Treatment enhancement (i.e. motivational interviewing) and additional supports (i.e. housing, employment) may also reduce criminogenic risk.

*Crisis Intervention*

Training of law enforcement officers – within the community and jail – has been effective in changing officer behavior and mitigating risk for individuals with mental health issues. Initial results from the 8-hour corrections training are very positive and future studies will assess if the effect is sustained over time.

Additionally, other counties who are thinking about CIT training may consider the objective they are trying to attain. For example, less than 1% of call reports designated as MH/Suicide were actually brought to jail. When officers recognize mental health symptoms, they are not bringing individuals to the jail. This means that CIT, in this county, did not reduce the number of individuals who have mental health issues within the jail. However, there was a change in where individuals were transported (increase in crisis center and decrease in hospital). CIT-trained officers were three times more likely to bring someone to the crisis center versus the hospital. This change in behavior is likely to reduce officer wait time in hospitals, as well as provide individuals with better access to continuing mental health services.

It should be noted that these officer behavioral changes could not be obtained in counties without a 24-hour drop off/crisis center. Other counties implementing CIT will need to create this type of access for officers if they want to affect hospital drop-offs. However, distance matters. If the likelihood that an officer will transport to a crisis center decreases 1% for every mile, regional crisis centers may not have the desired effect.

**B. What are the next steps for the evaluation?**

*System-level Evaluation*

MSU will engage in exploration of jail discharge activities, warm hand-off, and community-based law enforcement interactions and the continuum of care from jail to the community for individuals identified with a mental health concerns within the jail.

*Monitoring Program Processes*

MSU will continue to collect monthly process indicators for jail diversion programs and CIT trainings from the ten current pilot sites.
CIT Outcomes
MSU will continue to evaluate the impact of CIT in the jail through the collection of cell extraction reports to track and monitor the impact of CIT training on the number of incident requiring cell extraction team involvement.
### Appendix A: Definitions

<table>
<thead>
<tr>
<th>Group</th>
<th>Definition</th>
<th>Expect Program Completion</th>
<th>Expected LOS</th>
<th>Criteria for Completion</th>
<th>Low Dosage</th>
<th>Medium Dosage</th>
<th>High Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barry</td>
<td>CMH consumer (current or new) receiving JD services; non-CMH are not tracked.</td>
<td>Yes</td>
<td>10 wks</td>
<td>Completion of 10 topics; Completion of maintenance plan</td>
<td>Kite/consult appt; Referral to intake/svcs; Attend open-call group without being opened for svcs; Potential bridging to aftercare</td>
<td>Complete intake; Attends group, but does not complete services; Continued use of kites by inmate; Bridges to aftercare</td>
<td>Complete intake; Completes group; Individual therapy provided; Continued use of kites by inmate; Bridges to aftercare</td>
</tr>
<tr>
<td>Berrien</td>
<td>Two groups: 1) enrolled, and 2) received services</td>
<td>Yes</td>
<td>Varies</td>
<td>Completion of individualized treatment goals; close out services or transfer to long-term services with another department (psych, ACT, SMI OP, SUD, etc.). Considered &quot;successful completion&quot; if individual does not reoffend within 6 month period following treatment termination.</td>
<td>Not enrolled; Current CMH or do not qualify; Engagement of 1-2 hours per month; Referrals to other programs or linking to other community supports <strong>THIS DOSAGE IS NOT APPLICABLE FOR THE TREATMENT GROUP THOSE IN THE TREATMENT GROUP ARE ENROLLED.</strong></td>
<td>Enrolled; Combination of svcs including Prescreen (1 hr), Brief indiv Assessment (1 hr), BPS Assess (1.5 hrs 1x per year or to open), case mgt (6 - 8 units per month/2-3 hrs); Individual Therapy (2 - 4 units per month/2-4 hrs); Group Therapy (1 hr per week)</td>
<td>Enrolled; Combination of svcs including Prescreen (1 hr), Brief indiv Assessment (1 hr), BPS Assess (1.5 hrs 1x per year or to open), case mgt (6 - 8 units per month/2-3 hrs); Individual Therapy (2 - 4 units per month/2-4 hrs); Group Therapy (1 hr per week), Psych Eval (1 per yr/1 hr); Med Reviews 4-6 per yr/1-1.5 hrs); Peer Support Specialist (SUD referral)</td>
</tr>
<tr>
<td>Kent</td>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Received MH services; assigned to General Population.</td>
<td>Received MH services; assigned to Mental Health Unit.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Notes</td>
<td>Diversion Type</td>
<td>Length</td>
<td>Program Outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
<td>----------------</td>
<td>--------</td>
<td>-----------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Livingston</td>
<td>TBD</td>
<td>No, Based on Diagnosis</td>
<td>No set criteria, based on individual.</td>
<td>GAINS screening, providing resources, referring to specialty court. Per Site Visit, could also be based on diagnosis.</td>
<td>Referring to specialty court as appropriate, screening/assessment, determining level of tx needs including need for IP, case mgt, helping engage in services, coordinating with current providers, frequent contacts to monitor overall stability.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marq*</td>
<td>Enrolled in MRT (jail or community-based)</td>
<td>Yes, 6 - 9 months</td>
<td>Complete Step 12 of MRT workbook.</td>
<td>3 MRT group sessions</td>
<td>Up to 6 MRT group sessions</td>
<td>7+ MRT group sessions</td>
<td></td>
</tr>
<tr>
<td>Monroe</td>
<td>Two groups: 1) enrolled, and 2) &lt;90 days in jail receiving inreach from CCM</td>
<td>Yes, Jail LOS</td>
<td>Consumers successfully complete Jail Programming Services as evidenced by one or more of the following: 1) attend initial screen, if applicable BPS and IPOS; 2) attend jail groups as recommended; 3) successfully link to appropriate level of care upon jail release. It is considered unsuccessful if the consumer enrolls, but does not engage or participate in recommended services or if the individual does not follow-up with community-based services.</td>
<td>Screening completed; assessment and referrals to appropriate community-based services (CMH or other). 1 - 3 contacts.</td>
<td>Opened to jail services, screened, assessed, and IPOS created, if applicable; opened to MCMHA and receive case mgt, group, and referral at discharge; 4 - 6 contacts.</td>
<td>Opened to jail services and either already opened to MCMHA or screened and opened to MCMHA services; 7 or more contacts including screening, assessment, referrals, and discharge.</td>
<td></td>
</tr>
<tr>
<td>Oakland - Reach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wayne</td>
<td>Two groups: 1) enrolled, and 2) eligible, but not enrolled</td>
<td>Yes, 12 months or as ordered by court</td>
<td>Objectives based - stable health, income, permanent housing, and/or completion of probation.</td>
<td>1 - 5: screening, assessment, intake, and orientation</td>
<td>5-20: treatment planning, housing placement, case management, referrals</td>
<td>20-60+: case management, individual and group therapy, referrals, peer support services</td>
<td></td>
</tr>
</tbody>
</table>

*Program completion information copied from UDPP Update provided to Steven Mays 06/16.
Diversion Pilots: Long-Term Outcomes