

DIVERSION PILOTS: PLANNING FOR THE FUTURE WITH BASELINE DATA: April 2015 – March 2016

In 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 initial outcomes regarding individuals served by these various programs during the first six months of program operations. 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.

Aggregate Findings
across sites for those
served between
April 1, 2015 and
September 30, 2015

**Diversion Pilots
Planning for the Future with Baseline Data
April 2015 – March 2016**

Table of Contents

Section	Page Number
Executive Summary	1
SECTION 1: Prevalence of Serious Mental Illness in Jails	5
What is the level of serious mental illness (SMI) among those entering the county jail?	5
Individuals with SMI Symptoms Entering Jail	5
Mental health treatment and medication needs among those with and without SMI symptoms	6
SMI and recidivism	6
Does the proportion of individuals entering jail with SMI symptoms vary by county?	7
SECTION 2: Recidivism	8
How is recidivism refined?	8
What do we know about the 739 individuals who are part of this evaluation?	9
Demographic Characteristics of Evaluation Participants	10
Target Offense	10
Pre- and Post-Intervention Jail Intersection	12
Post-Intervention Offense Severity	13
What are the characteristics of those with post-intervention recidivism?	13
Patterns of Recidivism	14
What are the characteristics associated with those with multiple jail stays?	15
What variation in recidivism exists across counties?	15
SECTION 3: Crisis Intervention Team Training	17
Background on CIT trainings	18
What was the officers' overall response to the training?	18

Did the officers' opinions of mental illness change?	19
What skills and/or knowledge did the officers gain?	19
What are some other relevant findings and comments?	19
How many officer interactions involve persons with mental health issues?	20
What are the patterns of interactions with law enforcement, mental health drop-off site, and the jail?	21
Case examples	22
How can this information be useful in counties utilizing CIT interventions?	23
SECTION 4: Considerations and Next Steps	24
What needs to be considered when reviewing this data?	24
Jail-based interventions	24
Comparison of mental health screening	25
Crisis intervention team trainings	25
What are the next steps for the evaluation?	26

List of Figures

Figure		Page Number
1	Percent of individuals with SMI symptoms entering jail: 2015 & 2016	5
2	Self-reported mental health needs: total population & by SMI status	6
3	Self-reported recidivism at 1-month & 1-year: total population & by SMI status	7
4	Percent of individuals entering jail with SMI: by county	9
5	Flow of individuals included in evaluation	10
6	Target offense severity	11
7	Target offense type	11
8	Percent of individuals with pre- & post-intervention jail stays	12
9	Median number of days in jail pre- & post-intervention	12
10	Post-intervention offense severity	13
11	Post-intervention misdemeanor offense types	14
12	Percent of individuals with jail stays: target offense, pre- & post-intervention	14
13	Percent of individual with pre- & post-intervention jail stays: overall & by county	15
14	Median number of days spent in jail pre- and post-intervention: by county	16
15	Percent of individuals with jail stays across time periods: by county	17
16	Incidents involving law enforcement & persons with mental health issues within one county	21
17	Source of data for 56 individuals with multiple police interactions	22

Diversion Pilots

Planning for Future with Baseline Data

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 remaining seven offered exclusively jail-based interventions or a combination of jail-based interventions and law enforcement training (see the Diversion Implementation Process Report prepared by Michigan State University in March 2016, as well as in appendices to this report, for a complete description of programs). This report provides baseline data and information to the Diversion Council, as well as the pilot counties, to facilitate planning for future diversion activities. As such the report focuses on three main topics: 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. The final section offers recommendations.

Focus of Report

SECTION 1: Prevalence of Serious Mental Illness in Jails

This section uses two consecutive years of mental health screening within the county jails to assess change in prevalence of serious mental illness (SMI) over time. It examines the following questions:

- What is the level of mental illness among those entering the county jail?
- Does the proportion of individuals entering jail with SMI symptoms vary by county?

SECTION 2: Recidivism among Individuals with Serious Mental Illness

This section looks at individual-level recidivism outcomes across programs in counties that offered jail-based diversion-related interventions during the first six months of program operations (April 1 - September 30, 2015). It examines the following questions:

- How is recidivism defined?
- What do we know about the 739 individuals who are part of this evaluation?
- What are the characteristics of those with post-intervention recidivism?
- What are the characteristics associated with those with multiple jail stays over the study period?
- What variation in recidivism exists across the counties?

SECTION 3: Crisis Intervention Team (CIT) Training

This section focuses on CIT training and is limited to interviews with trained officers in the two counties that had the highest number of officers trained plus officer-related call reports in one county that focused on CIT exclusively. It examines the following questions:

- What was the officers’ overall response to the training?

- Did the officers' opinions of mental illness change?
- What skills and/or knowledge did the officers gain?
- What are some other relevant findings and comments from the officers?
- How many officer interactions involved persons with mental health issues?
- What are the patterns of interactions with law enforcement, mental health drop-off site, and the jail for individuals with mental health concerns?
- How can this information be useful in counties utilizing CIT interventions?

SECTION 4: Considerations and Next Steps

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

- What needs to be considered when reviewing this data?
- What are the next steps for the evaluation?

Highlights

- 286 officers received CIT or CIT-Y training.
 - In the one metropolitan county focused exclusively on CIT, there has been a significant and constant increase in drop offs at the mental health crisis center since training began.
 - Officers overwhelmingly believed that the training not only increased their knowledge and understanding of mental illness but gave them skills to identify possible mental illness, de-escalate the situation, listen actively and build trust.
- 739 unique individuals received at least one intervention service within the county jail in the 6-month implementation period. Of those who received at least one service:
 - 41% had a jail stay in the 6-month pre-intervention period
 - 39% had a jail stay in the 6-month post intervention period.
 - 62% did not return to jail after the intervention.
 - 48% had been charged with a misdemeanor when they came to the attention of the service provider.
 - 57% of those with post-intervention jail stay were there for a misdemeanor offense.
 - Younger individuals, those with a pre-intervention jail stay and those charged with a misdemeanor/ordinance offense were more likely to have a jail stay in the post-intervention period.
 - 20% of individuals had a jail stay in all three time periods (pre-intervention, target, and post-intervention).
- The proportion of individuals with SMI entering jails decreased from 24% (2015) to 18% (2016).

Observations

- Limitations of community resources for law enforcement officers – such as 24-hour drop off centers – may increase the use of jail for misdemeanor offenses such as disorderly conduct, trespassing, etc.
- Over reliance on, or extremely cautious interpretation of, HIPPA guidelines may limit the sharing of pertinent mental health related information to law enforcement officers, potentially disadvantaging officers in pursuing alternative interventions and keeping the public safe.
- Philosophical principles within the mental health treatment community and the mental health code, such as consumer choice regarding acceptance of and compliance with treatment, may be associated with an individual’s continual cycling between community mental health services and jail.
- Individuals entering the jail with mental health symptoms may or may not be ‘known’ to or enrolled in CMH services. Jail administrators want programs and services that alleviate risk and are less considered with CMH eligibility criteria.
- Programs that provide jail-based services to those with SMI are more likely to see ‘misdemeanor cycling and recycling’ than programs that serve those with mild and moderate mental health issues.
- Variation in the risk of recidivism suggests that a ‘one-size fits all’ intervention strategy may not be cost effective. Those with little risk need less and those with higher risk need more.

Recommendations

- **Community Advisory Boards:** Establish county-wide advisory boards – with some authority – in all counties. These boards would be charged with addressing issues for individuals with mental health concerns that cut across the criminal/legal system cut across multiple public safety, health and mental health systems. It is recommended that these boards utilize a process of data-driven decision making that uses data produced for this evaluation as well as other relevant community sources.
- **CIT:** Continue and expand CIT training, using booster sessions to reinforce officer skills. Consider training of other law enforcement personnel such as parole/probation officers.
- **Confidentiality.** Develop an understanding and accompanying training of what information is protected by HIPAA and how information can and should be shared with law enforcement.
- **AOT/Kevin’s Law:** Although AOT (Kevin’s Law) should not be the first treatment choice, adding it to the repertoire of what is available to county’s may decrease the rapid cycling in the jail (and the potential consequences of a jail stay) and avoid disruption in treatment.
- **Drop-Off Centers:** Develop alternatives to jail booking for misdemeanor and/or ordinance offenses (i.e., disorderly conduct and traffic violations) in order to divert individuals with SMI to treatment or supportive services in lieu of jail.
- **Reduced Jail Time for Misdemeanors:** Attempt to reduce jail time for low-level misdemeanor offenses (i.e., inability to pay bond) in order to minimize disruption to community-based mental health treatment and potentially reduce county- and state-level costs. In addition, data demonstrates an increase in the time served between pre and post intervention jail stays.

Assess the underlying reasons for the increase in jail days between the pre- and post-intervention periods.

- **Enhanced Linkage and Continuity of Care:** Increase attention to the jail discharge and community reentry process to help prevent minor offending, probation violations and functionality as best practices research indicates that more than jail-based services, interventions that pro-actively link individuals (i.e. warm hand-off) to community services upon jail release are more effective at decreasing recidivism and increasing functionality.
- **Tiered Approach:** Develop interventions that span the continuum from low to high service intensity when transitioning from jail.
- **Evaluation Design:** Develop a follow-up evaluation design to expand measurement beyond jail-based intervention to one that follows individuals through the systems and includes system-level, county-wide response.

Next Steps for Evaluation

Long-term outcomes will be assessed using a one-year pre/post intervention design which, in addition to recidivism, will include mental health treatment engagement and continuity outcomes.

Diversion Pilots

Planning for the Future with Baseline Data

Full Report

SECTION 1: Prevalence of Serious Mental Illness in Jails

This section uses two consecutive years of mental health screening within the county jails to assess change in prevalence of serious mental illness (SMI) over time.

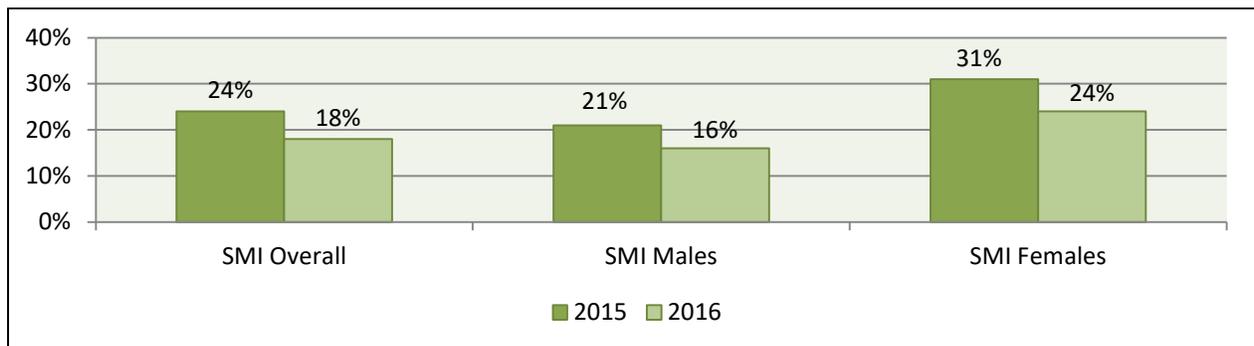
What is the level of serious mental illness (SMI) among those entering the county jail?

In an effort to assess the more global issues associated with individuals with symptoms of serious mental illness (SMI) entering the jail, a validated mental health screening instrument - the K6 - was given to every person booked into several county jails during a specified period of time in February 2015. The identical process was used 2016¹. Data were compared resulting in the following findings.

INDIVIDUALS WITH SMI SYMPTOMS ENTERING JAIL

Figure 1 (below) shows a comparison of individuals entering the jails with SMI symptoms in 2015 and 2016.

Figure 1: PERCENT OF INDIVIDUALS WITH SMI SYMPTOMS ENTERING JAIL: 2015 & 2016



The proportion of individuals with symptoms indicative of SMI dropped between 2015 and 2016, from 24% to 18%².

¹ Not all counties participated – or participated in the same way. Two counties were not able to collect the data uniformly and one county collected K6 data for an entire year due to low numbers booked into the jail. This entire year of data was categorized into the 2016 data in this report.

² $\chi(1)=17.362, p<.001$.

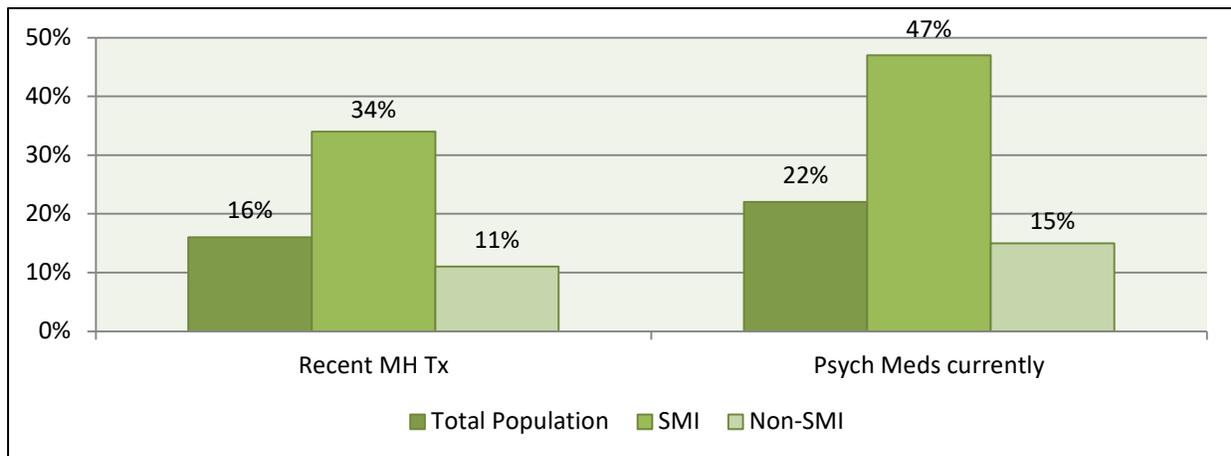
- One county was an ‘outlier’ in the proportion of decrease in SMI prevalence in 2016 as compared with 2015. When this outlier county and the county that collected data for the entire year (see foot note #6 below) were removed from the analysis, the significant drop no longer exists; 22% in 2015 to 21% in 2016. This first year of implementation shows a trending decrease in the proportion of individuals with SMI entering the jails. The next round of data collection in 2017 will test to see if these proportions stay stable or significantly change with additional time.
- The decrease in 2016 is present for both males and females as both saw decreases in the proportion of individuals entering jail with SMI symptoms.

MENTAL HEALTH TREATMENT AND MEDICATION NEEDS AMONG THOSE WITH AND WITHOUT SMI SYMPTOMS

Overall, 16% of those booked into the jails reported receiving mental health treatment within the past 30 days (see Figure 2 below): 34% of those with symptoms of SMI had recent treatment compared to 11% of those without symptoms of SMI.

Similarly, 22% entering the jails reported a need for psychotropic medication: 47% of those with SMI symptoms compared to 15% of those without symptoms. The difference between those with and without SMI symptoms is statistically significant for both mental health indicators.

Figure 2: **SELF-REPORTED MENTAL HEALTH NEEDS: TOTAL POPULATION & BY SMI STATUS**

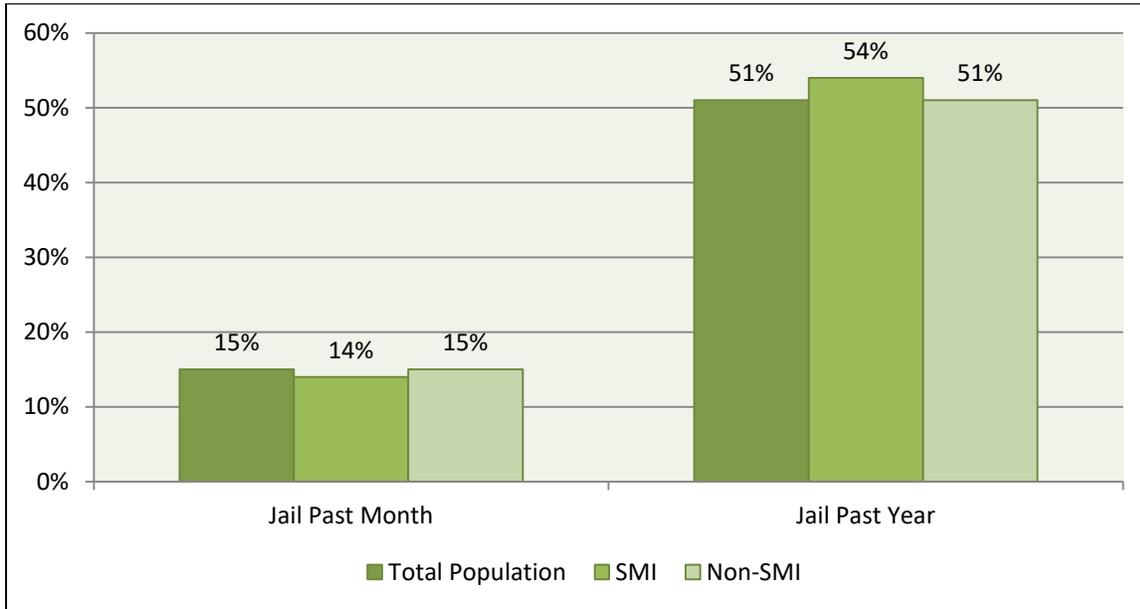


SMI AND RECIDIVISM

Figure 3 (below) looks at individuals with SMI symptoms who reported a jail stay in the past 30 days or the past year compared with those without SMI symptoms. A total of 15% of those who entered jail reported a jail stay within the past 30 days. For those with SMI symptoms, it was 14% compared to 15% of those without symptoms.

Similarly, a total of 51% reported a jail stay within the past year. For those with SMI symptoms it was 54% compared with 51% for those without symptoms. Neither recidivism indicator was statistically significant.

Figure 3: **SELF-REPORTED RECIDIVISM AT 1-MONTH & 1-YEAR: TOTAL POPULATION & BY SMI STATUS**

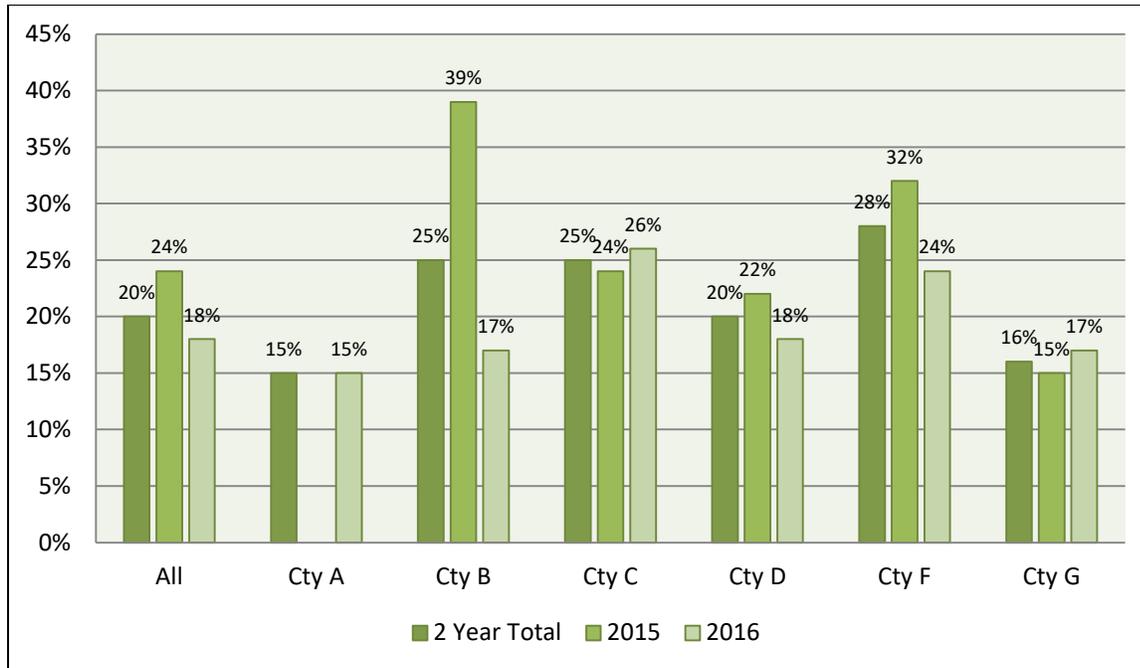


Does the proportion of individuals entering jail with SMI symptoms vary by county?

Across the six counties participating in the K-6 screening data collection, one-in-five individuals (20%) entering jail met the symptom criteria for SMI. **THIS PROPORTION DROPPED FROM 24% IN 2015 TO 18% IN 2016.**

The proportion of individuals with SMI varied across counties, with proportions ranging from 15% to 39% in 2015 and from 15% to 26% in 2016 (Figure 4 below). Two counties had slight increases in the proportion of individuals entering the jail with SMI from 2015 to 2016 (both 2%). The remaining three counties had decreases ranging from 4% to 22%.

Figure 4: PERCENT OF INDIVIDUALS ENTERING JAIL WITH SMI: BY COUNTY



Note: Cty A collected K6 assessments over the course of one year. All of these assessments were considered in the 2016 year. In Cty B we suspect that there may be a methodological flaw in 2015 that inflates that rate.

SECTION 2: Recidivism

This section looks at individual-level recidivism for persons with serious mental illness across programs in counties that offered jail-based diversion-related interventions during the first six months of program operations (April 1 - September 30, 2015). It is important to note that the variation across jail-based intervention programs is immense, ranging from jail-based groups/treatment to advocacy that immediately diverts the individual from jail. Similarly, the size of the sample in each county also varies. See the March 2016 Diversion Implementation Process Report for more details on the variation across sites.

How is recidivism defined?

For this report, recidivism is defined as any return to county jail where the intervention occurred within six months after receiving the intervention service. We are interested in new offenses or violations of previous court stipulations within the county where the individual received diversion services.

Recidivism for this study is based upon return to jail in the same county where the diversion intervention was administered.

As part of the evaluation design, three specific time periods were examined, as shown below:

- Pre-Intervention, i.e. the 6-month period prior to the intervention.
- Intervention or target offense, i.e. the point between 4/1/15 and 9/30/15 when the individual received the diversion service.
- Post-Intervention, i.e. the 6-month period after the diversion service ended.

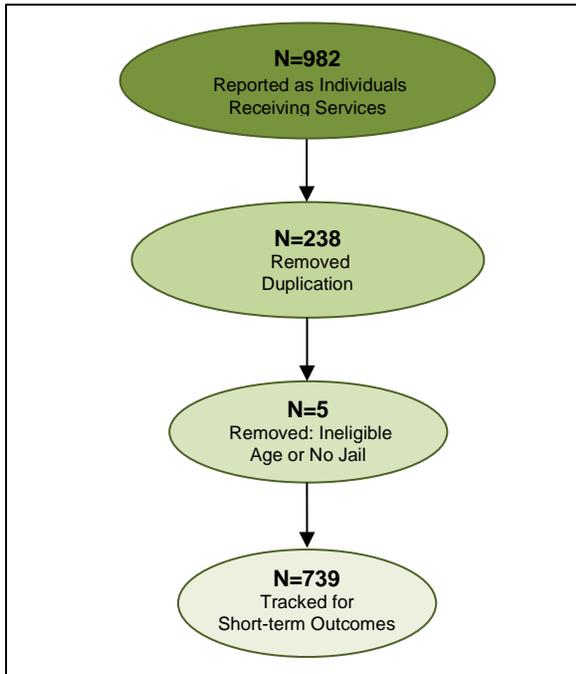


In an effort to use the individual’s own behavior as a marker of change, we compare jail stays in the pre-intervention period to those in the post-intervention period. Jail administrators in the county jails provided jail admission and discharge information for each individual receiving diversion intervention within their county.

What do we know about the 739 individuals who are part of this evaluation?

Figure 5 below shows the flow of individuals included in the evaluation. As previously reported in the March 2016 Implementation Report, a total of 982 individuals were reported as served by the eight jail diversion programs across the state during the 6-month implementation period. Of the 982, 238 were found to be either duplicate individuals (those who received more than one service during the intervention period) or reporting errors and thus the numbers were reconciled. Additionally, five cases were removed from analysis because they did not have a history of jail incarceration within the county where the diversion intervention occurred or were minors. ***It should be said from the outset that due to the variation in sample sizes across counties, counties with larger samples will have more influence on the aggregate findings of this combined sample.***

Figure 5: **FLOW OF INDIVIDUALS INCLUDED IN EVALUATION**



DEMOGRAPHIC CHARACTERISTICS OF EVALUATION PARTICIPANTS

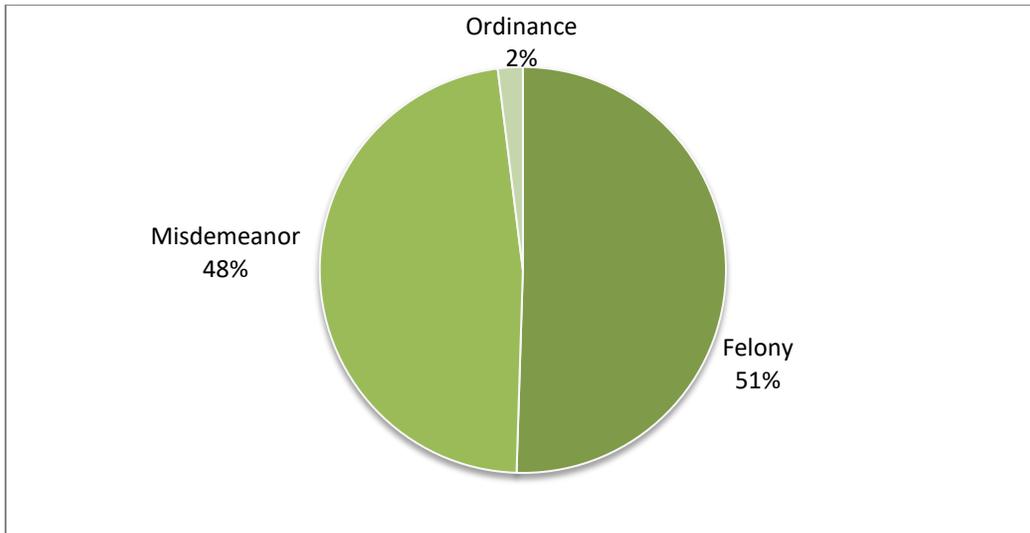
- Age: Range from 18-70 (average 38 years); over half (57%) are over 35
- Gender: Almost two-thirds male (65%)
- Race/Ethnicity: Minority 53% (primarily African American)

TARGET OFFENSE

The target offense is the offense with which the individual was charged at the time of the jail diversion intervention. Two components are considered: offense severity and offense type.

- Target Offense Severity
Half of all diversion participants were charged with a felony (51%) and half had either misdemeanor (48%) or ordinance (2%) offenses (Figure 6 below).

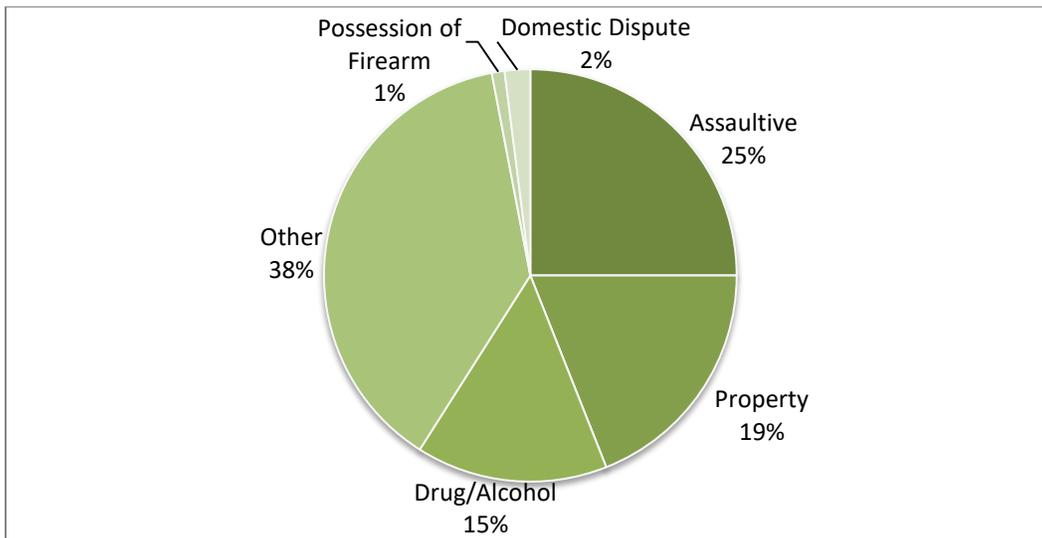
Figure 6: TARGET OFFENSE SEVERITY



Target Offense Type

One-quarter of offenses (25%) were categorized as assaultive, 19% as property offenses, and 15% as drug- or alcohol-related offenses (see Figure 7 below). Over a third (38%) were categorized as ‘other’ which includes charges such as probation violation, failure to appear, traffic offenses, disorderly conduct, or Friend of the Court default. Participants were rarely charged with firearm possession (1%) or domestic disputes (2%).

Figure 7: TARGET OFFENSE TYPE



PRE- AND POST-INTERVENTION JAIL INTERSECTION

Figures 8 and 9 below show the proportion of individuals with jail stays pre- and post-intervention, as well as the number of days spent in jail pre- and post-intervention.

- Pre-Intervention Jail Stays

Figure 8 shows that in the 6-month period prior to the jail diversion intervention, 41% (304) of the 739 individuals experienced a jail stay. Over one-quarter (27%) had two or more jail stays during this period. The average number of days in jail was 22 days, with half serving six days or less (median) as shown in Figure 9.

- Post-Intervention Jail Stays

Figure 8 shows that 39% (286) of the 739 individuals experienced at least one post-intervention jail stay. Half had more than one jail incident. The average number of post-intervention days in jail was 36 days, with half serving 20 days or less (median) as shown in Figure 9).

Figure 8: **PERCENT OF INDIVIDUALS WITH PRE- & POST-INTERVENTION JAIL STAYS**

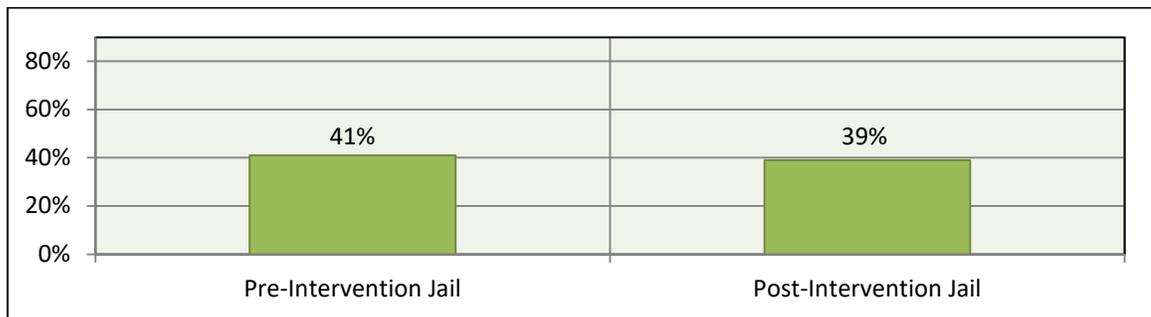
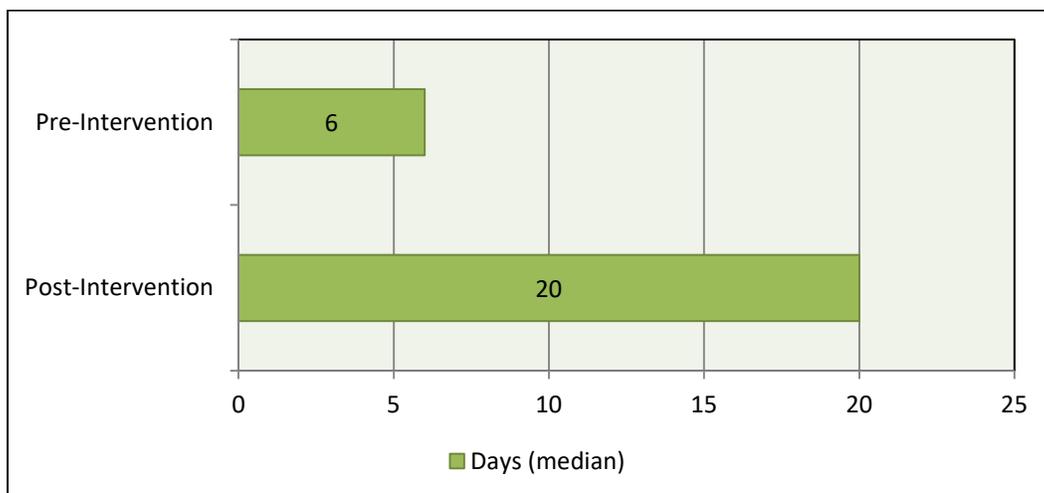


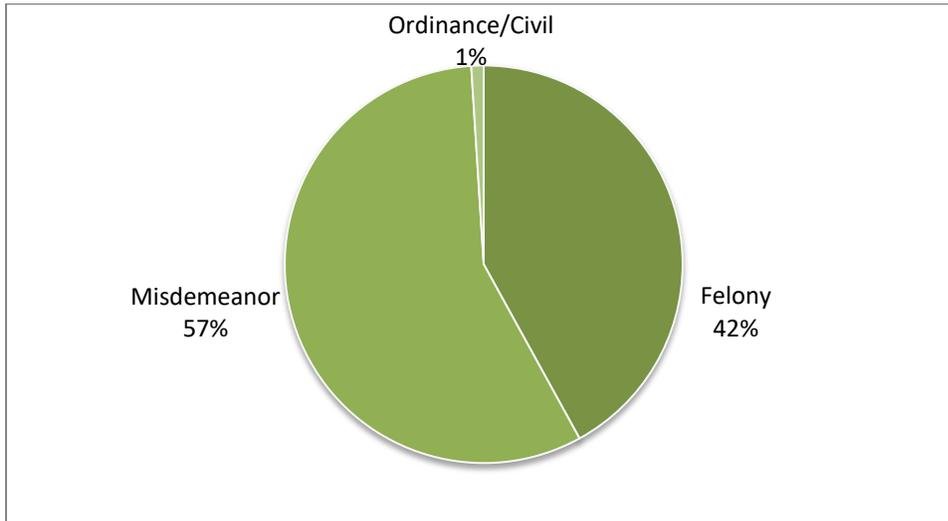
Figure 9: **MEDIAN NUMBER OF DAYS IN JAIL PRE- & POST-INTERVENTION**



POST-INTERVENTION OFFENSE SEVERITY

Of the 286 individuals who experienced a jail stay during the post-intervention period (Figure 10 below), 57% (n=154) were charged with a misdemeanor; 1% were charged with an ordinance/civil offense; and the remaining (42%) were charged with a felony offense.

Figure 10: **POST-INTERVENTION OFFENSE SEVERITY**



NOTE: Due to limitations with the jail data in one county, we were unable to discern if the post-intervention charges were a violation of a previous offense or if they were a new offense.

What are the characteristics of those with post-intervention recidivism?

Two factors were shown to be associated with an individual having a jail stay in the post-intervention period: a pre-intervention jail stay and the severity of the target charge³.

- Individuals with a pre-intervention jail stay were 2.3 times more likely to have a post-intervention jail stay⁴.
- Individuals charged with misdemeanor or civil/ordinance target offenses were 2.1 times more likely to return to jail in the post-intervention period⁵.

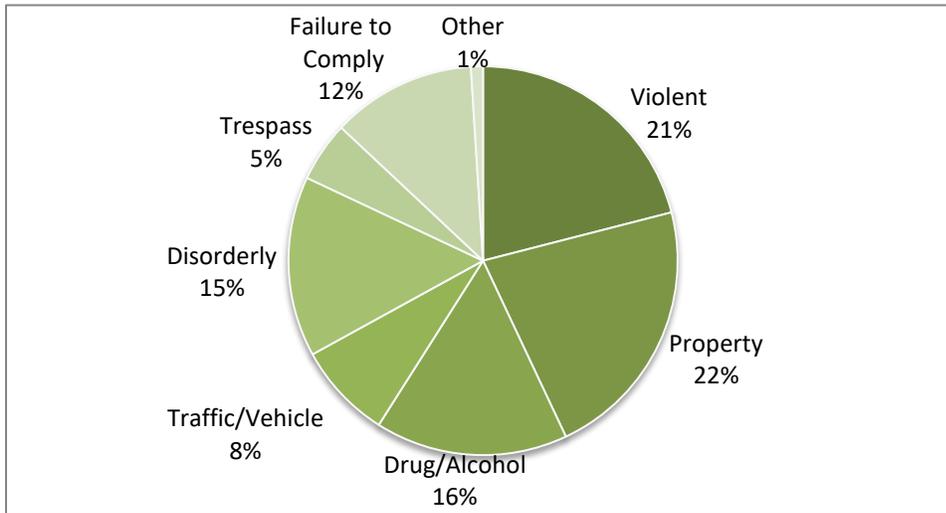
Figure 11 below displays the offense type for the 154 individuals with a misdemeanor or civil/ordinance charge in the post-intervention period. Almost two-thirds had a violent (21%), property (23%), or drug/alcohol charge (16%). The remaining charges included disorderly conduct (15%), failure to comply with a court order (12%), traffic/vehicle charges (8%), trespassing (5%), and 'other' (1%).

³ $\chi^2(5, N=739)=47.485, p<.001$

⁴ Wald $\chi^2=27.376, p<.001, \beta=2.293$

⁵ Wald $\chi^2=19.889, p<.001, \beta=2.056$

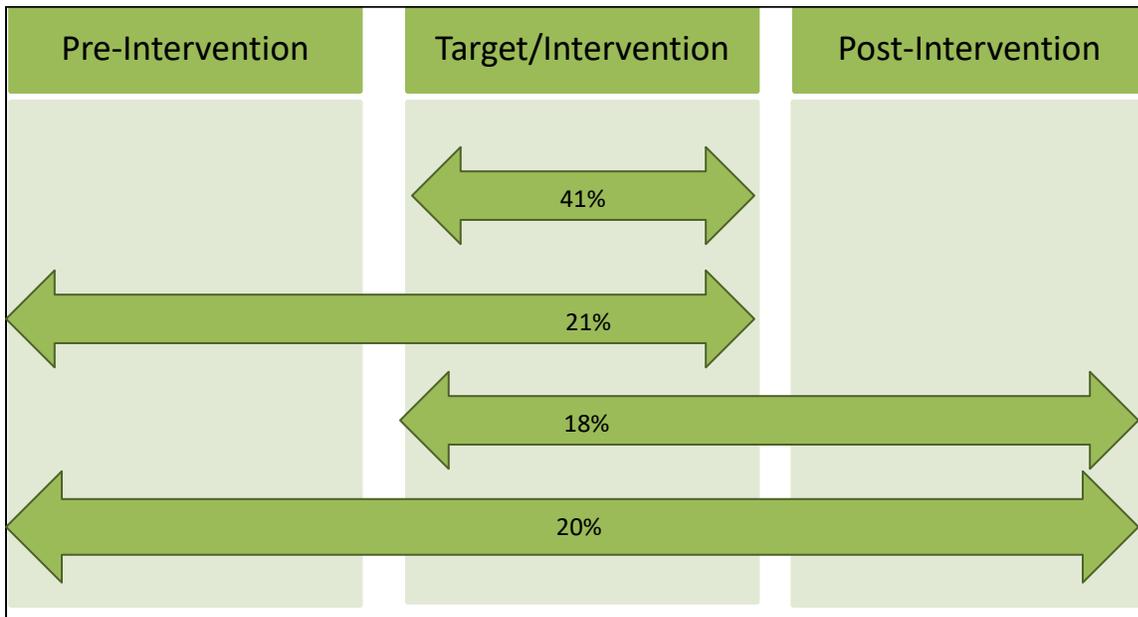
Figure 11: **POST-INTERVENTION MISDEMEANOR OFFENSE TYPES**



PATTERNS OF RECIDIVISM

In an effort to assess criminal behavior and jail intersection across time, each participant’s pattern of jail stays was examined. As shown in Figure 12 below, approximately four of ten individuals (41%) had a jail stay only at the time of the target offense where they experienced the intervention. In contrast, 20% of individuals experienced a jail stay at all three time points - target offense as well as pre- and post-intervention.

Figure 12: **PERCENT OF INDIVIDUALS WITH JAIL STAYS: TARGET OFFENSE, PRE- & POST-INTERVENTION**



What are the characteristics associated with those with multiple jail stays?

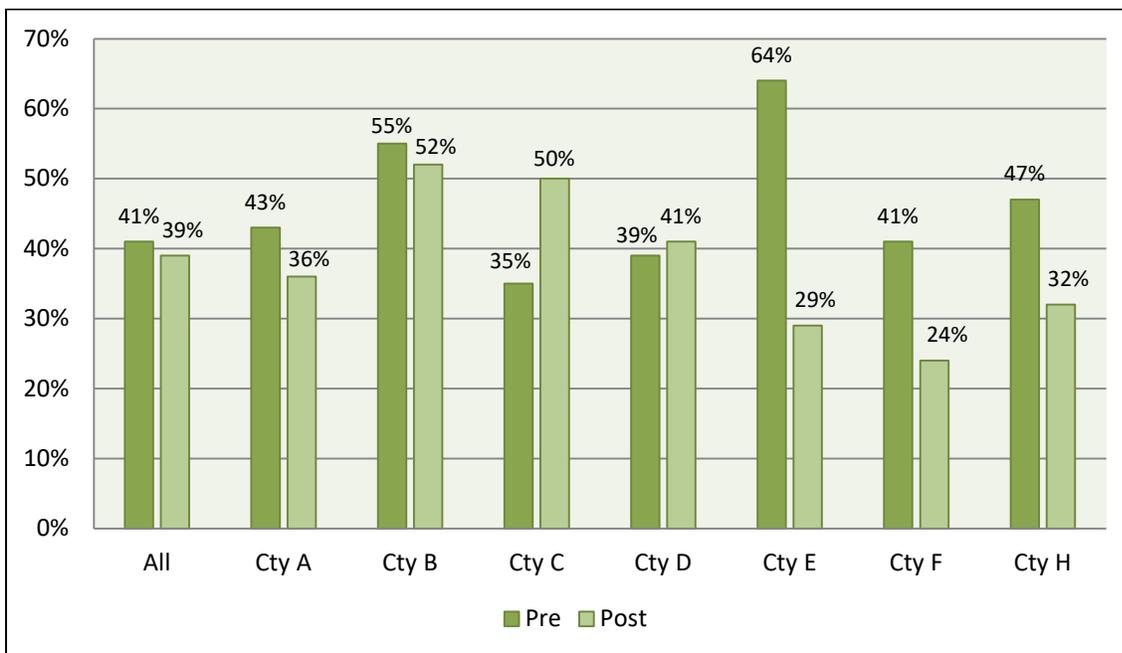
There were no differences by demographic characteristics (gender, race/ethnicity, age) in comparing those with post-intervention recidivism (n=286) to those without (n=453).

- A higher proportion of individuals charged with a misdemeanor or ordinance/civil target offense had a post-intervention period jail stay as compared to individuals charged with a felony target offense (47% vs. 31% respectively)⁶.
- Those with a pre-intervention jail stay were more likely to have a post-intervention jail stay than those without (49% vs. 31% respectively)⁷.
- The average return to jail post-intervention was 66 days; half recidivated in 53 days or less (median).
- Among those who recidivated (n=286), 52% (n=150) had a pre-intervention jail stay and 48% (n=136) did not.

What variation in recidivism exists across counties?

There was a slight drop in the number of individuals with jail stays pre-intervention (41%) to post-intervention (39%) across all pilot programs (see Figure 13 below).

Figure 13: PERCENT OF INDIVIDUALS WITH PRE- & POST-INTERVENTION JAIL STAYS: OVERALL & BY COUNTY



⁶ $\chi^2(1) = 17.953, p < .001$

⁷ $\chi^2(1) = 24.651, p < .001$

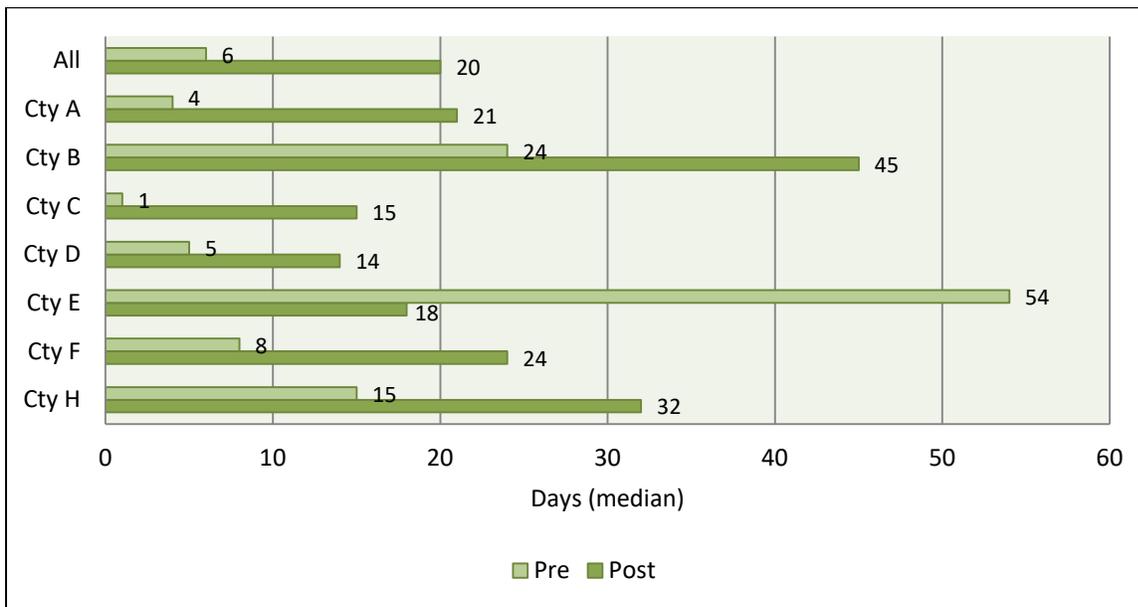
Figure 13 also shows that:

- Five counties showed a decrease in the proportion of individuals with a jail stay from the pre- to post-intervention period. These decreases ranged from 3% to 35%.
- Two counties showed an increase in the proportion of individuals with a jail stay from the pre- to post-intervention period. These increases were 2% and 15%.

Across all sites, the median number of days spent in jail increased between the pre- and post-intervention periods, from 6 days in the pre-intervention period to 20 days in the post-intervention period (see Figure 14).

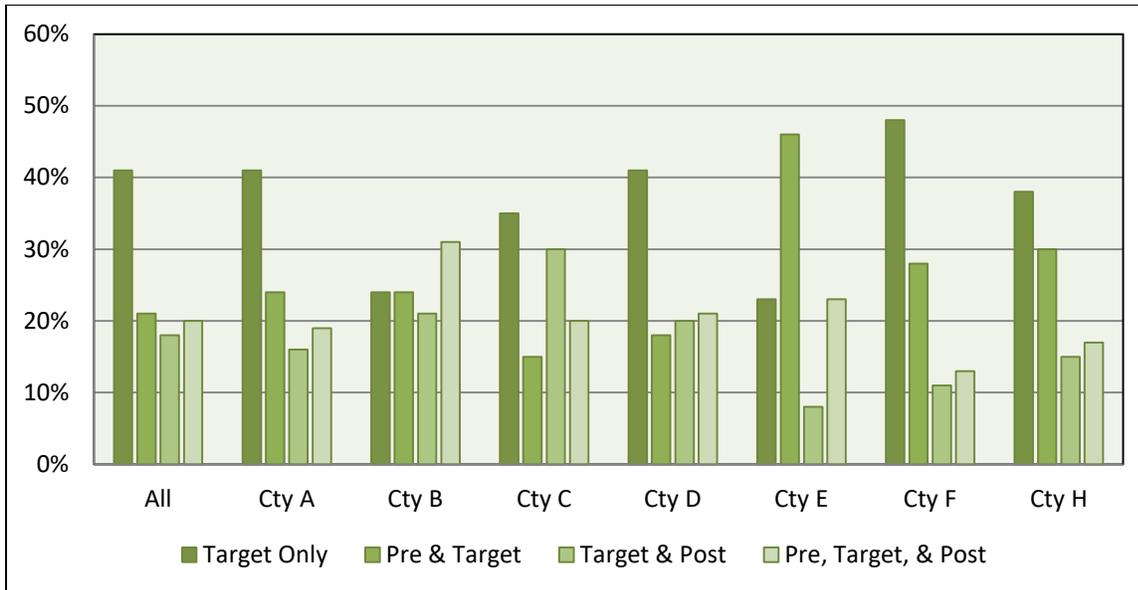
- All but one county saw an increase in the median number of days spent in jail from the pre- to post-intervention period, from a low of 9 days to a high of 21 days.
- Only one county had a decrease in the median number of days spent in jail from the pre- to post-intervention period with a drop of 36 days.

Figure 14: **MEDIAN NUMBER OF DAYS SPENT IN JAIL PRE- & POST-INTERVENTION: BY COUNTY**



Across all pilot programs (see Figure 15 below), a significant proportion of individuals receiving diversion services (40%) had only the target jail stay. This proportion varied across counties, ranging between 22% and 48%. One of five individuals (20%) receiving a jail diversion intervention experienced a jail stay in all three time periods (pre-intervention, target offense and post-intervention). This ranged from 12% to 31% across counties.

Figure 15: PERCENT OF INDIVIDUALS WITH JAIL STAYS ACROSS TIME PERIODS: BY COUNTY



Final Note: Before drawing conclusions about the merit of any specific program, the size of the sample studied (ranging from 8 to 461), intensity of the intervention (program model), and when the intervention occurs (current or future diversion activity) should be considered.

SECTION 3: Crisis Intervention Team Training

This section focuses on CIT training and is limited to interviews with trained officers in the two counties that had the highest number of officers trained plus officer-related call reports in one county that focused on CIT exclusively.

Crisis Intervention Team (CIT) Training is part of the diversion activities of five counties. Although the main focus of the training is to enhance officers’ knowledge of mental illness and skills toward de-escalation, CIT is also focused on decreasing jail recidivism for persons with mental illness. Short-term outcomes related to the change in officers’ knowledge and skills were reported in a previous report (see the March 2016 Diversion Implementation Process Report). This report focuses on providing officer perceptions of CIT training and their utilization of CIT related skills in the field. In addition, this report provides information on law enforcement officers’ utilization of community resources and the cycling between resources for individuals with serious mental illness.

This section of the report focuses on:

- Ascertaining officer perspectives on how CIT has changed their practice in two counties.
- Determining the number of interactions officers have with persons with mental health problems within the community.

- Assessing the relationship between officer interactions and jail stay for individuals with mental health issues.⁸

Background on CIT Trainings

Crisis Intervention Team (CIT) trainings were provided to law enforcement officers in Oakland and Kalamazoo counties in 2015. In addition, Kalamazoo County provided training specifically focused on youth - the Crisis Intervention Team-Youth (CIT-Y) - to officers who previously received CIT training.

In 2016, a total of 21 interviews were conducted with public safety officers in Kalamazoo County and deputies and sergeants in Oakland County by members of the Michigan State University evaluation team. The term “officer” is used in this report to connote both public safety officers in Kalamazoo County and deputies and sergeants in Oakland County.

The purpose of these interviews was to understand if participating in CIT and CIT-Y trainings impacted how officers did their work. In Oakland County, officers randomly selected for interviews up to nine months after completing the voluntary CIT training. In Kalamazoo County, there was more variability in the time between the CIT training and the interviews. For example, some officers participated in the first CIT training conducted in 2008. Interviewees across both counties were diverse by gender and rank.

What was the officers’ overall response to the training?

All interviewees were extremely positive about the training and what they learned. The mix of professionals as presenters, the opportunity to talk with individuals with mental illness about their experiences, and the scenario-based training made the training well rounded and effective.

Many participants stated that the scenario-based trainings were by far the most beneficial, eye-opening, and memorable and helped officers develop a comfort level with the new skills. As one officer stated, *“the hands-on scenarios were the best. They help show you your aggressiveness. CIT takes yourself out of the cop mentality and brings in a different attitude.”*

Officers also expressed the benefit of the panel discussions, noting that they humanized mental illness and brought the issue to a more personal level. Officers realized they could relate to those dealing with a mental health crisis, such as parents who had children affected by mental illness, recognizing that mental illness can happen to anyone.

“The hands-on scenarios were the best. They help show you your aggressiveness. CIT takes yourself out of the cop mentality and brings in a different attitude.”

⁸ Unfortunately, due to the variation in implementation across counties, the inability to collect officer level call reports, and the absence of 24-hour crisis centers in other counties, comparable data to level similar outcomes in other counties is beyond the scope of this evaluation.

Did the officers’ opinions of mental illness change?

Officers expressed that the CIT training changed their opinion about mental illness. A few officers in both counties shared that prior to the training, they did not believe in mental illness. Instead, they attributed crisis-related calls to bad behavior, lifestyle choices, poor parenting, or substance abuse. For some, the reason for the behavior did not matter, as *“a crime is a crime.”*

The CIT training helped officers understand how mental illness impacts behavior and about the implications of related medications. Officers shared that they are now better able to recognize signs of mental illness and there is less need to use force. One officer stated that *“officers [are] doing the work to understand rather than using the ‘argue and figure out later’ approach.”* Another officer stated that *“you can recognize more easily that the person isn’t just being a jerk and that they may have something else going on. The signs are more evident.”*

What skills and/or knowledge did the officers gain?

Besides learning a lot about mental illness, officers felt strongly that they have an increased ability to communicate. Some of the specific skills they mentioned include learning how to:

- Slow down and have patience
- De-escalate the situation
- Listen actively
- Build trust

“Officers are doing the work to understand rather than using the ‘argue and figure out later’ approach.”

Officers are now also better able to provide various resources to the families in crisis or dealing with mental illness. One officer shared how the CIT training helped him communicate with people on all types of calls. *“Before, I wouldn’t [talk or assess]. I would just hook ‘em and book ‘em.”*

What are some other relevant findings and comments?

Kalamazoo officers discussed how youth differ from adults developmentally, emotionally and mentally. *“Children are not mini-adults.”* Officers also discussed learning how the community mental health system works and that they now feel comfortable contacting caseworkers. Prior to the CIT-Y training, this option was not considered.

Oakland County deputies discussed the importance of having support from command and other officers in using CIT. They also expressed the need for long-term resources to treat persons suffering from mental illness in the community, especially with “frequent-flyer” individuals (i.e., those who repeatedly cycle in and out of the criminal justice and mental health systems).

Participants offered the following comments and suggestions:

- Everyone should participate in CIT training.
- Include refreshers so that officers can stay abreast of mental health issues and keep skills current.

- Clarify the concept of diversion during the training as this impacts how calls are coded.
- Create a forum where officers can discuss the more challenging cases.
- Include a walk-through of the local hospital or crisis facility during the CIT training
- Practice filling out petitions.
- Consider extending HIPPA privileges to CIT officers so they can receive viable information prior to going to the crisis. This could also open up opportunities for future follow-ups by officers.

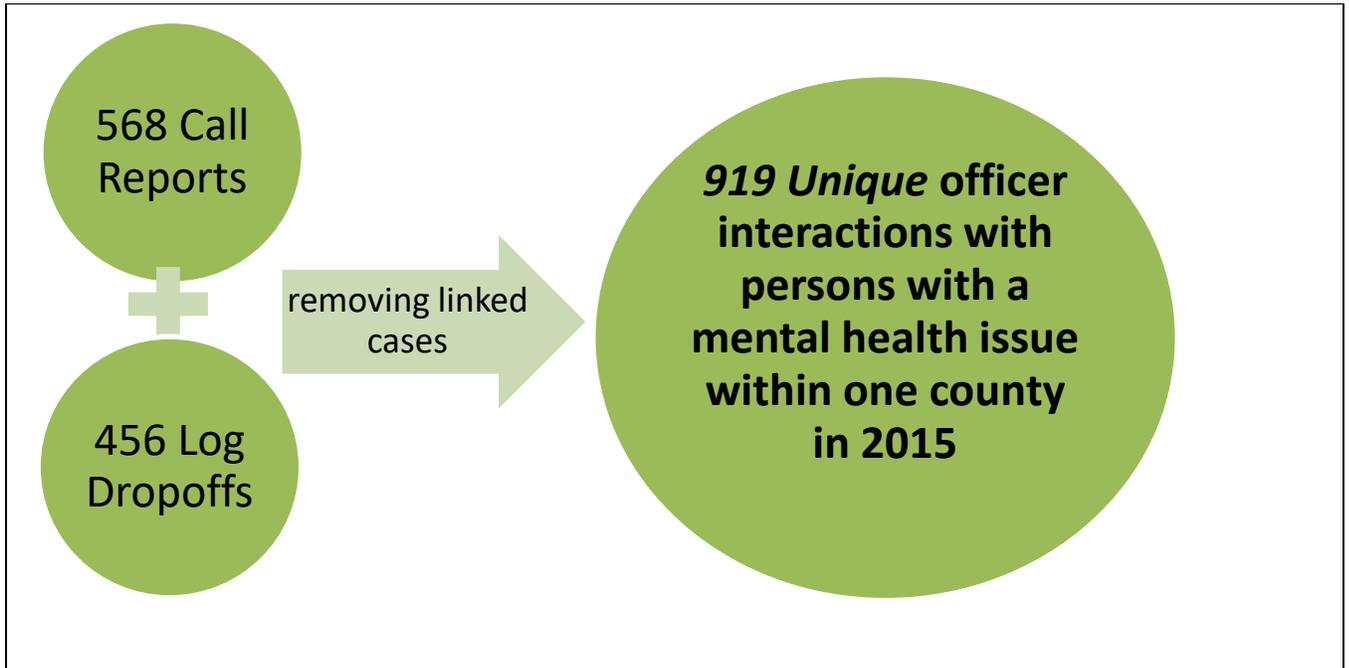
How many officer interactions involve persons with mental health issues?

In an effort to determine the number of law enforcement interactions with persons with mental health issues, data was collected in one county from two primary sources: (1) officers' call reports on each call designated as a 'mental health' or 'suicide' call, either attempt or completion; and (2) logs from the county-level crisis center that is used as a drop-off site for officers needing assistance with individuals with mental health issues. Data was collected for one full year.

In this county, after officers are alerted by a dispatcher to a particular problem within the community, a report of the call and action taken is written by the attending officers (i.e., Call Report). Because it is possible that the action taken for a particular problem is a drop-off at the crisis center, a particular individual could appear in both the Call Report and on the crisis log for the same incident. However, it is also possible that there is only a Call Report or only a Log entry.

Figure 16 below shows the 568 officer call reports involving those with a mental health or suicide designation in 2015 as well as the 465 individuals dropped off at the crisis center.

Figure 16: **INCIDENTS INVOLVING LAW ENFORCEMENT & PERSONS WITH MENTAL HEALTH ISSUES WITHIN ONE COUNTY**



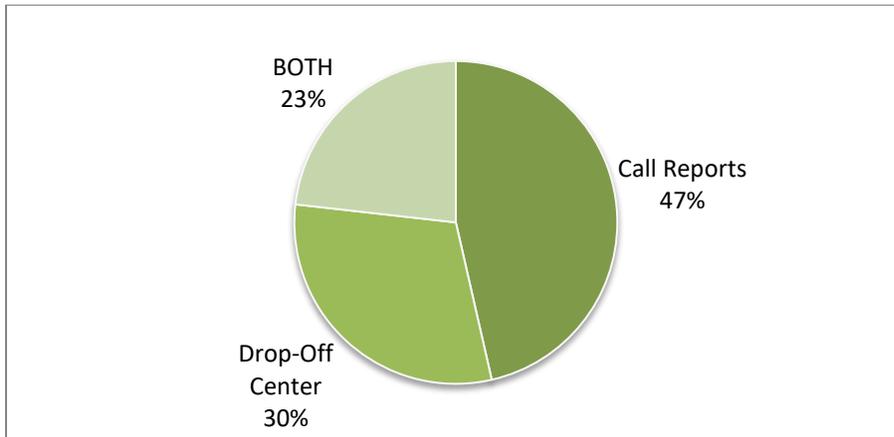
Accommodating the incidents that link call reports and log entries with the same person on the same day, there were 919 unique incidents involving an interaction between an individual with a mental health concern and a law enforcement officer.⁹

What are the patterns of interactions with law enforcement, mental health drop-off site, and the jail?

Using the call report and crisis log data to establish the individuals who appear multiple times in either source, in total, 56 individuals were found to have two or more police contacts in 2015: 47% in call reports, 30% in crisis center and 23% in both (see Figure 17 below). These 56 individuals, who comprise 6% of the 919 unique individuals with whom officers interacted in 2015, amassed 18% (161) of police interactions.

⁹ It should be noted that the 919 incidents are a low estimate for the county as the only call reports considered were for the county sheriff's office and not the multiple municipal police officers. Log entries at the crisis center include drop-offs by any law enforcement officer within the county.

Figure 17: **SOURCE OF DATA FOR 56 INDIVIDUALS WITH MULTIPLE POLICE INTERACTIONS**



Using these 56 cases and data obtained from the county jail, we find that two individuals had a jail stay prior to their first officer interaction – both for misdemeanors. In the 6-month period following their first interaction with law enforcement, 6 of the 56 (11%) individuals experienced at least one jail stay. The number of jail stays ranged from 1 to 4, with the average number of jail stays being 1.5. The number of days in jail ranged from 1 to 162 days, with the average being 56 days. Half of the offenses that individuals were jailed for were felonies and half were misdemeanors. The offenses varied and included disorderly conduct, trespassing, property, drug, child neglect and assaultive offenses.

CASE EXAMPLES

In an effort to illuminate the patterns of interaction an individual might have with law enforcement, the mental health crisis center and the jail, we explore three case examples. The first case example has multiple jail stays. The second has one jail stay. The third case has no jail stay.

Case #1: MULTIPLE JAIL STAYS

This case illustrates continual cycling between the jail and the mental health crisis center. There were multiple jail stays beginning in 2014 despite three drop offs to the crisis center as shown via logbook entries on 4/10/15, 7/6/15 and 10/7/15. In fact, in the four jail stays between December 2014 and February 2016, this individual spent 294 days in jail for misdemeanor offenses.



Case #2: ONE JAIL STAY

This case demonstrates an individual with multiple ‘warning’ interactions with law enforcement prior to a felony assault. As the graphic below illustrates, law enforcement brought the individual to the mental health crisis center on two occasions during the fall of 2015, but within two days of the last drop off, there is another call report coded as a mental health interaction but with no accompanying drop off at the crisis center. Two weeks later, there is a serious physical assault resulting in jail incarceration for 56 days. Could this assault have been preventable with more concentrated efforts within the community?



Case #3: NO JAIL STAY

This case demonstrates various police interactions with no jail stay. Within a four-month period, this individual had four interactions with law enforcement, one of which resulted in a drop off to the mental health crisis center. Again, questions of communication between law enforcement and CMH arise as well as questions regarding supportive care within the community.



How can this information be useful in counties utilizing CIT interventions?

The merging of data from these three sources - jail, call reports and mental health crisis center drop-off logs - permits a wider examination of the issues, and response to those issues, across the county wide system. The case examples poses questions such as: What communication exists between the criminal justice and mental health systems? Are there more intensive mental health services available that could benefit these individuals? Are there alternatives to long jail stays for individuals with mental health issues who have misdemeanor offenses?

These questions go to the heart of the full CIT model that includes a community level advisory board in tandem with training of officers and available community level supports (i.e. crisis centers). This data can help this specific county engage in system-wide problem solving and possibly develop system-wide interventions. It can also provide an evaluative framework for other counties engaged in similar intervention strategies.

SECTION 4: Considerations and Next Steps

What needs to be considered when reviewing this data?

This report focuses on three primary analyses: recidivism among those receiving jail-based interventions; comparison of two years of mental health screenings conducted across multiple jails; and officer response to CIT training. As every analysis has caveats to be considered when drawing conclusions from the data, this section illustrates considerations for each analytic area.

1. JAIL-BASED INTERVENTIONS

Definition of Recidivism

The definition of recidivism used in this analysis is return to jail in the county where the diversion intervention occurred. Although recidivism can be measured in multiple ways (i.e., arrest, conviction, probation violation, jail or prison sentence, etc.), we use jail for a number of reasons. First, being booked into the jail can be a close proxy for arrest, but can also occur if there is a violation of court/probation orders, as well as new charge. Therefore, a booking can be indicative of a variety of law enforcement actions.

Second, since the goal of the jail diversion pilot program is ultimately aimed at keeping individuals with serious mental health problems out of the local jail, it was important to assess all of the ‘ins’ and ‘outs’ effecting that county-level institution. However, the focus on recidivism within the county negates our ability to assess if the individual was booked into a neighboring county jail or the state prison, thus perhaps inadvertently under-estimating actual return to criminal/illegal behavior. Our hope is to use a statewide measure of recidivism at the 1-year outcome report.

Evidence-Based and Best Practices

Within the request for proposal from the state, counties were encouraged to use best practice standards. However, definitions of ‘evidence-based’ and ‘best practices’ are dependent upon specific research standards (e.g. was there a randomized control study that proved efficacy or was it a non-equivalent group comparison?). Often models that have demonstrated efficacy with one population may not be transferrable to other populations. For example, MRT has some evidence to indicate success with individuals with substance use disorders and minimal research on use with those who have SMI. Similarly, jail-based treatment has not been found as effective as interventions that provide linkage to community services and treatment. A review of current practices in line with the research on best practices should be considered when moving forward.

Movement Between Counties

As discussed above, this baseline report measures county-level jail recidivism only. Acknowledging the limitation in defining recidivism, there is also an issue when defining CMH enrollment. Because CMH eligibility is connected to a specific county or region, when an individual experiences a law enforcement interaction and jail booking outside of their CMH jurisdiction, they are not considered CMH-enrolled. For purposes of this report, the definition of CMH enrollment is confined to those who are enrolled in CMH

within the same county in which they are jailed; those who are enrolled in CMH in a different county than where they are jailed are considered to be Non-CMH.

Some Missing, Incomplete or Ill-Categorized Offense Data

Ascertaining specific types of offenses was sometimes difficult due to incomplete or missing data obtained from jails. Moreover, coding and grouping offenses from text data may in some cases be erroneous. However, we are confident in our categorization of the charge offense as felony, misdemeanor, or civil/ordinance and will collect more refined information in the 1-year long-term outcome report.

2. COMPARISON OF MENTAL HEALTH SCREENING

Participating Counties

Of the eight counties originally invited to participate in the global, time-limited K-6 screening, only six were able to implement the screening process with enough rigor and consistency to trust the integrity of the data. Therefore, the screening data presented in this report focuses on those six counties only. Based on other studies, we do not believe that the 20% SMI prevalence figure differs greatly in those counties.

Alternate Explanations

It is not clear what produced the fluctuations in the prevalence of SMI between 2015 and 2016, but it is possible that increases or decreases may be related to other community-based interventions (i.e. the advent of a mental health court in the county), officer training (i.e. CIT), law enforcement behavior and even the weather (as many sheriffs have told us)!

3. CRISIS INTERVENTION TEAM TRAININGS

Differing Design for the County That Implemented Only CIT Training

Although recidivism was still a primary outcome in the one county that implemented CIT only, the selection of who was followed in that county and why differs from the 739 individuals included in this analysis. In selecting individuals who were diverted multiple times and then subsequently following them through the jail data to assess jail interface, the design varied enough that those individuals are not included in this aggregate overview of jail services.

Best Practices in CIT Training

Similar to the discussion above, fluctuations in the model specifics may not yield the same results. CIT research has primarily been conducted on training models that include 40 hours of officer training. It is possible that fewer hours can yield positive results (as our pre/post testing has indicated), but rigorous testing of that variation in hours has not been tested. Although this project seems like a perfect incubator for that type of study, the variation in the number of officers trained, hours of training, and available data have so far precluded the evaluation's team ability to test this question.

Addressing Issue of Confidentiality Between Law Enforcement, Jail and Mental Health

An issue emerging from the officer interviews and our site visits is officer frustration about the ‘one- way street’ that occurs with sharing information about a specific individual. Although officers believe that information from mental health could be helpful to them in doing their jobs (and potentially keeping them and the community safe), mental health professionals invoke HIPAA regulations, thus excluding the officers from pertinent information. This suggests an examination of HIPAA regulations to determine how and if vital information can be shared with CIT officers who are handling mental health crisis calls, as well as jail intake staff.

What are the next steps for the evaluation?

This baseline report is the precursor to a larger, more conclusive report that will be completed on long-term outcomes. In that report we will use a similar design, but look at individual- level behavior in the 1-year periods before and after the intervention. In addition, we expect that outcome measures will be expanded beyond recidivism to include the following:

Treatment Engagement and Continuity

All pilot interventions involve collaboration between mental health and criminal/legal professionals within each county. Enhancing and maintaining mental health services for individuals with mental health issues is an important goal of the pilot programs and, as such, is an important outcome indicator. However, the ability to capture both community mental health (CMH) data as well as Medicaid data for non-CMH service recipients is a complex, regulated, and time-intensive process requiring specific permissions. It is our expectation that treatment data will be available and included in the 1-year long-term outcome report.

Defining Program Models

It should be noted that this report captures the first six months of program operations. In counties where programs were newly implemented this often meant that programs were still in ‘design’ mode when providing services for these early enrollees. As such, program models and eligibility criteria were often ill-defined and there was little information on ‘dosage’, how much service was received, or if fidelity to the program model was maintained. As programs evolve and develop, the evaluation team is working with stakeholders to better define program models for potential replication and to use that information to refine outcome data (e.g., Do more services produce better outcomes?).

Determination of What Works for Whom

Individual-level data obtained from each of the county sites has been limited to demographic characteristics, but has not routinely included information on indicators that might predict successful outcomes. The evaluation team is working with stakeholders to find information on known predictors of successful versus non successful treatment outcomes, such as the presence of a co-occurring substance use disorder and if the individual completed the treatment intervention. Having this information for the one-year outcome report will provide additional information to county stakeholders on improving programs.

County-Wide Assessment

As additional funding in counties with pilot programs produces additional interventions across the sequential intercept model, the efficacy of any one intervention becomes more difficult to determine (outside a randomized control study). Therefore, the evaluation team is proposing a more global evaluation of interventions across intercepts by focusing the evaluation of individuals entering the jail with a SMI and following them through various systems (i.e. law enforcement, CMH, jail, courts). The goal is to begin collecting the preliminary data in February 2016 (with the third wave of K6 data collection in the jails) and using county and state level data to track the person through various systems.