Mental Health Jail Diversion:

Using a Cohort Sample to Evaluate Diversion across the Sequential Intercept Model

Report on Stage 1

Statewide

May-August 2017

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MENTAL HEALTH JAIL DIVERSION:
REPORT ON STAGE 1: STATEWIDE
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EXECUTIVE SUMMARY

For the past three years, ten counties in Michigan have been working with the Governor's Diversion Council and the Michigan Department of Health and Human Services to improve their responses to individuals with serious mental illness (SMI) who are involved in the criminal justice system. A system-based evaluation is underway to identify the variety of interventions across all five points to the sequential intercepts of the criminal/legal system (i.e. law enforcement, courts, jail detention, jail services and re-entry into the community) and their impact.

This report details how individuals who are booked into these county jails are identified with SMI within the jail and receive mental health services during their jail stay. Standardized screening instruments were collected on a sample of individuals as they were booked into each of the county jails. The screening instrument detected symptoms indicative of SMI, presence of alcohol or drug use disorders, and housing stability. Results of current jail processes for identifying SMI were also reviewed and compared with the standardized screening results. The process for providing follow-up referral, assessment, and services to those with mental health issues was also assessed. Below are the key findings.

Findings

Prevalence of mental health issues

- Based on results of the standardized screening tool alone, 20% of those booked into the jail show symptoms of a serious mental illness (SMI), down from last year's prevalence of 22%. Across the jails, the prevalence ranges from 16% to 22%. The prevalence is much higher among females (28%) than males (17%).
- Based on jail staff/officer observation of mental health issues in addition to the results of the standardized screen, nearly one third (32%) of the population booked into the jail were identified with mental health issues. Across jails, prevalence ranges from 18% to 45%; the wide variation is largely attributable to detection or lack of detection by jail staff.
- Comparing the results of the standardized screen and jail staff/officer observation shows that *both* are necessary to identify mental health issues. Officers identified about half (46%) of the individuals who had screened positive for SMI via the standardized screen. Conversely, among the individuals with screens that indicated no mental health issue, officers identified an additional 16%.

Prevalence of other risk factors

- Substance use disorders are widespread in the jail, with 40% demonstrating symptoms of alcohol use disorders and 30% with symptoms of drug use disorders. Among those with SMI, 66% demonstrate symptoms of either a drug or alcohol use disorder compared with 51% of those without SMI.
- Nearly half (45%) of those entering the jail report insecure housing. The rate of SMI is significantly higher among those with insecure housing (23%) compared to those with secure housing (17%).
- Forty-three percent report past-year incarceration, and 9% report incarceration within the past month. The rate of SMI is significantly higher among those with past-month incarceration (27%) compared to those who had not been incarcerated in the past month (19%).

- Examining cumulative risks and needs of mental health, substance use, housing insecurity, and recent recidivism, those with SMI are much more likely to report *multiple* risk factors. Over half (54%) of those with SMI report 3 or more risk factors while 51% of those without SMI report 0 – 1 risk factors.

Follow-up referral, assessment, and services

- Individuals identified by jail staff/officers as having mental health issues are likely to be referred for assessment by a mental health professional (93% of the time); however, only 69% of those referred received a mental health assessment or service.

Funding configuration

- Configuration of funding for and delivery of mental health services within the jail varies by county; some are supported wholly by community mental health (CMH), others are supported solely by jail resources, and still others braid the funding and resources of both CMH and jail. Funding source may have implications for service provision within the jail.

Recommendations

- Every jail should utilize a valid screening tool at intake/booking that assesses both serious mental health symptoms as well as substance use disorders.
- A combination of officer observation and valid screening instruments provides the best detection and risk management tools.
- Intervention strategies need to employ principles of 'risk and responsivity' that match the needs of the individual with the level of the intervention; those with more risks will require more intensive services.
- Continue to enlist other supports and community providers; prevention of incarceration for those with mental health symptoms requires collaborations beyond law enforcement, jail, and CMH. Housing providers, substance abuse programs specializing in integrated treatment, employment supports, and parenting skills training are a few examples of potential collaborators.

Next Steps

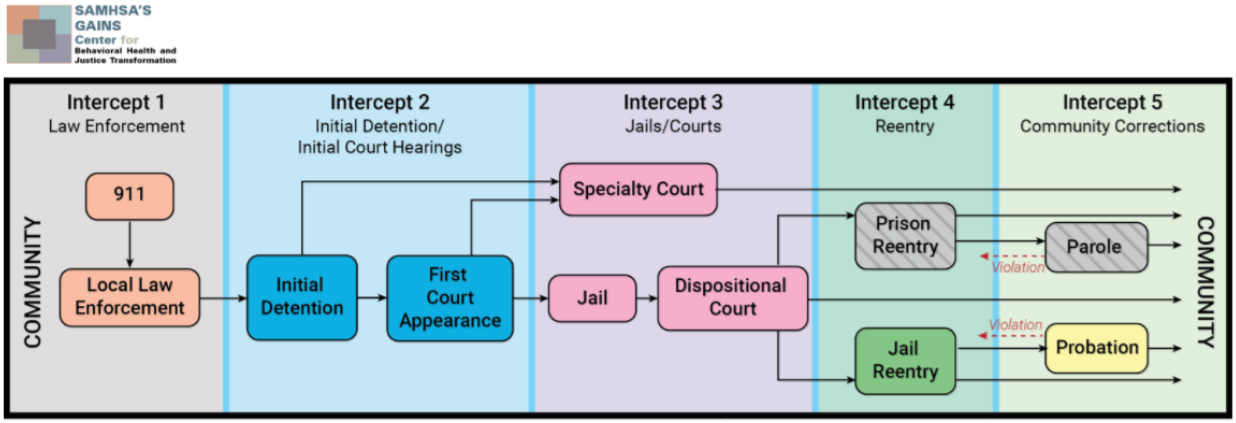
- MSU to engage in future evaluation of discharge activities and the continuum of care between jail and community-based treatment for those identified as having a mental health issue.
- MSU to determine if identification and treatment of individuals with SMI within the jail affects recidivism rates.

INTRODUCTION

Background

In February of 2013, Governor Snyder formed the Mental Health Diversion Council and appointed Lt. Governor Brian Calley as the chair. The goals of the Diversion Council are to assist individuals with mental illness who are involved in the criminal justice system by 1) strengthening pre-booking diversion; 2) improving mental health treatment in jails; 3) expanding post-booking diversion options; and 4) reducing rates of incarceration and re-incarceration.

The Diversion Council and the Michigan Department of Health and Human Services sought proposals from applicants around the State for jail diversion initiatives. Applicants were to propose pilot interventions at one or more points along a framework known as the *Sequential Intercept Model* (see SAMHSA model below), which aligns with the goals of the Council in providing interventions and improvement across various systems along the criminal/legal continuum. Eligible applicants were agencies working extensively with populations with mental illness and/or developmental disabilities including but not limited to county-level Community Mental Health (CMH) agencies, CMH providers, law enforcement, courts, jails and jail providers.



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

Phase 1: Project-Based Evaluation Design

In Phase 1, an evaluation team led by Sheryl Kubiak, Ph.D. focused on assessing implementation, illustrating processes and measuring outputs. An ***Implementation Report*** (2016) documented activities, variations in program design and implementation strategies across the eight funded counties. In Fall 2016, the evaluation team disseminated a ***Baseline Report***, which provided information on serious mental illness (SMI) prevalence within jails, crisis intervention team (CIT) outcomes, and recidivism on 739 individuals who received services funded through the Diversion Council. The ***Long-term Outcomes*** report will be published in 2018.

Phase 2: System-Based Cohort Evaluation Design

In 2017 the Diversion Council elected to support the ten counties, funded across multiple years (2014 – 2016) and already involved in pilot projects rather than fund additional counties. This decision requires these counties to improve their responses to those with mental health issues across all points along the

Sequential Intercept Model (i.e., Intercepts 1 through 5). This shift calls for an evaluation of the entire system as opposed to the original project-based evaluation. The reason for the system evaluation is primarily due to the potential for an individual to interact with multiple initiatives within the same county. Therefore, each intervention influences the others and the individuals involved. The goal is to assess the baseline operation of the Sequential Intercept Model in each county in 2017 and then assess efficacy by replicating the data collection in 2019.

In this first stage, the focus is on initial detention (Intercept 2) and jail services (Intercept 3) (see SAMHSA Figure above). More specifically, the focus is on identification, referral and services for those entering the jail with signs of a mental health issue. Without robust processes for identification and referral, comprehensive diversion is difficult to achieve. **The purpose of this stage is to determine the mechanisms within the jail (and between CMH and the jail) for identifying individuals with mental health issues so that pre/post booking diversion services, as well as jail-based services, can be initiated.**

All ten counties involved in the jail mental health diversion pilots accepted the invitation to join the system-based evaluation. In this report counties are not identified by name.

Phase 2, Stage 1: Evaluation Questions

1. What are the characteristics of those who completed the mental health screen (K6)?
2. What are the results of the jail-based mental health screen?
    a. How many individuals screened positive for SMI symptoms in 2017, and how does the overall rate compare to previous years?
    b. Do rates of SMI differ based on demographics?
    c. Do rates of SMI differ based on risk factors?
    d. Do those with SMI have greater risks/needs than those without SMI?
3. How do the K6 and existing processes for referral, assessment, and services work together? How do the results of the K6 screen compare with the results of jail staff identification of SMI?
4. Who receives mental health services within the jails? What is the proportion of those who screen positive on the K6 who receive services in the jails?

In future system evaluations, criminal justice interactions and treatment services of the cohort identified with mental health issues in Stage 1 will be tracked for a year. Interactions across each of the sequential intercepts will be reviewed including law enforcement, courts, jail, treatment, and prison.

REPORT ON THE FIRST STAGE of SYSTEM EVALUATION

Data collection began during March of 2017 with the goal of collecting 455[1] usable mental health screens at each jail. Duration of data collection differed based on the population size of the jail. Large metropolitan

[1] The goal of 455 screens was based upon a predicted 22% prevalence rate of SMI within the jail, with the expectation of yielding a minimum cohort size of 100 individuals for follow-up study.

jails (Wayne, Oakland and Kent) collected for approximately 1 week; urban jails (Berrien, Kalamazoo, Livingston and Monroe) collected for approximately 2 weeks, and in the rural jails (Barry, Marquette and St. Joseph), data collection lasted 6 weeks. A total of 2,972 screens were collected across 8 jails[2].

Figure 1: Number of Usable K6 Screens in Each County

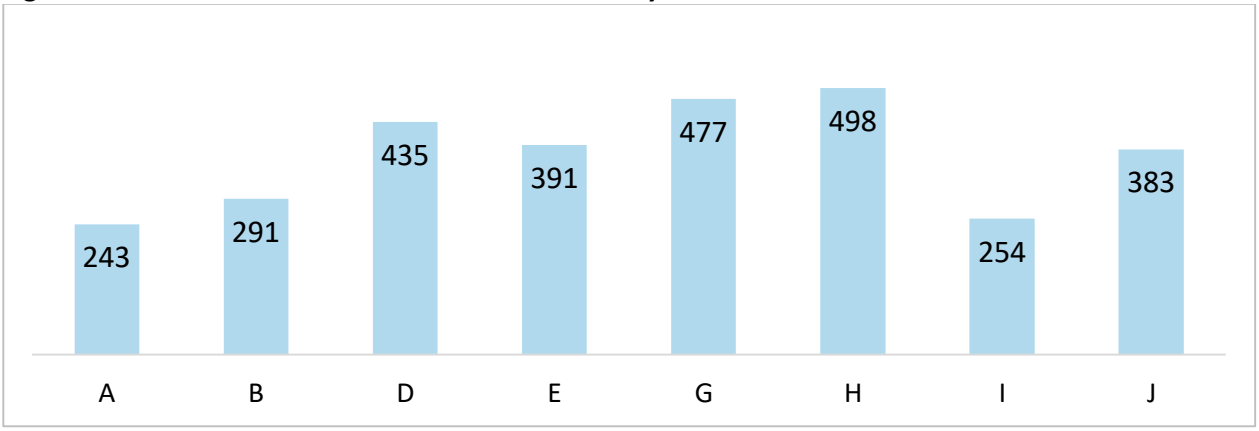
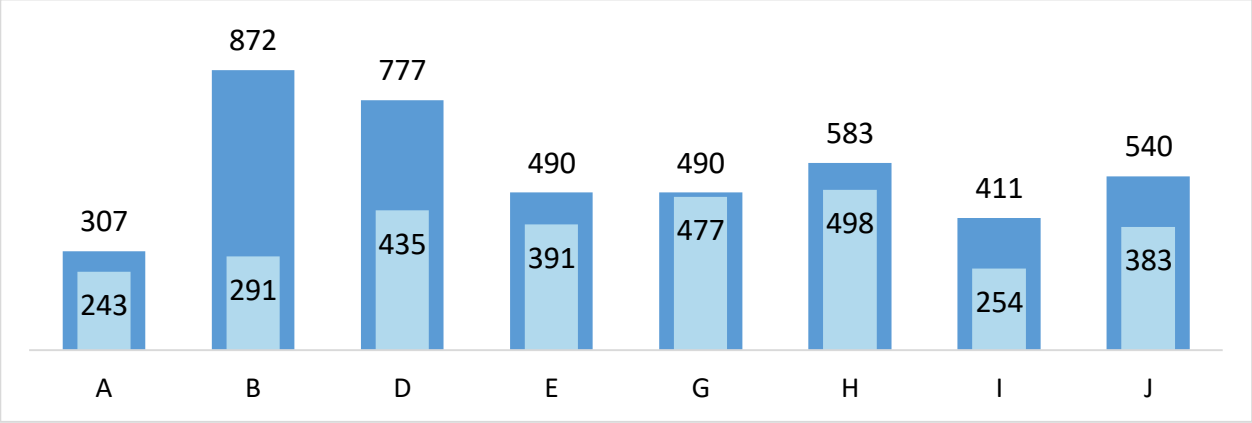


Figure 1 above shows the number of usable screens in each of the eight counties, with 3 of the 8 surpassing or nearing the target of 455. In the rural jails it was not anticipated to reach 455 due to the small size of the jail and the six-week collection period. Other variations in numbers per county were caused by incomplete information collected, refusals of the detainees to participate, or other issues with data collection. A full booking report from each jail provided verification of the number of individuals booked into the jail versus the number of screens collected (see Figure 2), demographic information, and a booking number for linking to jail-based services information.

Figure 2: Number of Usable K6 Screens out of Number of Bookings in Each County

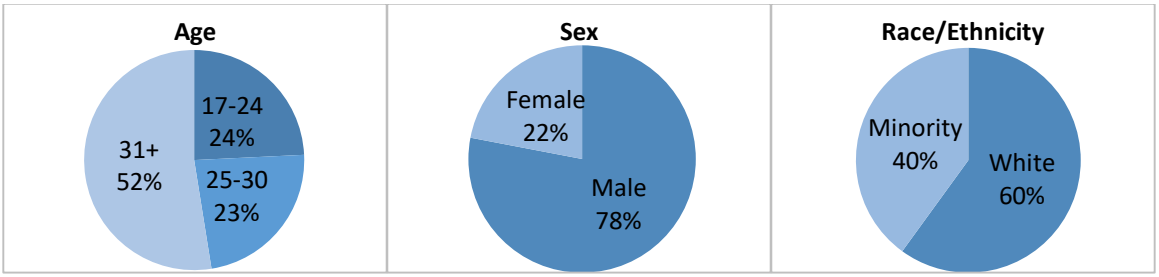


[2] Data from two jails were excluded from this analysis due to issues with data collection and limited reliability.

1. What are the characteristics of those who completed the K6?

Figures 3 and 4 below show the demographics and risk factors among the 2,972 individuals included in the K6 evaluation.

Figure 3: Demographics of Individuals who Completed the K6

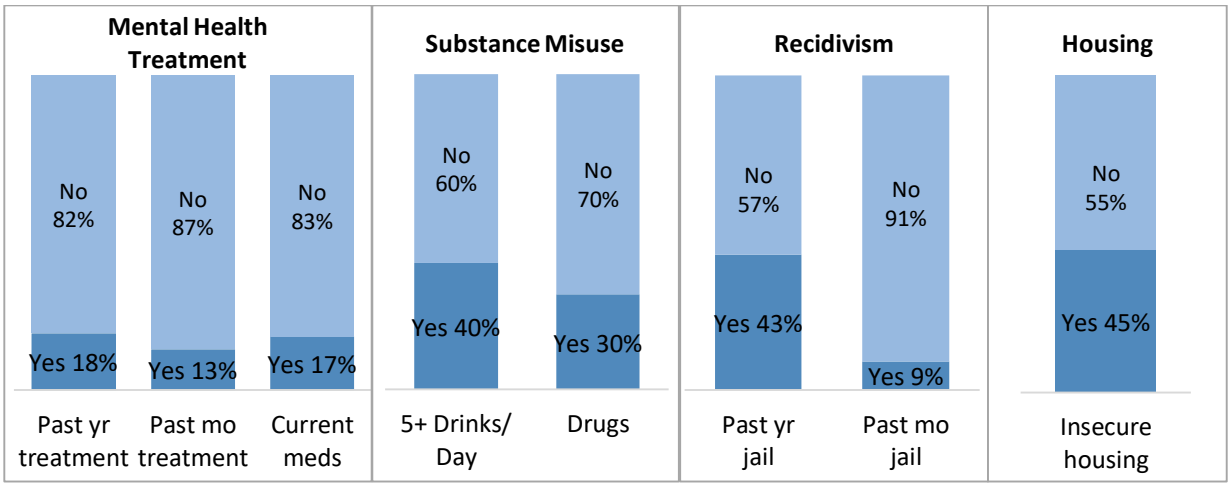


Over half of the population is age 31 or older

Over three quarters are male

Forty percent are Minorities

Figure 4: Mental Health Treatment, Substance Misuse, Recidivism, & Housing among Individuals who Completed the K6



Just under one fifth of the population is currently on medication for mental health needs. Similar rates of past-year mental health treatment were reported.

Forty percent reported at least one episode of binge drinking in the past year, and almost one third reported using illegal drugs or inappropriately using prescription drugs.

Close to one half reported having been incarcerated in the past year, and nearly one in ten had been incarcerated in the past month.

Nearly half had been living in insecure housing, including with a friend or in a motel.

2. What are the results of the K6?

A. How many screened positive for SMI symptoms?

Twenty percent screened positive for SMI symptoms in 2017 as indicated by a positive K6 screen (see Figure 5)[3]. Rates range from 16% to 22% across all counties. The rate has decreased from 24% in 2015 (see Figure 6).

Figure 5: Rate of Positive K6 Screens

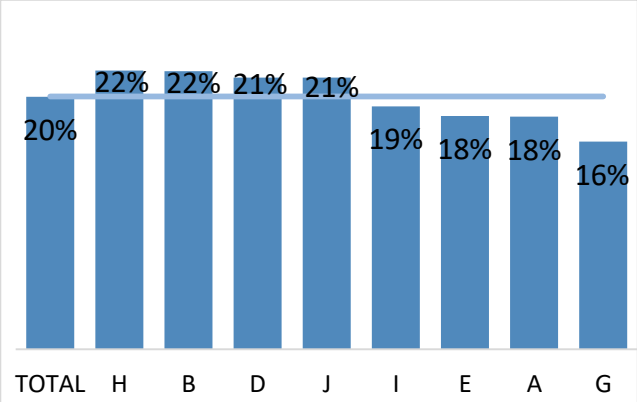
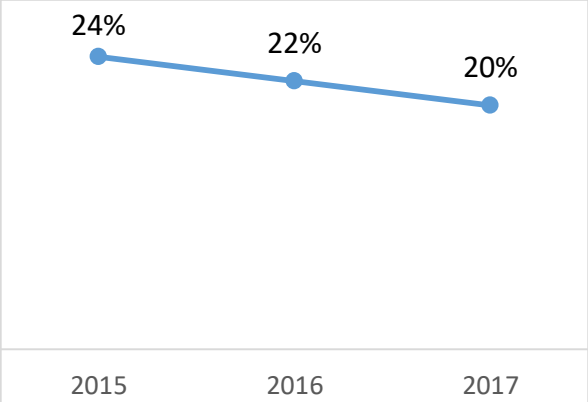


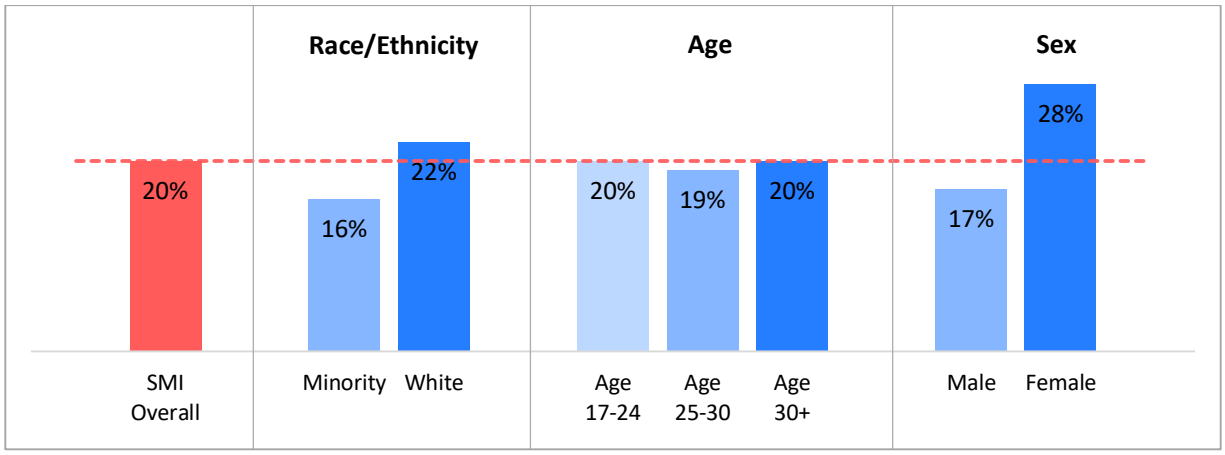
Figure 6: Rate of Positive K6 Screens, 2015-17



B. Do rates of SMI differ based on demographics?

Although the rate of SMI overall is 20%, rates differ based on demographic characteristics (see Figure 7 below). Statistically significant differences in SMI rates are related to sex and race. Over one quarter (28%) of females compared to 17% of males screened positive for SMI[4]. Whites are almost one and a half times as likely as Minorities (22% vs 16%)[5] to screen positive for SMI. Rates are around the same for all age groups.

Figure 7: Differences in SMI Rates based on Race, Age, and Sex



[3] The K6 cutpoint for SMI among the general population is 13. Using that cutpoint, 10% of this population screened positive for SMI. A 2009 study within the jail using the K6 and 13 cutpoint found that 15% of those within the jail had symptoms of SMI (Kubiak et al, 2011).

[4] $\chi^2(1, N=2{,}940)=36.56, p<.001$

[5] $\chi^2(1, N=2{,}863)=15.34, p<.001$

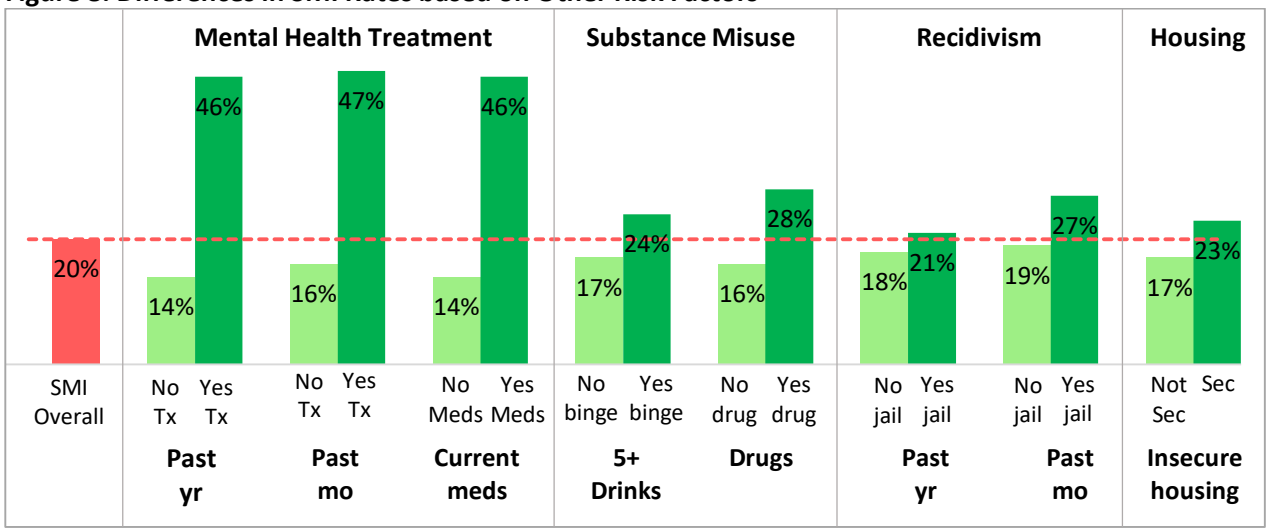
C. Do rates of SMI differ based on risk factors?

Criminal justice theory regarding risk and responsivity (Bonta and Andrews, 2010) posits that certain criminogenic risk factors increase the chance of recidivism. Therefore, the theory states that reduction of risk factors can reduce recidivism. COMPAS, the risk assessment tool used by the MI Department of Corrections, includes mental health, substance use, criminal history, and residential instability as risk categories. These risk factors (mental health treatment, substance misuse, recent recidivism, and housing insecurity) were also assessed with items on the K6 survey.

Eight items – mental health treatment in the past month, mental health treatment in the past year, current psychiatric medication, drinking five or more alcoholic beverages at once in the past year, using drugs or misusing prescription drugs in the past year, incarceration in the current county in the past year, incarceration in the current county in the past month, and insecure housing – were examined to determine if presence of that item is associated with a higher rate of SMI. Results show that seven of the eight risk-related items are associated with a higher rate of SMI (see Figure 8 below).

Rates of SMI are approximately three times greater for those with current or recent mental health services i.e., medication or treatment[6,7,8]. Differences in SMI rates are seen between those who reported binge-drinking and those who did not (24% vs 17%)[9] and those who reported drug use and those who did not (28% vs 16%)[10]. Incarceration in the past month is also a significant differentiator, with over one quarter (27%) who reported past-month incarceration screening positive for SMI compared to 19% of those who had not been incarcerated during the same time frame. Finally, almost one quarter (23%) of those in insecure housing screened positive for SMI compared to 17% of those in secure housing. Slight differences were seen based on past-year incarceration.

Figure 8: Differences in SMI Rates based on Other Risk Factors



[6] $\chi^2(1, N=2,904)=281.35, p<.001$ [past-year mental health tx]

[7] $\chi^2(1, N=2,468)=165.590, p<.001$ [past-month mental health tx]

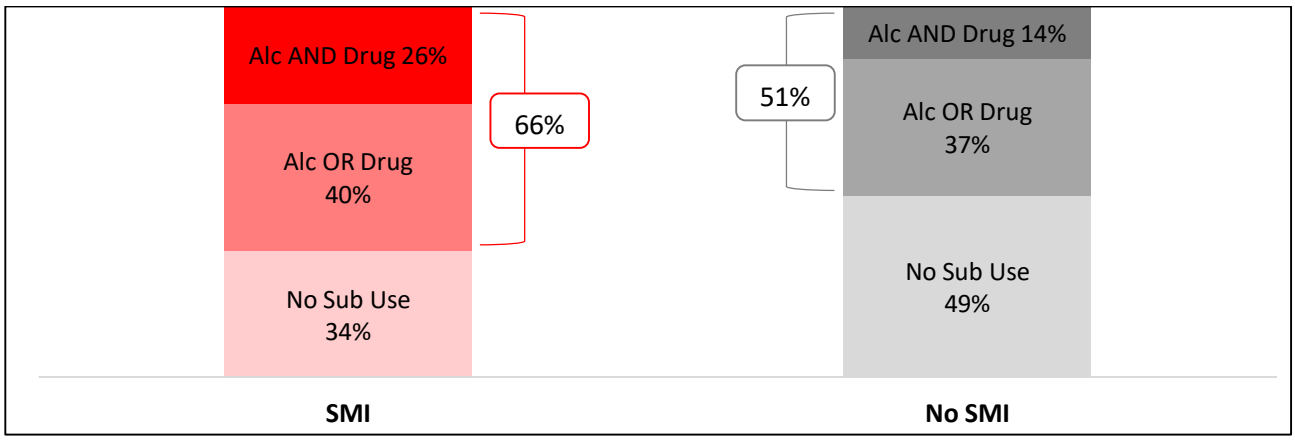
[8] $\chi^2(1, N=2,916)=274.22, p<.001$ [current medication for mental health]

[9] $\chi^2(1, N=2,937)=26.40, p<.001$

[10] $\chi^2(1, N=2,918)=59.89, p<.001$

As shown in Figure 8, rates of SMI are higher among those who reported binge drinking and those who reported drug use. Figure 9 below displays this information from a different perspective: binge drinking and drug use among those with SMI or no SMI. Again the differences are significant, with 66% of the group with SMI reporting co-occurring substance use issues compared to 51% of those without SMI reporting substance use issues[11].

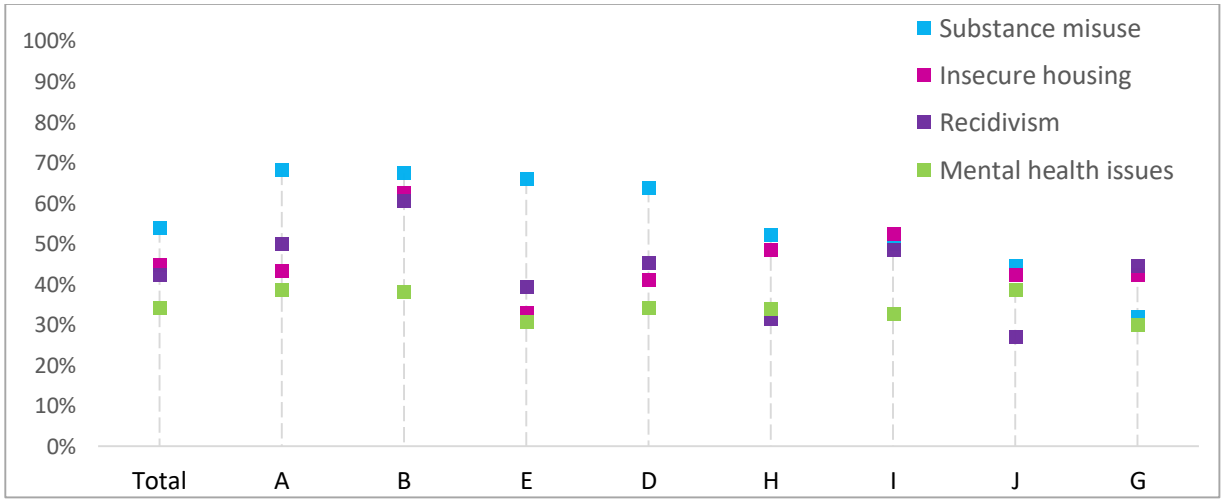
Figure 9: Co-occurring mental health and substance use issues



D. Do individuals with SMI have greater risks/needs than individuals without SMI?

The individual risk-related items discussed above were used to calculate the prevalence of the four risk factors overall. Results, displayed in Figure 10, show that in total over half (54%) reported some type of substance use issue. Just under half reported insecure housing (45%) or recent incarceration (42%). Over one third (34%) had an indication of mental health issues (recent mental health treatment or a positive K6 screen).

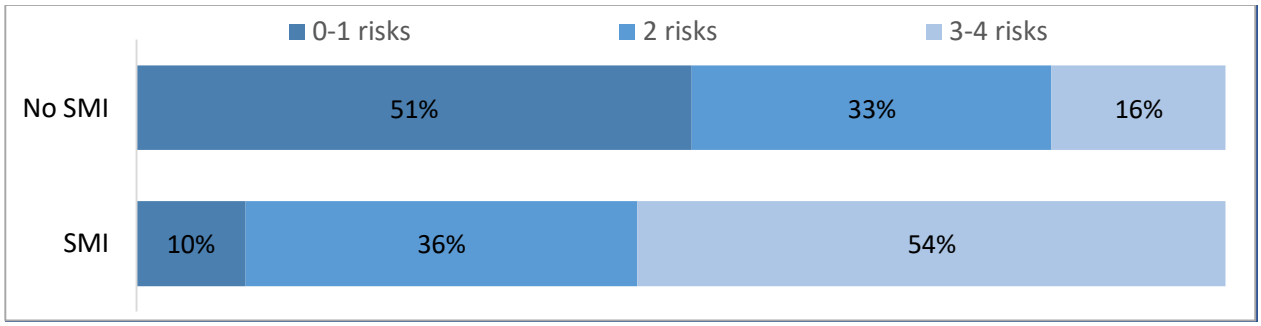
Figure 10: Rates of Each Risk Factor by County



[11] $\chi^2(2, N=2,913)=71.38, p<.001$

To account for the cumulative nature of risk, we calculated the number of risk factors per person and assessed differences between those with and without SMI symptoms. Figure 11 illustrates that those with SMI are much more likely to have 3 and 4 risks compared to those without SMI. In fact, over half the individuals (54%) entering the jail with symptoms of SMI have 3 or 4 risk factors. In comparison, half (51%) of those entering without SMI symptoms have 0 or 1 risks.

Figure 11: Number of Risks/Needs



3. How do the K6 and existing processes for referral, assessment, and services work together? How do the results of the K6 screen compare with the results of jail staff identification of SMI?

The American Psychiatric Association (APA) under its principles for provision of psychiatric services in jail (2000) lists a number of steps in the process of identification, referral and assessment (see Table 1). The processes and practices at each of these stages vary across the jails e.g., The use of standardized assessment instruments and/or routine questions about mental health treatment history or current medication (Note: See individual county reports for more specific information). All counties rely on the observation of officers to detect unusual behavior or other signs/symptoms of mental health issues.

Table 1: APA Standards for Identification, Referral, and Assessment

Identification	Officers or jail medical personnel involved in booking, intake or classification screen for mental health through observation, standardized questions, and history.
Referral	Indication of a mental health problem that creates a risk for self-harm or violence generates a referral for a brief mental health assessment by a qualified mental health professional.
Assessment/ Services	A positive brief mental health assessment generates either a more comprehensive assessment and/or mental health treatment.

The K6 provides an objective, standardized, and empirically-derived measure of serious mental illness/distress. This objective measure is compared and contrasted to the practices within the jail where officer identification and/or routine questions are used to assess mental health concerns.

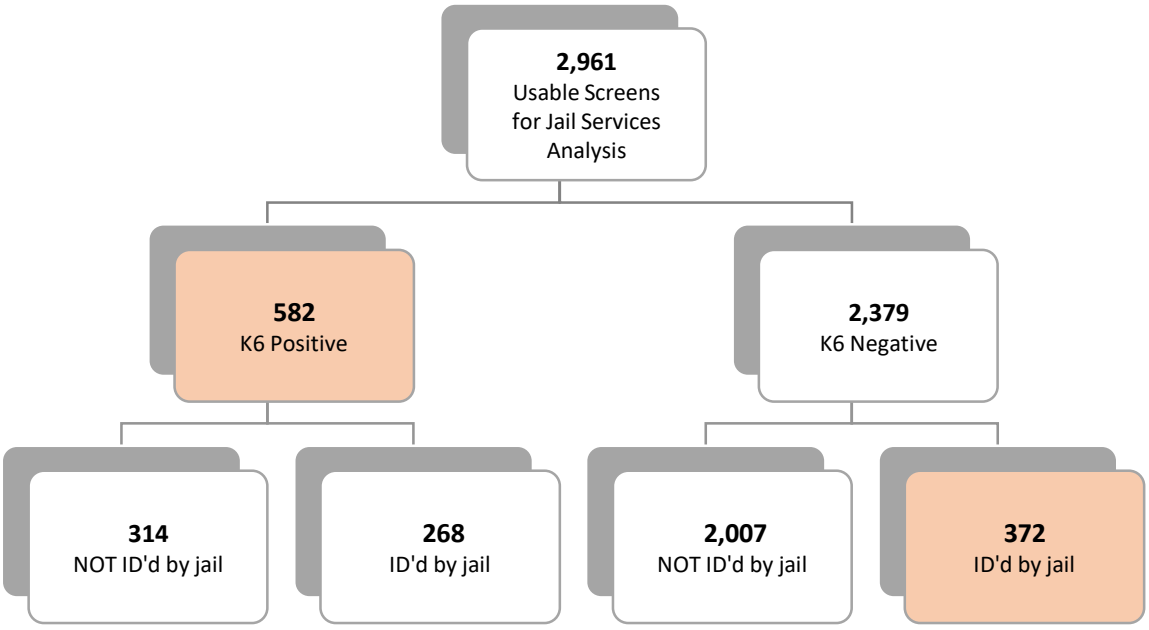
Of the 2,972 usable screens across the eight sites, 11 were excluded from the analysis of follow-up services because of missing identifiers, so 2,961 are included in the following section. A total of 954 were identified

(by either the K6 or jail staff) as having a mental health issue (see Figure 12 below). Using the standardized K6 screen *and* identification by jail staff **32% of those entering County Jails were identified as having mental health concerns.**

Of these **954** identified individuals:

- **372 (39%)** individuals screened negative on the K6 but were identified by jail staff as positive for mental health concerns.
- **314 (33%)** individuals screened positive on the K6 and were not identified by the jail.
- **268 (28%)** were identified by both the K6 and the jail staff as positive for mental health concerns.

Figure 12: Identification of Mental Health Issues via K6 or Officer Observation



372 with Negative K6 but Positive Identification by Jail Staff

Jail staff identification of the 372 individuals who screened negative on the K6 is likely based on questions asked during the booking and classification process that query current or past mental health treatment and medication. This reinforces the use of mental health history questions in the booking process to identify at-risk individuals and enhance safety within the jail. If these seemingly asymptomatic individuals do have a community mental health treatment history and/or are currently on medications, they can quickly experience psychological decompensation if medications are destabilized or jail conditions trigger symptoms. Collecting information at multiple time points and from multiple sources is a way to reduce the number of 'false negatives'.

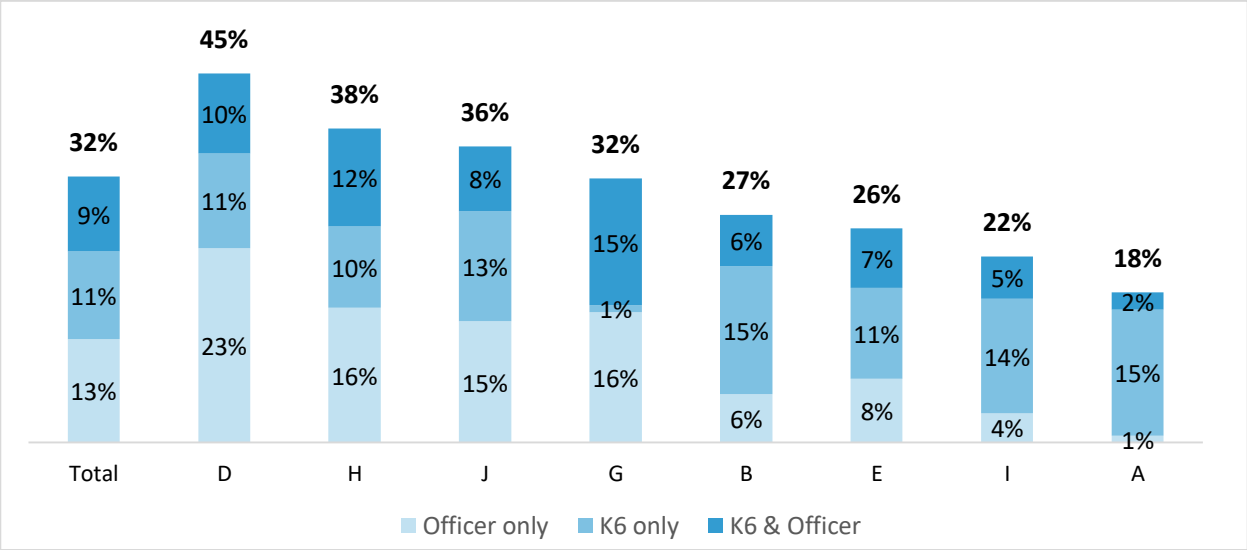
314 with Positive K6 but Negative Identification by Jail Staff

The K6 identified 314 individuals who screened positive for SMI but were not identified by jail staff. There could be several reasons for this incongruence (e.g., inflation of symptoms, falsifying of symptoms, early release). It is also possible that someone without a mental health history or someone who has symptoms that are unremarkable (e.g., withdrawal, sadness, lack of appetite) is not identified by jail staff. Moreover,

these individuals may deny symptoms exist. However, the results in Table 2 suggest that these 314 individuals were experiencing serious distress as their K6 scores averaged 13.5 points (SMI cut score is 9).

Figure 13 illustrates the rates of identification of mental health issues in total and by source (i.e., K6, officer, or both). Prevalence of mental health issues identified by any source ranges from 18% to 45% across sites. The prevalence as identified by K6 alone ranges from 1% to 15%, and the prevalence by officer identification alone ranges from 1% to 23%. These findings demonstrate the improved identification outcome when multiple sources are used.

Figure 13: Rates of Persons with Mental Health Issues and Source of Identification



4. Who receives mental health services within the jail? What proportion of those who screen positive on the K6 receive services within the jail?

The combination of the K6 screening tool and jail staff identification offers insight into who is referred for assessment (or other service) by a mental health professional. Below in Table 2, we present four groups defined by their identification of mental health issues (or lack of) within the jail. Group 1, the largest group (68%, n=2,007), is comprised of individuals who were negative on the K6 screening measure and were not identified by jail staff. Of those 2,007 who were negative on screening and observation, the average K6 score was 1.9 (Note: a cut score of 9 was need to be flagged for SMI). Only 26 individuals were referred, but 72 received an assessment and 62 received a diversion service through one of the pilot programs. It is possible that these were individuals who were asymptomatic, but known to CMH. In contrast, Group 4 (9%, n=268) was positive for SMI per the K6 and were also identified by jail staff. These individuals averaged a score of 14.4 on the K6 illustrating a high degree of distress. Of the 268 identified, 62% (n=167) received a mental health service and 30 received a diversion service. It is unclear why 38% did not receive any service from a mental health professional, but preliminary feedback from staff suggests that early jail release may be one explanation. Subsequent studies will be able to assess this theory.

Table 2: Identification, Referral, and Assessment/Services within the Jail (N=2,961)

	Group 1	Group 2	Group 3	Group 4	
	Negative K6/ NO Jail Identification **n=2,007** **K6 avg=1.9**	**Positive K6/ NO Jail Identification** **n=314** **K6 avg=13.5**	**Negative K6/ YES Jail Identification** **n=372** **K6 avg=3.0**	**Positive K6/ YES Jail Identification** **n=268** **K6 avg=14.4**	**TOTAL 2,961**
Referral	26	8	344	249	627
Assessment/ Services	72	22	243	167	504
Diversion	62	19	32	30	143

Because the K6 was used as a data collection tool only, and jail staff did not know the results of the scoring at the time of booking, *it was not anticipated that those identified as having mental health issues ONLY by the K6 would receive a referral, assessment, or services in the jail. However, it was anticipated that those who were identified by officers would receive a follow-up mental health assessment or service.* Figure 14 below illustrates the relationship between identification by jail staff and subsequent referral and mental health assessment/service by county.

Figure 14: Follow-Up Referrals and Services among those Identified by Jail/Officers ONLY

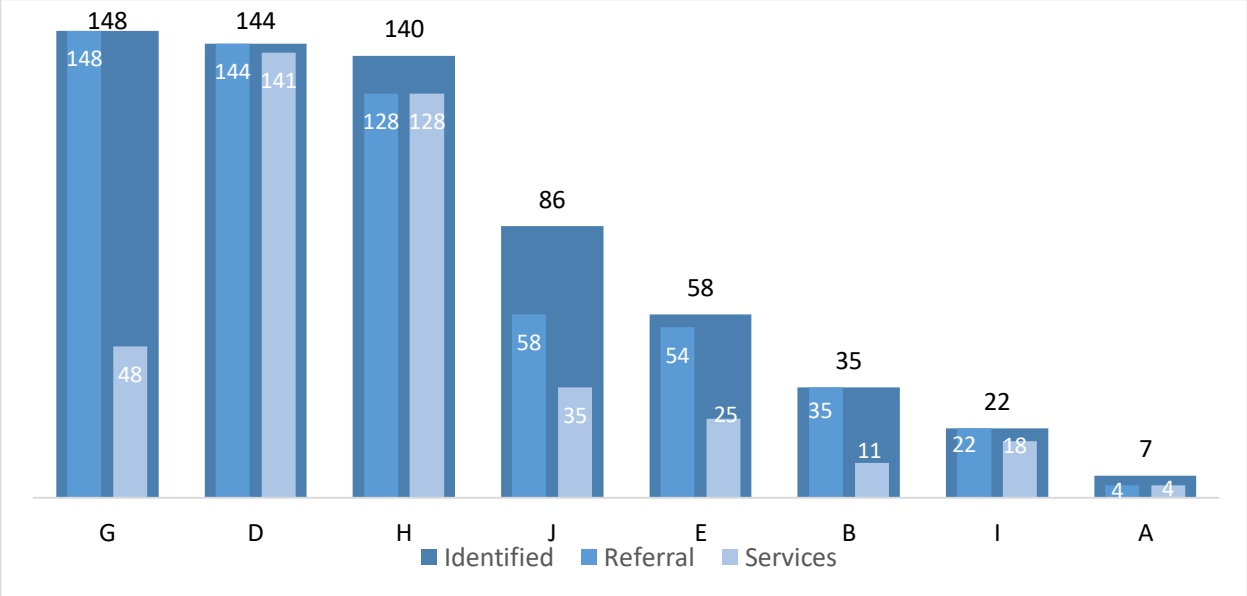


Figure 14 above illustrates the variation across counties in their identification, referral, and provision of mental health services in the jail. In some counties there is near perfect concordance between the number of individuals identified, the number referred, and the number assessed (e.g., County D). In other counties there is wide disparity in the proportion referred versus those who receive a mental health service (e.g., County G). Finally, in some counties, very few individuals are identified (e.g., County A). This variation warrants examination of current organizational processes within the jail.

Organization of Funding and Services Across Sites

In the study of these various county jails, considerable differences were seen in the organization and delivery of mental health services within the jail. These differences include the structure of services (specifically funding mechanism and entity responsible for providing services), practices around identification and referral, and characteristics of service.

Table 3 illustrates the similarities and differences in funding and responsible entity, with special attention to county size (metropolitan, urban and rural), which may impact resources and service delivery. Three possible configurations exist for funding mental health service within the jail: CMH-funded only, jail-funded only, and CMH/jail collaborative funding. In the large metropolitan counties, the jail and CMH share the funding responsibilities. In the urban and rural areas either the CMH *or* the jail fund mental health services within the jail.

Similarly, service delivery within the jail has different configurations. Many of the jails use funds to contract 3rd party providers to deliver mental health services within the jail. These 3rd party providers range from a large corporation (i.e., Correct Care Solutions or CCS) to an individual contracted for a few hours per week. 3rd party providers are responsible for services in four counties; CMH is responsible in four counties; and a CMH-3rd party collaboration is responsible in one county.

It is important to note that the inclusion of 3rd party providers requires more time and attention devoted to communication between these providers and CMH. This is particularly true at jail admission and discharge where regulation of medication is needed. Although this care coordination constitutes best practice standards for continuity of care, the evaluation team noted many instances of communication breakdowns among jail, 3rd party, and CMH staff.

Table 3: Comparison of Jail Mental Health Services and Organization

Jail Based Services		Metropolitan			Urban				Rural		
		D	H	J	B	C	E	G	A	F	I
Structure	Funding Source	CMH/ Jail	CMH/ Jail	CMH/ Jail	Jail	CMH	Jail	CMH	CMH	Jail	CMH
	Service Provider	3rd Party	CMH/ 3rd Party	3rd Party	3rd Party	CMH	3rd Party	CMH	CMH	3rd Party	CMH

To review a more comprehensive grid including funding source, service provider, and identification, referral and assessment within each of the jails, please refer to Appendix C. This appendix also illustrates the effect of current Diversion Council funding on service provision and those jails engaged in actively diverting current detainees.

Conclusions

Using only the K6 results, 20% of individuals booked into the eight county jails examined have symptoms of serious mental illness. This is a lower prevalence than the national rate. A 2017 Bureau of Justice Statistics report on the mental health of national jail and prison populations uses the K6 to establish the prevalence of serious psychological distress. The report, which uses a higher cut score on the K6 (cut score of 13), indicates that 26% of those residing in jails have symptoms of serious psychological distress. However, in the current analysis when results of the K6 *and* identification by jail staff are both considered, the rate of individuals with mental health issues across counties increases to 32%.

Replication of this study across three years demonstrates that the prevalence rate for SMI within these counties is declining. However, the limitations of the study in terms of variation in the data collection methods (e.g., one county collects data at classification, not booking; one county had large refusal rates in 2017), needs to be considered. Nonetheless, counties are engaged in this process and using the results of these studies to improve practices.

The 2017 data collection included the examination of 'practices as usual' within the county jails. To improve outcomes, an understanding of existing processes and their associated outcomes is necessary. Therefore, methods of identification, referral, and screening were examined in relation to the standardized measures. Office identification within the jail was a robust indicator of referral to a mental health service provider within the jail for further assessment; however, many of those identified on the standardized screen were not identified by staff. More specifically, this analysis demonstrates that across the state, the existing screening and referral processes are *identifying slightly over half of those with current mental health symptoms or SMI* and/or a history of mental health treatment. Enhancing the role of the booking officer in the jail identification process to mirror the APA guidelines may improve the number of individuals identified at booking and increase the rate at which individuals with SMI receive referrals and services.

Although there may be concerns that the use of a standardized measure will increase the number of those requiring a professional screening, preventative measures at the front end of the jail intake process may decrease subsequent problematic behaviors, psychiatric decompensation, and even suicidality later in the incarceration period.

Future studies (i.e. Stage 2 on Intercept 3 and 4) will establish a timeline for those identified as having a mental health issue (by the K6 or staff) that will include jail admission and exit to determine if an 'expected' identification or service occurred prior to jail discharge. This temporal approach will provide greater detail and more information to the state as to how jail identification and mental health service can be enhanced.

Appendix A: Measures Included in Jail-Based Screening

The goal of the project was to screen each individual entering the jail for a specific period of time. Multiple measures were used to assess symptoms of SMI, indications of substance use disorder, past use of mental health services, incarceration history and living situation prior to this jail episode. These measures include the following:

1. **Serious Mental Illness (SMI)** was identified using the K6 mental health screening tool, which encompasses six questions regarding symptoms of serious psychological distress or serious mental illness over the past 4 weeks. The symptoms are: (1) nervous, (2) hopeless, (3) restless or fidgety, (4) so depressed that nothing can cheer them up, (5) everything was an effort, and (6) worthless. Respondents indicate how often they experience these symptoms with a value from 0 (none of the time) to 4 (all of the time), with the total score ranging from 0 to 24. A total of 9 or greater indicates SMI symptoms. Note that although the cut score for community samples is 13, studies have found that among jail populations, a cut score of 9 is more accurate in detecting SMI (Kubiak et. al., 2009; 2010).

2. **Substance Misuse or Substance Use Disorder (SUD)** was defined in two ways: alcohol misuse and drug misuse. Single item questions were used in both cases (i.e., How many days in the past year have you had 5 or more drinks in one day? and How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?). Both questions predict the presence of a substance disorder. If a detainee answers one or more days on the drug use question, there is a 74% likelihood of a current drug use disorder (Smith et al, 2010). If the person answers one or more days per year on the alcohol use question, there is an 82% likelihood of an alcohol use disorder (Smith et al, 2009).

3. **Criminal Justice History** was defined as the self-report of 1) incarceration in the current jail within the past 30 days; and 2) incarceration in the current jail within the past year.

4. **Utilization of mental health services** was defined as the self-report of: 1) any receipt of mental health services during the past month; 2) any receipt of mental health services during the past year; and 3) current use of medications for a mental health concern.

5. **Insecure housing situation** was defined using the U.S. Department of Housing and Urban Development definition (2011). A single item question was used: “Where did you live during the four weeks before you came to jail?” In Livingston County, this was asked as an open-ended question with the officer writing down the respondent’s answer verbatim. This differed from other counties, where prescribed response categories included “house/apartment that I own or rent,” “with a family member or friend,” “moved around or stayed with more than one family member/friend,” and “homeless shelter, treatment facility, housing program.” A variable was created to identify participants with insecure living situations.

Appendix B: Data from Jail Administrators

In addition to the above assessments, three months of data was collected from the jail mental health professional on the identification, referral, and assessment of individuals with mental health disorders within the jail. Staff provided monthly updates on the individuals that had been referred for a mental health assessment. This information was used to infer who was identified at booking, as individuals could only be referred for a mental health assessment if identified by jail staff. Each month over a three-month period, jail staff provided information on which individuals within the jail who were identified as having a mental health issue, which were referred to a mental health professional within the jail, and /or which received at least one mental health service within the jail. Jail staff had no indication whether the individuals reported had a positive or negative score on the K6 mental health screen.

Identification: Jail processes for identification of individuals with mental health disorders by jail staff differed by site. Some already used standardized measures at jail booking and others used intake questions to identify individuals. Any individual who answered 'yes' to history of mental health treatment (i.e., psychotropic medications) or current/recent suicidal thoughts was referred to for further assessment by a mental health professional.

Referral: The jail mental health professional recorded all referrals during the data collection period when the presence of an electronic medical or jail record was not available.

Service: The jail mental health professional recorded whether or not a service was provided to the referred individual. The type of service provided was not detailed.

Diversion: Data related to diversion activities funded through the Diversion Council were also applied to the service provision data. This data was collected primarily from the mental health provider funded to implement services, independent of the jail administrators. These services were not uniform across providers – as their program models differed by county – but are included here to assess match between identification, referral and assessment/service by a mental health professional.

Appendix C: Infrastructure and Service Components

The grid below shows the variation in funding mechanism, service providers, and current components of processes to identify, refer, and provide jail-based services.

Jail Based Services		Metropolitan			Urban				Rural		
		D	H	J	B	C	E	G	A	F	I
Structure	Funding Source	CMH/ Jail	CMH/ Jail	CMH/ Jail	Jail	CMH	Jail	CMH	CMH	Jail	CMH
	Service Provider	3rd Party	CMH/ 3rd Party	3rd Party	3rd Party	CMH	3rd Party	CMH	CMH	3rd Party	CMH
ID	Officer Observation										
	MH History Verification										
	Empirically Validated Screening Instrument										
Referral	Automated Flag to MH Services from Screening										
	Instant Communication from Jail to MH Staff										
	Jail & MH Staff Engage in Case Consultation										
Service	Full-time mental health professional at jail	*				*		*			
	Post-booking diversion option at jail	*				*	*		*		*

Key

Jail	Jail/CMH	CMH	Jail/3rd party	3rd party	CMH/3rd party	Not provided	* All or part funded by Diversion Council