The SIMPLE Scorecard

Improving outcomes for people with serious mental illness in the criminal justice system with Sequential Intercept Model Practices, Leadership and Expertise

The SIMPLE Scorecard

Presented by the Wayne State University School of Social Work
Center for Behavioral Health and Justice

Welcome

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The SIMPLE Scorecard

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Center for Behavioral Health and Justice

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The SIMPLE Scorecard

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WAYNE STATE
School of Social Work
Center for Behavioral Health and Justice

We envision communities in which **research**, **data**, and **best practices** are used by multiple stakeholders to *enhance the optimal well-being of individuals with mental illness and/or substance use disorders who come in contact with the criminal/legal system*.

We work with local communities, organizations, and behavioral health and law enforcement agencies across Michigan to provide

EXPERTISE, EVALUATION, TRAINING, and TECHNICAL ASSISTANCE

to optimize diversion of individuals with mental health or substance use disorders from jail or prison.

We Help Stakeholders…

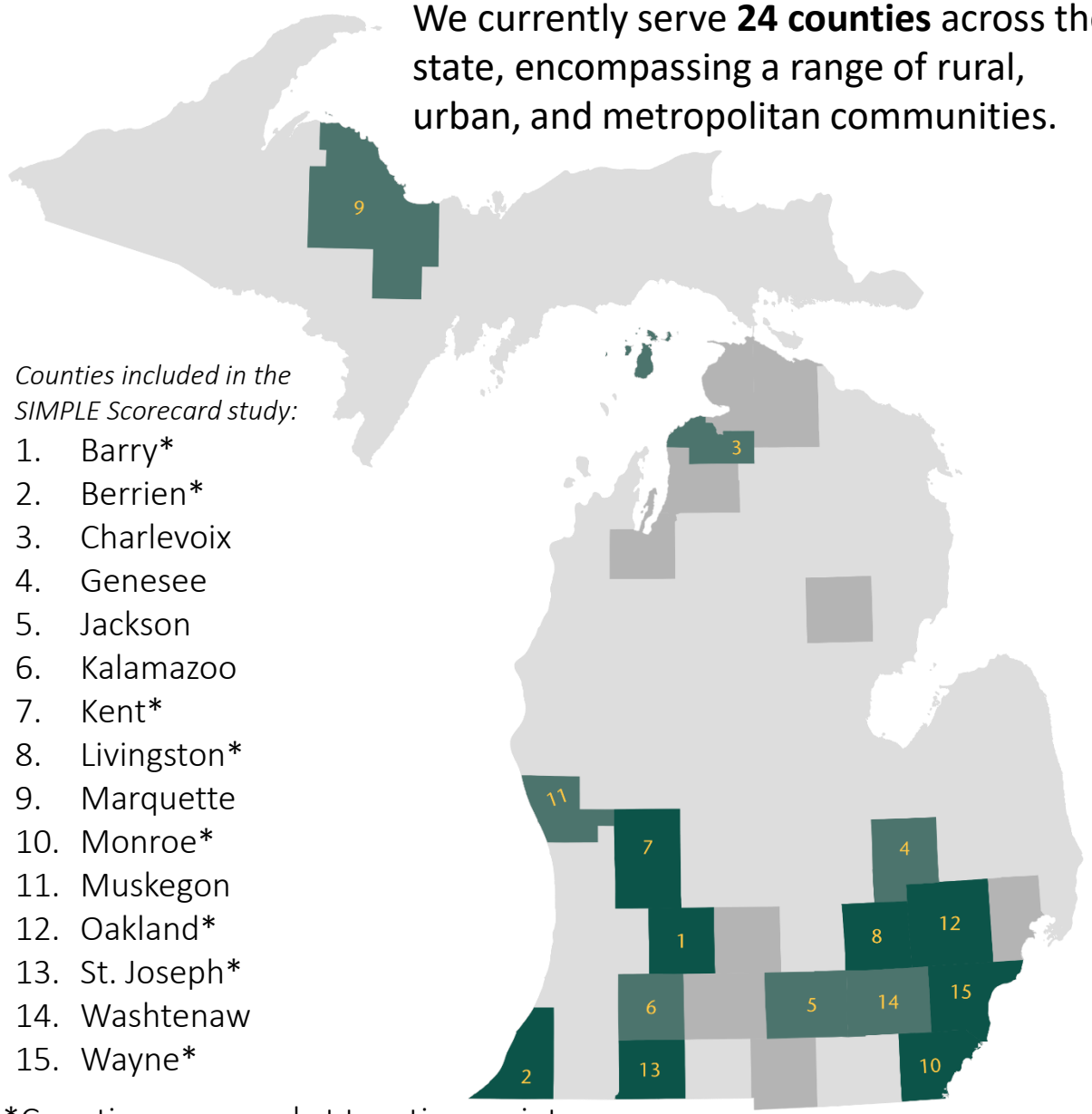
Implement best and innovative practices at every intercept of the criminal/legal continuum.

Collect and use data to drive decisions.

Create linkages to solve problems.

Develop action plans to achieve goals and sustain initiatives.

We currently serve **24 counties** across the state, encompassing a range of rural, urban, and metropolitan communities.

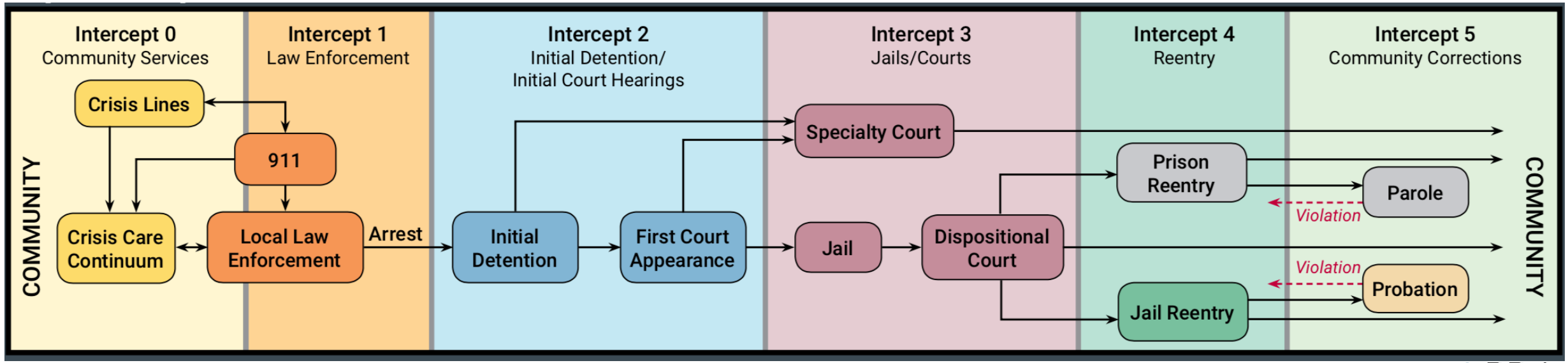


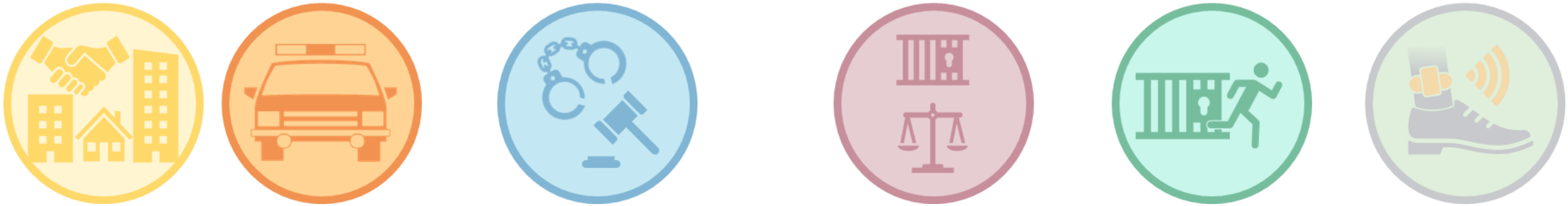
Counties included in the SIMPLE Scorecard study:

1. Barry*
2. Berrien*
3. Charlevoix
4. Genesee
5. Jackson
6. Kalamazoo
7. Kent*
8. Livingston*
9. Marquette
10. Monroe*
11. Muskegon
12. Oakland*
13. St. Joseph*
14. Washtenaw
15. Wayne*

*Counties measured at two time points

Sequential Intercept Model





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.*

The SIMPLE Scorecard

- The Center for Behavioral Health and Justice created the SIMPLE (Sequential Intercept Model Practices Leadership, and Expertise) Scorecard to assess county-level behavioral health and justice collaborations.
- The scorecard could be used as an **evidence-based strategic planning tool** to drive behavioral health and criminal legal system change at a county level.
- Examples of SIMPLE score points included: **alternative law enforcement drop-off** centers, evidence-based **screenings at booking**, and more.
- Pre-booking and post-booking SIMPLE scores were associated with two key outcomes: **reduced prevalence of serious mental illness in jails**, and **more connections to jail-based treatment**.

The **S**equential **I**ntercept **M**odel **P**ractices, **L**eadership, and **E**xpertise Scorecard

Intercept	SIMPLE Scorecard Point	County 1 (2017)	County 1 (2019)	County 2 2017)	County 2 (2019)	County 3 (2019)	County 4 (2018)	County 5 (2018)	County 6 (2017)	County 6 (2019)	County 7 (2017)	County 7 (2019)	County 8 (2017)	County 8 (2019)	County 9 (2017)	County 9 (2019)	County 10 (2017)	County 10 (2019)	County 11 (2018)	County 12 (2017)	County 12 (2019)	County 13 (2017)	County 13 (2019)	County 14 (2019)	County 15 (2017)	County 15 (2019)
Intercept 0	Outside Grant	✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
	County Funding							✓		✓	✓	✓					✓	✓	✓					✓		
	Millage							✓																✓		
	CMH SUD	✓	✓	✓	✓		✓				✓	✓	✓	✓				✓	✓	✓	✓	✓	✓		✓	✓
	ACT			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Intercept 1	Police Training				✓				✓	✓				✓			✓	✓			✓			✓		✓
	Police Coding of MH Calls											✓		✓										✓	✓	✓
	Police Referrals to Tx			✓	✓				✓	✓				✓				✓		✓	✓			✓		
	Dispatch Sends Trained LE			✓	✓																			✓		
	Co-Responder Model								✓	✓															✓	✓
	Alternative Drop Off							✓								✓				✓	✓					
Intercept 2	Evidence Based Screening									✓							✓	✓				✓	✓	✓		
	Diversion						✓		✓	✓	✓	✓	✓	✓	✓	✓			✓					✓	✓	✓
	Jail-CMH Data Matching			✓	✓		✓	✓	✓	✓			✓	✓			✓	✓		✓	✓	✓	✓		✓	✓
	Jail Meetings			✓	✓				✓	✓	✓	✓				✓	✓	✓	✓	✓	✓			✓	✓	✓
Intercept 3	Not For Profit Jail Provider	✓	✓			✓		✓	✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓	✓		
	Jail Clinician	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Jail SUD Services	✓	✓			✓	✓		✓	✓	✓	✓					✓	✓	✓	✓	✓	✓	✓	✓		✓
	MOUD Continuation									✓		✓		✓							✓					
	MOUD Induction																				✓					
	Low Circuit Court to Prison		✓					✓	✓	✓				✓					✓		✓	✓	✓	✓	✓	✓
	Specialty Court	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Intercept 4	No Data Sharing Issues	✓	✓			✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓			
	Release Time			✓	✓						✓	✓										✓	✓			
	Psych Medications			✓	✓		✓								✓	✓	✓	✓		✓	✓	✓	✓			
	Discharge Planning	✓	✓		✓			✓					✓	✓			✓	✓		✓	✓	✓	✓	✓		
	Medicaid Reactivation																	✓								
Intercept 5	Specialty Probation			✓	✓				✓	✓	✓	✓													✓	✓
	CMH-Probation Collaboration			✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					✓		✓	✓
Ldrshp	Champion	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓
	No Resistance to Change	✓	✓		✓	✓		✓		✓			✓	✓		✓	✓	✓	✓	✓	✓	✓		✓		
	Strategic Planning		✓								✓	✓		✓			✓	✓	✓	✓	✓			✓		✓
Expertise	Measure Own Outcomes																			✓	✓			✓	✓	✓
	Networking			✓	✓				✓	✓			✓	✓	✓	✓	✓	✓						✓		
	Evaluation Experience		✓		✓				✓	✓	✓	✓		✓		✓		✓			✓		✓	✓		
	Boundary Spanner	✓	✓	✓	✓		✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓

Pre-booking SIMPLE Score and Jail SMI Prevalence

- Eight counties were assessed for SIMPLE score and jail SMI prevalence at two time points: 2017 and 2019.
- Some counties improved their score by making system changes at intercepts 0 and 1, such as **mental health training** for law enforcement, **coding mental health calls** in police reports, and establishing **law enforcement referrals** to mental health services.
- **Non-rural** counties, as well as those with **high median household income**, were also found to have **fewer SMI bookings**.

County	Pre-booking SIMPLE Change Score	SMI Jail Prevalence Change Score
County A	+3	-2%
County B	+2	-4%
County C	+1	-3%
County D	+1	+1%
County E	+1	+3%
County F	0	0%
County G	0	+9%
County H	0	+13%

*trending significant at p<.10

Counties who improved their pre-booking SIMPLE scores (intercepts 0 & 1) booked *fewer* people with serious mental illness (SMI) to jail two years later*

Post-booking SIMPLE Score and Jail SMI Treatment

- Each dot represents a county's SMI treatment connection score and SIMPLE score at the time of data collection.
- Post-booking SIMPLE score points included: **data matching** between jail and CMH, regular **interdisciplinary meetings** between corrections and mental health staff, **discharge planning** during jail-based mental health services, and more.
- Eight Jail Diversion pilot counties were evaluated twice, and were assigned two dots for SIMPLE scores and jail-based treatment connections in 2017 and 2019.

**Significant at p<.05, after controlling for median household income and county size (rural/non-rural)

A high post-booking SIMPLE score (intercepts 2, 3, 4, & 5) is correlated with the receipt of jail-based treatment**

Intercept 0

Community Services

Outside Grant

Did the county have a grant to help behavioral health services in criminal/legal settings?

Access to outside funding can support programmatic expenses related to innovative change (Abreu et al., 2017; Bonfine, Wilson, & Munetz, 2019).

Counties who were awarded Jail Diversion pilot funding received this point. Stepping Up counties needed to have mentioned a prior grant.

County Examples: Barry, Kalamazoo, Wayne

County Funding

Did the county, sheriff's office, or law enforcement agency pay for a public behavioral health position?

As public mental health providers struggle to fund services outside of state- and federally-driven criteria, funding from other local sources designated toward the criminal/legal system can impact criminal/legal related outcomes (Andrews & Bonta, 2010).

Researchers needed to hear about the funding arrangement to award the point. For-profit mental health services in jails did not count.

County Examples: Jackson, Livingston, Oakland

Millage

Did the county pass a millage to support behavioral health programming?

Some public mental health organizations are able to leverage additional funds from a county-level tax millage to support innovative criminal/legal programming, particularly as jail-based services are not eligible for Medicaid reimbursement. (Andrews & Bonta, 2010)

Researchers needed to hear about the millage from a key stakeholder.

County Examples: Jackson, Hillsdale, Washtenaw

CMH SUD

Was the public mental health organization authorized to bill Medicaid for SUD services beyond its designated 10% carveout?

Some public mental health organizations contract out its SUD provider, and are not able to provide SUD services 'in-house', complicating coordination of care; the presence of SUD presents a high recidivism risk (Andrews & Bonta, 2010)

Researchers needed to hear about whether the CMH could bill SUD services.

County Examples: Genesee, Kent, Wayne

ACT

Did the county have an Assertive Community Treatment (ACT) program?

ACT programs target high-need clients, who are often involved in the criminal legal system, and provide a daily interventions with a team of clinicians. (Beach et al., 2013).

Researchers needed to hear about the presence of an ACT program.

County Examples: Charlevoix, Livingston, Hillsdale

Intercept 1

Law Enforcement

Police Training

Are at least 20% of patrol officers trained in CIT or 50% trained in at least 8 hours of in-service behavioral health training (for Michigan, MMHC, MI-CIS, or MHFA)?

While shorter training modules do not have much of an evidence base, the 40-hour CIT training curriculum has been shown to increase officer mental health knowledge (Compton et al., 2014) and affect officer behavior (Comartin, Swanson, & Kubiak, 2019; Kubiak, et al., 2017; Watson, Compton, & Draine, 2017)

Researchers did not have data on all police departments. A point was awarded if county hosted its own training program, not if they sent a handful of officers to another county's program.

County Examples: Berrien, Calhoun, Kalamazoo

Police Coding of MH Calls

Do officers categorize mental health calls in police reports and report prevalence (MH code used on over 1% of total calls)?

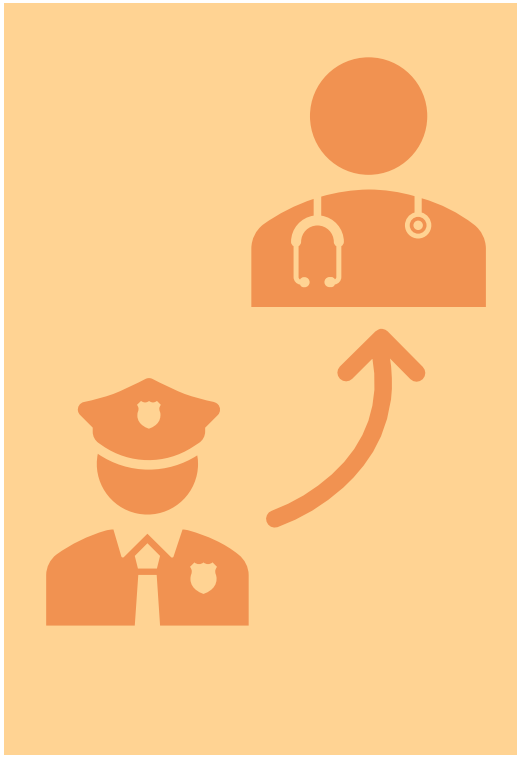
Officers are not likely to divert subjects to appropriate resources without recognition of behavioral health symptoms, and coding of crises is a key indicator for officer recognition. (SAMHSA, 2018).

Researchers did not have data on all police departments. A point was awarded if the county had a reporting mechanism for mental health calls as a proportion of all calls.

County Examples: Kent, Livingston, Washtenaw

Police Referrals to Treatment

Do law enforcement refer directly to CMH or a provider for mental health crises?



Some law enforcement departments have established referral processes after or during crises to coordinate cases with treatment resources; otherwise, the treatment provider may not be aware of emergency incidents. (SAMHSA, 2018)

The CMH had to know about the referrals and talk about how it worked.

County Examples: Monroe, Oakland, Washtenaw

Dispatch Sends Trained LE Officer

Did dispatch know which officers have received behavioral health training, and send them to appropriate crises?

Dispatch has the ability to maximize efficiency by recognizing and sending behavioral health trained officers to crises, who may be less likely to escalate (Morabito, Kerr, Watson, Draine, and Angel, 2012) and result in additional charges.

Researchers did not connect with every county dispatch center. A point was awarded if a CIT or other LE/behavioral health stakeholder mentioned this kind of arrangement.

County Examples: Berrien, Calhoun, Washtenaw

Co-Responder Model

Did the county have a co-responding unit of law enforcement and a mental health clinician to either respond to real-time crises or follow up after mental health-related incidents?

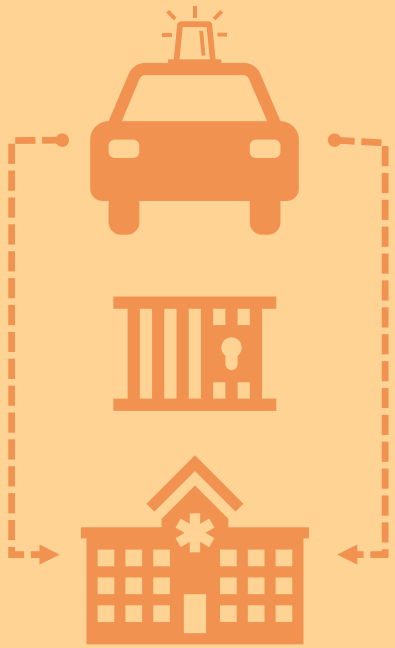
Co-response units, especially those with the capability of responding to real-time crises, are associated with greater linkage to treatment and fewer arrests (Shapiro et al, 2014)

Researchers needed to hear at key stakeholder describe a ride-along program.

County Examples: Kalamazoo, Wayne

Alternative Drop-Off

Did the county have an alternative law enforcement drop-off center?



Behavioral health training for law enforcement is more effective in tandem with an alternative drop-off location than emergency departments (Comartin, Swanson, and Kubiak, 2019).

The drop-off center needed to be a separate location from the jail that CMH would actively promote to law enforcement agencies.

County Examples: Jackson, Marquette, Oakland

Intercept 2

Initial Detention/ Initial Court Hearings

Evidence Based Screening

Did the jail use empirically validated screening instruments to identify and refer people during the booking process?

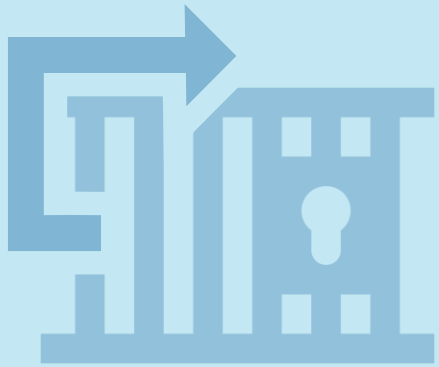
As processes for identifying behavioral health concerns vary widely across jails (Kubiak et al, 2020), using evidence-based screening tools can optimize minimal resources toward a population with behavioral health risk. (Martin, Colman, Simpson, & McKenzie, 2013).

Either the K6, BJMHS, or RODS needed to be used at booking as a referral tool. Other tools would count if they had been empirically verified.

County Examples: Monroe, St. Joseph, Washtenaw

Diversion

Did the county have a program designed to divert pretrial detainees who show signs of mental illness?



Some counties have processes in place to advocate early release when the charges were directly related to a person's behavioral health condition. (Gill & Murphy, 2017)

Researchers needed to hear a program that included advocacy for early release during pretrial status.

County Examples: Berrien, Genesee, Marquette

Jail-CMH Data Matching

Did the county have a mechanism to match CMH client lists with jail bookings on a regular basis?

When systems are in place to match names across public mental health and jail booking databases, jail clinical resources have an opportunity to connect with clients and coordinate jail-based and post-release care. (Gill & Murphy, 2017)

Researchers needed to hear the CMH describe record matching as a regular process, either automated or performed by hand.

County Examples: Genesee, Jackson, Wayne

Jail Meetings

Did the jail have regularly scheduled interdisciplinary meetings to address behavioral health and criminal justice issues for jail case coordination next week or month?

Ongoing communication between jail corrections and clinical staff can preempt crises, and additional charges, through a coordinated approach to cell placement, clinical services, and release planning. (Gill & Murphy, 2017)

Meetings needed to be ongoing at a regular time, where a researcher could theoretically attend.

County Examples: Berrien, Marquette, Monroe

Intercept 3

Jails/Courts

Jail Clinician

Did the jail have dedicated clinician(s) whose primary place of work is the jail?

Though jail-based mental health services are not eligible for Medicaid reimbursement, some counties have clinicians positioned at the jail to attend to ongoing behavioral health needs (Ford, 2015).

A clinician usually had to be 40 hrs/week at the jail. One exception spent 12 hrs/week since it was one of their primary responsibilities, as opposed to access center or emergency mental health callouts for crises.

County Examples: Charlevoix, Livingston, Wayne

Jail SUD Services

Did the jail offer SUD therapeutic services (not just NA or AA)?

As SUD is a criminogenic risk factor (Andrews and Bonta, 2010), jail-based therapeutic interventions targeting SUD may have an impact on subsequent recidivism.

Any SUD clinical service would count if it was not NA/AA, or a vivitrol shot.

County Examples: Barry, Genesee, Kent

MOUD Continuation

Were either Methadone or Buprenorphine available in jail for continuation?

Though Medications for Opioid Use Disorder (MOUD) are the best practice for treating Opioid Use Disorder (Moore et al., 2019), , they are rarely available for continuation in jail, which can lead to relapse and subsequent criminal activity. (Brezel, Powell, & Fox, 2020).

Researchers needed to hear the program mentioned by a key stakeholder. A program for only pregnant women did not count.

County Examples: Kalamazoo, Kent, Livingston

MOUD Induction

Were either Methadone or Buprenorphine available in jail for induction?

Some jails have moved their MOUD programming beyond the point of continuation to an intervention of inducing medications for those showing signs of opioid risk, which may impact ongoing treatment engagement and avoid relapse. (Ferguson et al., 2019).

Researchers needed to hear the program mentioned by a key stakeholder. A program for only pregnant women did not count.

County Examples: Oakland

Specialty Court

Did the county have a specialty court other than a drug or sobriety court?

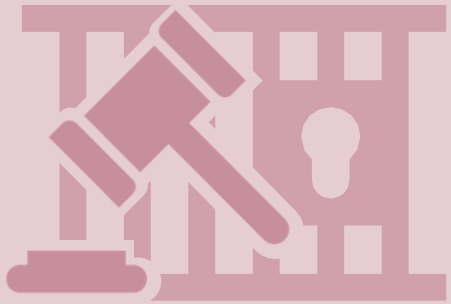
Most counties have either a drug or sobriety court, but some have established mental health or veteran's courts that have shown positive impacts (Steadman et al., 2011).

Used the public database for specialty courts https://courts.michigan.gov/Administration/admin/op/problem-solving-courts/Documents/Forms/AllItems.aspx

County Examples: Berrien, Muskegon, Wayne

Low Circuit Court to Prison

Were under 20% of circuit court dispositions sent to prison?



A proxy for 'tough on crime' approaches to sentencing, circuit court judges weigh prison sentences against jail sentences, which are typically shorter, and may decrease entrenchment in the criminal legal system. (Arazan, Bales, & Blomberg, 2019).

Counties with fewer than 20% prison dispositions gained a point https://www.michigan.gov/corrections/0,4551,7-119-1441---,00.html 2018 data was used for 2019 SIMPLE Score

County Examples: Barry, Livingston, Muskegon

Not For Profit Jail Provider

Did the county contract third-party not-for-profit providers for jail behavioral health programming?

Counties jails with for-profit behavioral health providers serve fewer people than counties with publicly-funded behavioral health providers (Comartin et al, 2020).

The jail's mental health clinicians needed to be employed by a non-profit agency.

County Examples: Barry, Oakland, St. Joseph

Intercept 4

Reentry

No Data Sharing Issues

Have stakeholders described HIPAA/42CFRPart2 as a barrier to care coordination in the jail and upon release?

Misunderstanding of data protection laws can inhibit a continuity of care plan, potentially resulting in a lack of treatment connection post-release. (McCarty, Rieckmann, Baker, & McConnell, 2017

Did researchers hear HIPAA concerns come up in conversations with stakeholders? If not, a county gained a point.

County Examples: Genesee, Kent, Monroe

Release Time

Did the county have a daytime time-served release policy (anything that's not midnight), not just in special cases?

County release time policies vary; releases at 12:01am on the last day of a sentence can be cumbersome to plan around, as most treatment agencies are only open during standard business hours. (McCarty, Rieckmann, Baker, & McConnell, 2017).

5am was the earliest acceptable time. Researchers did not count exceptions for special cases.

County Examples: Calhoun, Kent, St. Joseph

Psych Medications

Were people who receive psychotropic medications in jail routinely released with a prescription or supply, not just upon request, not just if someone takes back what they brought in?

Discontinued psychotropic medication can lead to decompensation, which can inhibit care continuity after release; some jails ease the transition by supplying extra medication or a prescription. (Rohrer & Stratton, 2017).

Stakeholders in the jail could typically describe medication policies. Researchers did not count medications brought in by the individual, or by special request.

County Examples: Berrien, Genesee, Marquette

Discharge Planning

Was discharge planning/care coordination a standard process in jail-based mental health services?

Discharge planning is a distinct phase of jail clinical services that often involves high-intensity case management and linkage to treatment (Osher & King, 2015), though not all jail clinicians provide discharge planning in every clinical service.

By 'standard process', can we assume that everyone who got a mental health service also had a conversation about post-release?

County Examples: Barry, Livingston, Oakland

Medicaid Reactivation

Was Medicaid reactivation part of a standard release process?

Medicaid accounts are suspended during incarceration, and require re-activation upon release; some jails aid continuity of care by installing a process to automatically reactivate Medicaid upon release. (Sinkewicz, Chiu, & Pope, 2018).

One county made an arrangement with the DHHS office to automatically re-activate Medicaid upon release.

County Examples: Monroe

Intercept 5

Community Corrections

Specialty Probation

Did district and circuit courts have specialty probation officers for people with behavioral health needs?

Specialty caseloads can attend to particular behavioral health needs, and which may inform violation decisions that involve a return to jail (Eno Louden, O'Manchack, Connor, & Skeem, 2015).

Researchers needed to hear stakeholders describe specialty probation officers as a distinct role.

County Examples: Berrien, Kalamazoo, Wayne

CMH Probation Collaboration

Did the public mental health system have frequent interactions, a formal interdisciplinary program, a regularly scheduled meeting, referral system or established processes with either probation or parole?

As parole and probation officers frequently encounter people with behavioral health issues, frequent communication with the mental health system may help clients avoid violations through the added support of case management. (Morrissey, Fagan, & Cocozza, 2009).

If a county did not have a formal program or regularly scheduled meeting, researchers also awarded a point if we heard stakeholders describe several informal interactions.

County Examples: Marquette, Monroe, St. Joseph

Champion

Leadership

Did the county have a behavioral health and justice champion, defined as someone who can move a project along regardless of boundaries or institution?

Interdisciplinary work benefits from strong, localized leadership to envision and enact change beyond traditional confines of a segmented system. (Hendy & Barlow, 2012).

Did the key stakeholders have power? As in, could they actively call people to meetings and get people to act?

County Examples: Genesee, Muskegon, Washtenaw

No Resistance to Change

Did leadership welcome change, work through data sharing barriers, or take on new behavioral health and justice matters?

Resistance to change among leadership of any institution in the system can thwart innovative action. (Appelbaum, Degbe, MacDonald, & Thai-Son, 2015).

Was there a person that presented roadblocks to either the data collection or a new project? If not, a county gained a point.

County Examples: Charlevoix, Jackson, Oakland

Strategic Planning

Leadership

Did the county have regular strategic planning meetings to address behavioral health and justice issues?

A formal, scheduled meeting between interdisciplinary partners shows a shared commitment and embedded structure to facilitate system changes. (Vinson et al., 2020).

Strategic planning group needed to have been operating for months prior to K6 collection. Meetings must occur either every month or quarter.

County Examples: Calhoun, Kent, Monroe

Measure Own Outcomes

Expertise

Was the county able to measure outcomes on their own (e.g. prevalence, length of stay, recidivism, and connections to treatment for people with SMI)?

Strategic planning at a county level is best informed by local data, and having internal mechanisms to track outputs and outcomes can expedite the data-driven decision making process. (National Association of Counties, The Council of State Governments, & American Psychiatric Association, 2017).

Could the county report on any of the four key outcomes without 3rd party help?

County Examples: Oakland, Washtenaw, Wayne

Networking

Expertise

Did the mental health staff/supervisors regularly mention connections with counterparts in other counties?

Frequent networking between systems can bolster sharing of best practices and innovative adaptations to common problems. (Steadman, Case, Noether, Califano, & Salasin, 2015).

Did one of the key stakeholders already know other key stakeholders in other counties?

County Examples: Berrien, Kalamazoo, Hillsdale

Evaluation Experience

Expertise

Did the county work with an evaluation organization before the screenings took place?

A working history and familiarity with research institutions, and evaluation methods, can improve knowledge of best and evidence-based practices to implement in the field (Steadman, Case, Noether, Califano, & Salasin, 2015).

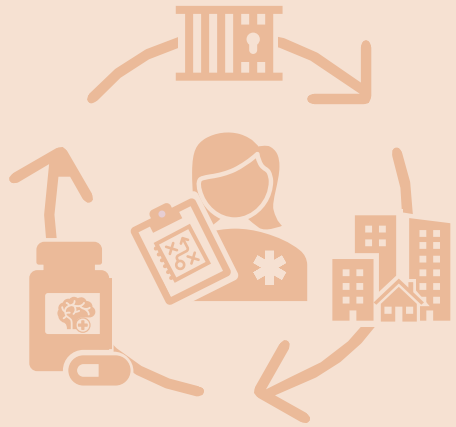
Did we hear them describe working with an evaluator, if they had not worked with the WSU CBHJ in years prior?

County Examples: Barry, Kent, St. Joseph

Boundary Spanner

Expertise

Did the county have a boundary spanner, defined as someone who knows two or more systems intimately?



A champion with 'boots-on-the-ground', a boundary spanner can use knowledge of mental health and criminal/legal systems to advocate for clients at key junctures in a criminal legal system (e.g. bond hearings, sentencing, or enrollment in specialty programs). (Steadman, 1992; Pettus & Severson, 2006; Munetz & Bonfine, 2015).

Did our mental health contact in the county operate across multiple intercepts? Or did they remain siloed within their single intercept?

County Examples: Jackson, Muskegon, Oakland

Median Household Income

Control Variables

Standardized median household income (median household income divided by the standard deviation of the median household income variable).

Richer communities provide more tax revenue to public county systems, and are more likely able to afford private mental health services without burdening the public mental health system.

Link to the data can be found here
https://www.census.gov/library/visualizations/interactive/2014-2018-median-household-income-by-county.html

Rural

Was the county rural?

Rural counties generally have a smaller tax base and smaller public institutions, which makes it difficult to attempt innovative programming at scale.

A county was considered rural if its population was under 100,000.

Wrap Up

- The SIMPLE Scorecard's comprehensive list of practices and policies, linked with key outcome measures, could **direct strategic planning** on a county level
- Some counties excelled in pre-booking intercepts, and others excelled in post-booking intercepts, but **no county received a perfect score**.
- **No single practice or policy was a silver bullet;** multiple points were needed to affect the amount of SMI jail bookings and connections to jail treatment**.**
- **Innovative practices and policies work best in tandem with others.**

The SIMPLE Scorecard

Presented by the Wayne State University School of Social Work
Center for Behavioral Health and Justice

Discussion + Q&A

Facilitated by Rahni Cason

Project Coordinator, Center for Behavioral Health and Justice

Closing Remarks

Presented by Brad Ray

Associate Professor, Director - Center for Behavioral Health and Justice

Thank you