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Mental Health Across the Criminal Legal Continuum: A Summary of Five Years of Research in Ten Counties

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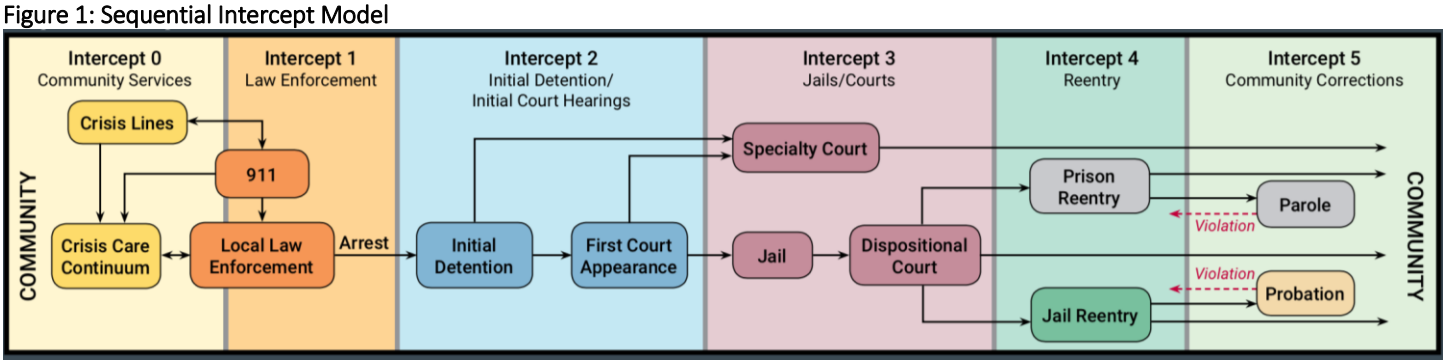
Introduction

The Michigan Mental Health Diversion Council (MMHDC) was established in 2013. The intent and focus of the MMHDC is on diverting individuals with mental health disorders and/or developmental disabilities from the criminal/legal system across the state. The MMHDC systematically organized these activities using the Sequential Intercept Model (SIM) to assess barriers in each of the six intercepts of the criminal/legal system continuum.

Figure 1: Sequential Intercept Model



Data Source: Abreu, Dan, et al. "Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0." Behavioral sciences & the law 35.5-6 (2017): 380-395.

Since then, the MMHDC has initiated several legislative, programmatic, and evaluative projects. This report summarizes the programs initiated by the MMHDC, as well as the evaluation of those initiatives, including: **1) pilot intervention projects (Phase I); and, 2) improvements of county-wide diversion efforts across all criminal/legal intercepts (Phase II)**. Both initiatives have been evaluated by an evaluation team under the direction of Sheryl Kubiak, initially through Michigan State University and now at the Wayne State University Center for Behavioral Health and Justice (CBHJ).

Phase 1

In 2014, the MMHDC, through the Michigan Department of Health and Human Services (MDHHS), sought proposals for jail diversion initiatives statewide. Applicants were to propose interventions at one or more points along the SIM framework (See Table 1). The goal of these initiatives was to determine if these 'pilot' intervention strategies were successful, and, if so, could be replicated in other counties. Recognizing that communities had existing jail diversion efforts already underway, the MMHDC encouraged grantees to utilize resources to initiate or bolster efforts.

Table 1: Alignment of Michigan Mental Health Diversion Council Priorities with the Sequential Intercept Model

2014 MMHDC Priorities for Pilot Projects	Alignment with SIM
Initiate or bolster efforts to expand the use of **Alternative Outpatient Treatment (AOT)** through "Kevin's Law".	0
Initiate expanded services with law enforcement to include **Crisis Intervention Teams (CIT)** training among local police, first responders, and dispatch personnel through use of the 40-hour CIT training model including backfill funding for police officers during training.	1
Explore need for a **centralized crisis assessment** and/or treatment facility for law enforcement to utilize in lieu of jails.	1
Focus on **comprehensive and enhanced mental health treatment** for those in jail and transitioning out of jail including access to psychotropic medications during incarceration and upon release, bolstered housing efforts prior to and after release, minimal wait times to see doctors/psychiatrists in and out of jail, increased support systems prior to and after release, and use of educational and vocational opportunities pre- and post-release.	3-5

Pilot projects were funded in eight counties in 2015 including Barry, Berrien, Kalamazoo, Kent, Marquette, Monroe, Oakland, and Wayne Counties. All programs focused primarily on CIT for law enforcement and jail services. Two additional counties, Livingston and St. Joseph, were funded by 2017. Kubiak and team lead an implementation and long-term outcome study of the pilot projects.

Table 2. Jail Diversion Pilot Programs Approved by the Michigan Mental Health Diversion Council

MMHDC Priorities	Kevin's Law	CIT	Centralized Assessment	Jail Services	Reentry*	Community Support
SIM Intercept	0	1	2	3	4	5
County	Priorities Addressed					
A	X	X		X		
B	X	X		X		
C		X		X		X
D				X		
E		X		X		
F		X		X		
G				X		
H		X				
I		X		X		
J		X**		X		

**All of the jail-based service programs engage in some type of discharge planning or follow-up, however re-entry was not the primary priority.*
***County J initially proposed a pre-arrest diversion program involving a local police department, which was later modified.*
Data Source: Proposals to MDHHS 2014/2015

Phase 2

In 2017, the MMHDC committed to continue to support the initial ten pilot counties to allow those communities to further focus on and bolster diversion efforts across the SIM rather than funding new pilot programs in additional counties. This decision required the initial pilot counties to improve responses to those with mental health issues across all intercepts along the SIM. This expansion in diversion programming required an evaluation encompassing all intercepts—an expansion from the original project-based evaluation focused on the initial pilot programs only. This expanded approach recognized that individuals interact with multiple initiatives across the criminal/legal continuum within the same county and accounts for the influence of multiple interventions within the system. Given that an evaluation of this type had not previously been undertaken across multiple intercepts and within multiple counties, a two-phase evaluation was developed to first assess the baseline operation of the SIM in each county in 2017 and then to assess efficacy by replicating the data collection in 2019.

Report Organization

Using these two programmatic initiatives of the MMHDC and the evaluation research supporting them, this report highlights 'lessons learned' between 2014 and 2019. To do so, it uses data that illustrates prevalence, illuminates intervention implementation, and describes the outcomes related to recidivism, treatment engagement, and continuity of care. In addition, and where relevant, individuals identified with serious mental illness (SMI) within the jail are compared to those without SMI to assess potential differences and areas of needed intervention.

This report is organized by the SIM and begins with law enforcement intervention (Intercept 1) and continues through what we have learned about individuals with mental health issues on probation and parole (Intercept 5). The SIM was updated in 2017 to include Intercept 0 – community services. Because community services were not the primary area of focus, Intercept 0 does not have a separate section in this report. However, in the recommendation section we include changes in community services that may prevent or minimize criminal legal involvement for those with mental health disorders.

Intercept 1: First Responders

Dispatch and law enforcement officers are often the first responders when there is a mental health crisis. They may respond to family and community distress calls or conduct welfare checks. Dispatch units are organized differently across county and municipal governments and are charged with determining what type of emergency exists and who should respond. Early on we learned that dispatch personnel use preapproved queries to determine the nature of the emergency and do not flag or code the distress call as a 'mental health' crisis. If the physical health of an individual is the primary concern (i.e., heart attack, suicide attempt), dispatch will send Emergency Medical Services (EMS) who are mandated to take the individual to a hospital. If the call involves criminal activity, assault, or an individual who poses a threat to medical personnel, law enforcement officers are also called to the scene.

Efforts to educate first responders – or enhance their skills – take many forms across county and municipal law enforcement and EMS. Although, the 'Request for Proposals' (RFP) from MDHHS was specific to CIT, other education and training models were employed during the evaluation period (see the Other Training Options section on page 9). However, because the RFP was specific to CIT, the resources of the evaluation team were used to assess the efficacy of only CIT efforts.

Crisis Intervention Team Training as an Intervention Model for Law Enforcement

Mental health training within the police academy is generally brief. Academy training is more focused on the 'life saving' knowledge required of an officer to work within the community. However, the inability to recognize and appropriately respond to a mental health crisis may result in unintended consequences for the officer and community.

CIT was developed in 1998 by Memphis Police Chief Sam Cochran after an officer shooting of a mentally ill man. He put together a community task force comprised of treatment professionals, law enforcement personnel, and mental health advocates to develop what is now known as the Memphis CIT Model. The primary goals of CIT are to increase safety in police encounters and divert appropriate persons with mental illness from the criminal/legal system into mental health treatment. 'Appropriate' infers a person who does not pose a threat to public safety or someone who has not committed an assaultive offense.

CIT has three core elements:

1. A 40-hour police training model.
2. Collaboration with community partners including mental health providers.[1]
3. A central, psychiatric emergency drop-off with a no refusal policy that gives police priority so officers can be back out on the street within 15–30 minutes.[2]

Although these are the core elements, variations of this model were implemented in Phase I.

Table 3: Crisis Intervention Team Training by County 2015 - 2018

County	New Program	Training Type	Training Target			# CIT Trained Officers	Length of CIT Training Delivered (Hours)	Presence of Advisory Board	24-hr Drop-Off Available	Alternative Training Offered
			Patrol	Dispatch	Jail					
A*	X	Adult	X		X	6	24	No	No	MHFA
B	X	Adult	X	X	X	56	40 / 24	Yes	No	N/A
C**		Adult/Youth	X			139+	40 / 8	Yes	No	N/A
D†	X	Adult	X	X	X	143	40 / 32	Yes	Pending	N/A
E	X	Adult	X			0	N/A	No	No	MMHC
F	X	Adult	X	X		18+	16	Yes	Yes	N/A
G‡	X	Adult	X		X	7	24	No	No	MHFA
H	X	Adult/Youth	X	X		217	40 / 8	No	Yes	N/A
County H Jail	X	Adult			X	306	8		NA	N/A
I	X	Adult	X			0	N/A	No	No	MMHC

Data Source: County proposals to MDHHS; Interviews with County Stakeholders
**In County A, an initial 40-hour CIT was offered, but efforts switched to an 8-hour MHFA model.*
*** In County C, 40-hour CIT was offered to officers under a previous diversion grant.*
† In County D, an initial 40-hour CIT was offered, but recently moved to an abbreviated 32-hour CIT curriculum. Both were implemented in 2018 under a separate grant.
‡ In County G, officers were initially trained in MHFA; training advanced to a 24-hour CIT model in April 2018.

[1] *Dupont, Cochran & Pillsbury, 2007.*
[2] *Steadman et al 2001.*

Assessing Crisis Intervention Team Training Effect on Officer Knowledge and Skill

Standardized measures were used to assess officer's attitudes and knowledge about psychiatric treatment within the community (Opinions of Psychiatric Treatment (OPT) measure) and their skills in de-escalating a situation (De-Escalation Scale). Across sites, officers demonstrated acquisition of more accurate knowledge about psychiatric treatment, showing a statistically significant increase in the average score[3]. It should be noted that males demonstrated a greater increase in their knowledge acquisition[4], but there were no significant differences in change scores on the OPT scale by education level, or number of years in law enforcement.

CIT was successful in increasing de-escalation skills among patrol officers, corrections officers, and dispatchers[5]. There were no significant differences in change scores on the De-Escalation Scale by gender, type of officer, education level, or number of years in law enforcement.

Comparing Sites on Training Outcomes

While the evaluation did not set out to compare counties to each other, a natural experiment is occurring among the pilot sites because of the differences in the trainings being offered across the counties. While there were differences in the 'change scores', the change between pre- and post-tests, the differences on both scales are not statistically significant. However, the lack of statistical differences in these scores should not suggest that there is no difference in a 40-hour training versus a 24-hour training. The lack of difference is likely reflective of the measures used[6] that may capture the 'essence' of any CIT training or it could be a reflection of small numbers in some of the counties. These differences should be monitored over time, using more rigorous randomized design, as well as behavioral and practice outcomes.

Behavioral Outcomes Associated with Crisis Intervention Teams

Attempts to measure behavioral outcomes associated with CIT training focused on officer interviews pre-/post-training and monitoring police decision-making regarding drop-offs to a crisis center.

Interviews

Twenty-one officers and sergeants were interviewed in two counties (one west and one east; one urban and one metropolitan). 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 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*."

> "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.

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*."

Officer Response within the County

Only County H had access to a 24-hour crisis drop-off center for law enforcement officers and provided access to law enforcement data (Sheriff's Office). The prevalence of calls to dispatch coded as involving mental health issues and/or suicide attempts were analyzed. Figure 2 shows that 568 officer call reports in one year (2015) involved those with a mental health or suicide designation, and 465 individuals dropped off at the crisis center by an officer. Accommodating the incidents that link call reports and crisis center 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[7] in one year.*

Figure 2: County H Sherriff's Interactions with Persons with Mental Health Issues in 2015

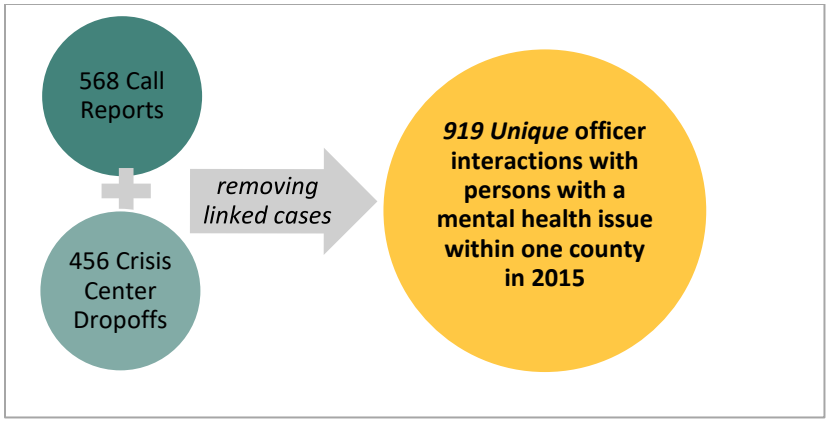
[3] *Statistically significant differences suggest that the change was not a result of 'chance' and therefore the change is the result of the intervention – in this case, the training. Average change score of 6.2 ($t(117)=11.5, p<.001$)*

[4] *Males increased their knowledge on the scale by an average of 6.9 points, compared to 4.3 points for females ($t(116)=2.097, p<.05$).*

[5] *Again, this statistically significant result indicates the change was not a 'chance' occurrence. Average change score of 1.3 between pre and post ($t(116)=-6.135, p<.001$).*

[6] *Measures were selected from those tested by Broussard, Compton and colleagues (2011) in an evaluation of CIT in one state. The measures selected here OPT and de-escalation were the only two with strong psychometric properties and likely represent the 'essence' of any CIT training.*

[7] *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.*



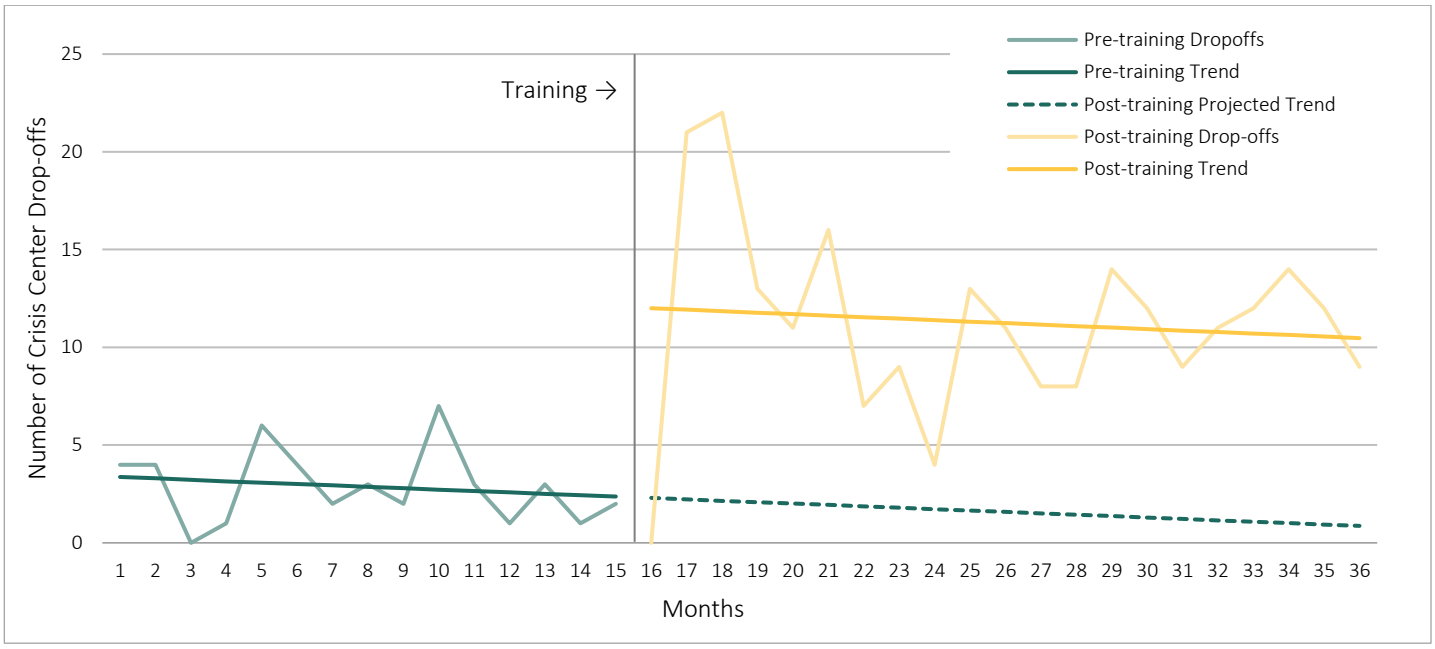
Data Source: County Sheriff Call Reports; County Crisis Center Sign in Logs

County H began providing CIT training in May 2015.

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

A more sophisticated analytic technique (Interrupted Time Series Analysis) was used to determine if the behavioral change in transportation decisions to the crisis center was statistically significant and if the post-CIT training behavioral changes were sustained over time. Figure 3 shows that there was an immediate increase in transport decisions to the crisis center following training.

Figure 3: Trends in Transport Decisions to Crisis Center



Data Source: County Sheriffs Data 2015-2017

What Factors Predict Deputies' Decisions to Transport to the Crisis Center?

After analyzing transport decisions, other information from the call reports was used to understand what predicts a deputy's decision to transport an individual to the crisis center versus ER. After removing cases where there was evidence of physical injury[8], a statistical model was used to examine the factors associated with an officer transport decision to the crisis center[9]. This analysis found:

- Non-intoxicated individuals[10] were 2.6 times more likely to be transported to the crisis center than those who were intoxicated.
- For every 1-mile increase in the distance between the call location and the crisis center, officers were 1% less likely[11] to take the individual to the crisis center.
- CIT officers[12] were 3 times more likely to transport to the crisis center than non-CIT officers.
- Calls coded as mental health[13] were 4.5 times more likely to be transported to the crisis center than those coded as suicide.

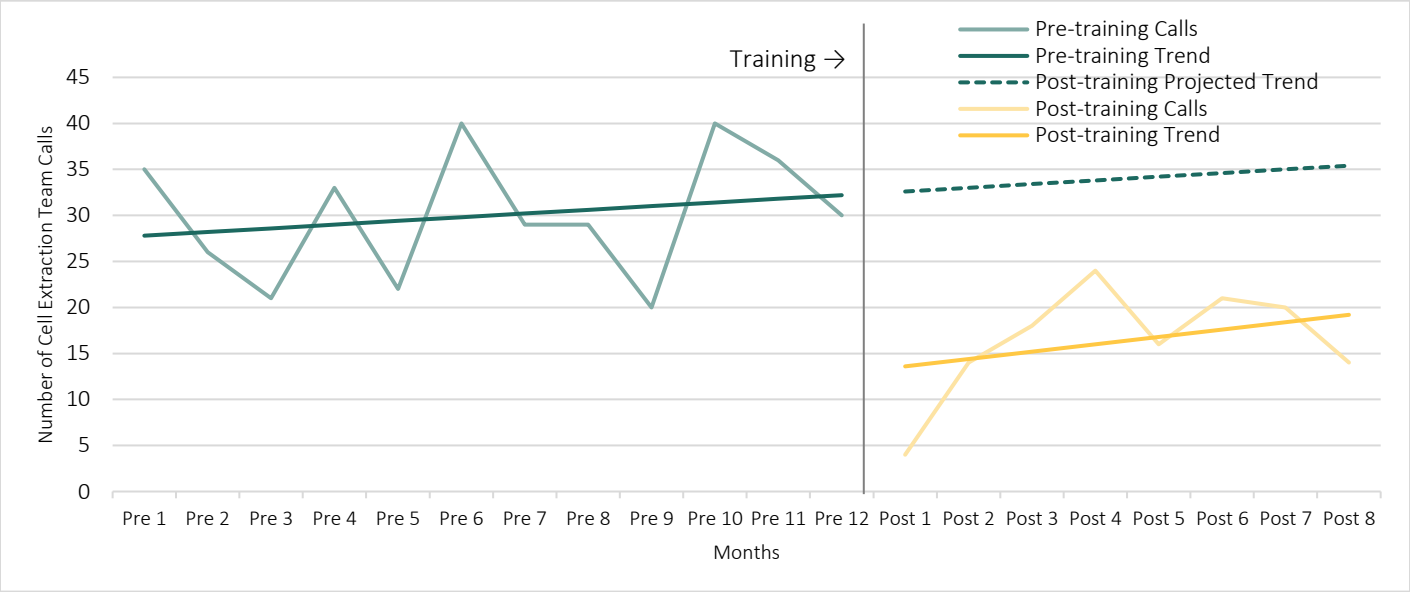
Jail-Based Crisis Intervention Teams

During the third year of grant funding, a modified version of CIT was offered to all corrections officers working within the County H Jail. The 8-hour training focused primarily on de-escalation techniques. The outcome for assessing the effectiveness of the training was based on two measures: 1) pre/post test scores on similar measures used in community CIT; and 2) the number of times the jail's Cell Extraction Team (CET) was called in to assist in moving a jail detainee from their cell. The CET is a group of corrections officers specifically trained and equipped to respond to incidents of non-compliance within the jail.

In 2017, 305 Corrections Officers (COs) in the county jail attended an 8-hour CIT training. Evaluation of outcomes found:

- COs significantly changed their attitudes towards individuals with mental illness, their de-escalation skills for this population, and their feelings of confidence in handling someone in crisis.
- In the 12 months prior to CIT implementation, there were an average of 30.1 calls for the CET; 8 months after, there was an average of 16.4 calls for CET.
- There were 18.7 fewer requests for the CET 3 months after the training and 14.6 fewer requests 8 months post-training.

Figure 4: Trends in Request Calls for the Cell Extraction Team



Data Source: County Jail Cell Extraction Reports

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

[9] $\chi^2(8, N=663)=91.950, p<.001$

[10] *Wald=12.486, p<.001*

[11] *Wald=6.087, p<.05*

[12] *Wald=24.305, p<.001*

[13] *Wald=23.091, p<.001*

Other Training Options

Michigan Crisis Intervention System (MI-CIS) was developed in collaboration with Western Michigan University (WMU) Homer Stryker M.D. School of Medicine, MDHHS, and Kalamazoo County Mental Health and Substance Abuse Services (KCMHSAS). MI-CIS is an inter-professional educational curriculum targeting first responders that has many modules available online, with in-person scenario training limited to two 8-hour days. This option allows officers to take modules of the training during 'down' times at work or in their patrol car, thus eliminating the need for 40 hours of training in one week and decreasing the amount of 'backfill' required to replace officers who are in training. The evaluation of this curriculum is underway by Stacy A. French, Ph.D., from WMU.

Managing Mental Health Crisis (MMHC) was developed based on the Massachusetts Municipal Police Training Committee program in conjunction with the University of Michigan and initially piloted in Washtenaw County before being adopted by the MMHDC. MMHC is a two-day training that combines law enforcement and mental health professionals. It uses principles of CIT and Mental Health First Aid and can be a very good in-service or new recruit training. Many counties concerned with the 40 hours of backfill necessary for a full CIT model are opting for this training. Two of the pilot counties have implemented MMHC as part of an overall law enforcement training strategy.

Mental Health First Aid (MHFA) is an 8-hour course targeting community members, teachers, first responders and other community groups. It teaches participants how to identify, understand, and respond to signs of mental illness and substance use disorders. The adult course is appropriate for anyone 18 years and older who wants to learn how to help a person who may be experiencing a mental health related crisis or problem. Topics covered include anxiety, depression, psychosis, and addictions. Two pilot counties have implemented MHFA in lieu of the more resource-intensive CIT model; one of which is now in the process of implementing an abbreviated CIT curriculum.

Intercept 2: Initial Jail Detention and Courts

Identification, Referral and Service within the Jail

Post-arrest, individuals are routinely taken to the district or county jail. The American Psychiatric Association (APA, 2000) has established guidelines for best practices for identification of mental health issues, followed by referral and service guidelines.

Table 4: American Psychiatric Association 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.

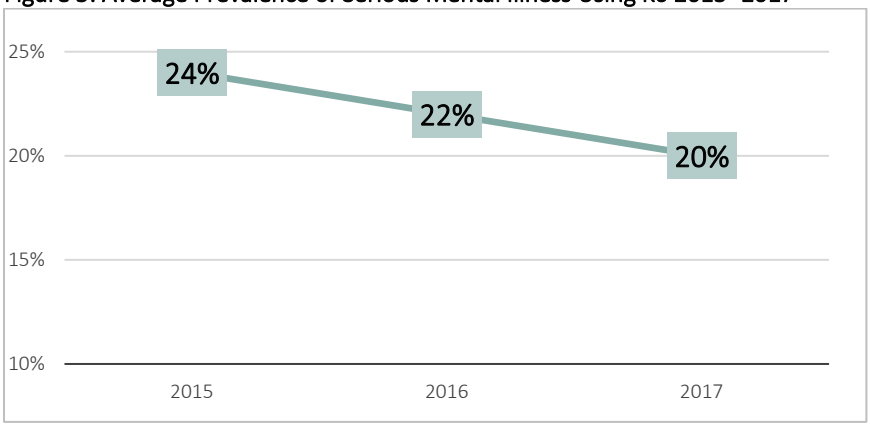
Data Source: American Psychiatric Association (2000)

Identification Using Evaluation Tools

While best practices (and the Michigan Department of Corrections (MDOC) administrative rules) require all jails to do mental health screening, the methods—as well as their reliability and results– vary across jails. Jails may rely on a single question (i.e., 'Are you suicidal?'), an individual's history in the jail or Community Mental Health (CMH), and/or, in some cases, a standardized screening tool. Because the variation in screening methods at jail booking made it difficult to compare the prevalence of SMI across all ten jails, the evaluation team used the same standardized 6-item mental health screening tool (the Kessler 6 (K6)) to assess the population entering each of the jails during multiple years. In addition to this standardized screening tool, the evaluation team also included questions about current mental health medications and history of treatment, as well as indicators for other criminogenic risk factors (i.e., substance use, housing instability, and recent recidivism).

In 2015, the evaluation team began an anonymous collection of baseline booking data using the standardized screening instrument described above. Prevalence rates for SMI in the first collection ranged from 17% - 37%; often varying by method of collection or jail practices. In subsequent more systematic collections, we find that prevalence – based on K6 screening alone – range from 16% - 22% across jails – suggesting a statewide prevalence of 20% using the standardized measure only.

Figure 5: Average Prevalence of Serious Mental Illness Using K6 2015 -2017

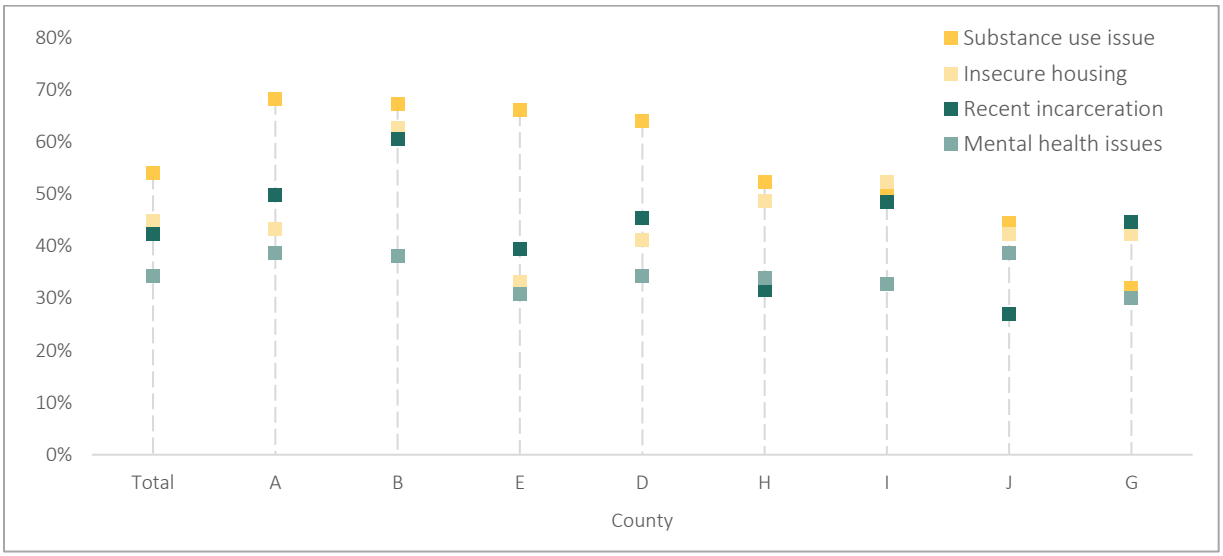


Data Source: Evaluation Team Primary Data Collection in Target Jails 2015-2017

For the most recent collection in 2017, the evaluation team moved to collecting an identified screening tool. The need for identifiers was motivated by the change to a 'system wide' evaluation, allowing the team to 'follow' the individual through multiple state and county administrative databases. In this 2017 collection, there was an established goal of 455[14] completed and usable mental health screens at each jail. Duration of data collection differed based on the number of bookings at each jail. Large metropolitan jails collected for approximately one week; urban jails collected for approximately two weeks; rural jails collected for six weeks. A total of 2,972 screens were collected across eight jails[15] - falling short of the intended goal. Collection issues at two jails greatly contributed to this shortcoming.

Figure 6 provides a snapshot of the variation in risk factors across the county jails. Results show that over half (54%) of all individuals booking into all jails reported some type of substance use issue; just under half reported insecure housing (45%) or recent incarceration (42%); and over one third (34%) had an indication of mental health issues. It should be noted that the mental health risk factor is calculated using both a positive K6 and/or a report of recent mental health treatment.

Figure 6: Risk Factor Rates by County



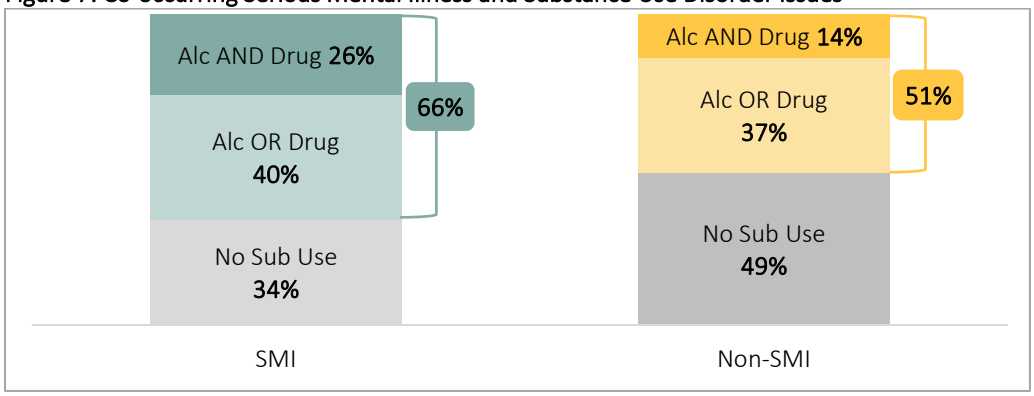
Data Source: K6 Collections across jails 2017

Using only the K6, 20% of individuals entering jail met criteria for SMI, with a range between 16% and 22% across the jails. However, the rates vary by certain demographic characteristics: 28% of women score positive on the K6 compared to 17% of men.

In addition, those with SMI also had higher incidence of substance use disorders (SUD) as shown in Figure 7.

[14] *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.*
[15] *Data from two jails were excluded from this analysis due to issues with data collection and limited reliability.*

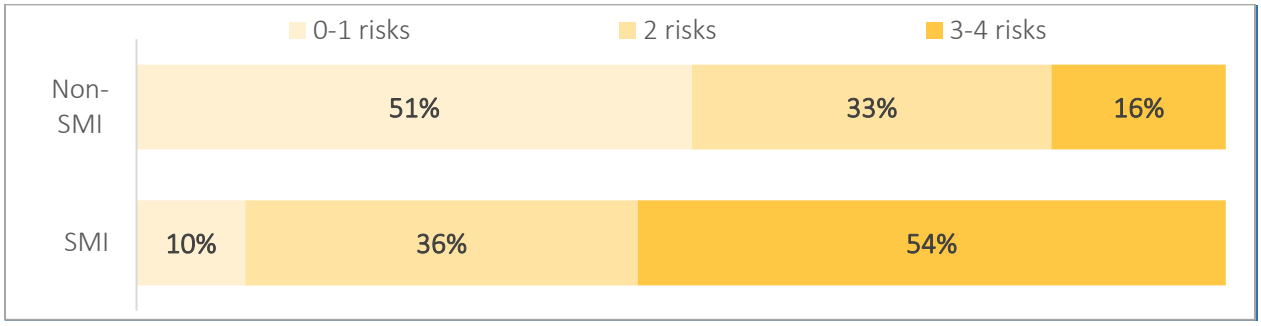
Figure 7: Co-occurring Serious Mental Illness and Substance Use Disorder Issues



Data Source: K6 Collections across jails 2017

To account for the cumulative nature of risk, we calculated the number of risk factors (i.e., mental health issues, substance abuse issues, housing insecurity and recent incarceration) per person and assessed differences between those with and without SMI symptoms. Figure 8 illustrates that those with SMI are much more likely to have 3 and 4 risks compared to Non-SMI. In fact, over half of the individuals (54%) entering jails with symptoms of SMI have 3 or 4 risk factors. In comparison, half (51%) of those entering without symptoms of SMI have 0 or 1 risks.

Figure 8: Number of Risks/Needs by Mental Health Identification Type



Data Source: K6 Collections across jails 2017

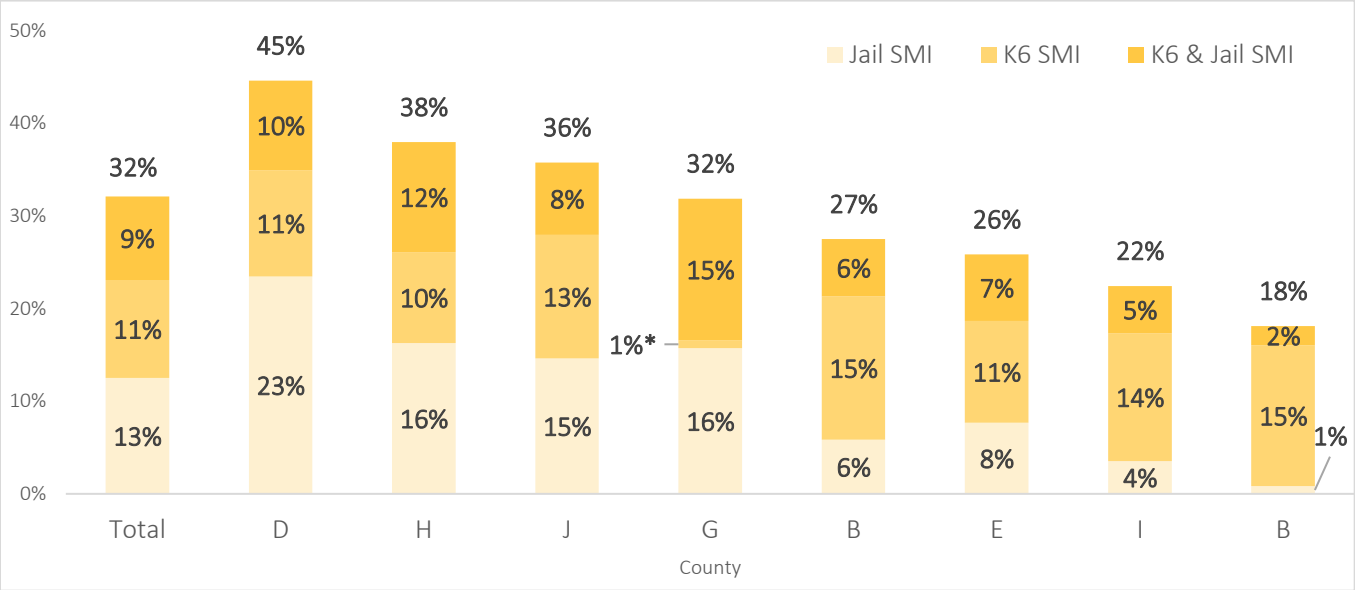
Identification Using Jail Practice as Usual

Using the standardized K6 screen and identification by jail staff 32% of those entering county jails were identified as having mental health concerns. It is clear that the use of both methods augment each other and offer greater ability to detect mental health concerns. The K6 identified 33% more individuals than officer identification alone. Of those **identified** with mental health concerns:

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

Figure 9 illustrates the rates of identification of mental health issues and by source (i.e., K6, Jail, or K6 & Jail SMI). 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 Jail identification alone ranges from 1% to 23%. **These findings demonstrate the improved identification outcome when multiple sources are used (e.g., officer observation, recent history of treatment/medications, and standardized tools).**

Figure 9: Rates of Persons with Mental Health Issues and Source of Identification

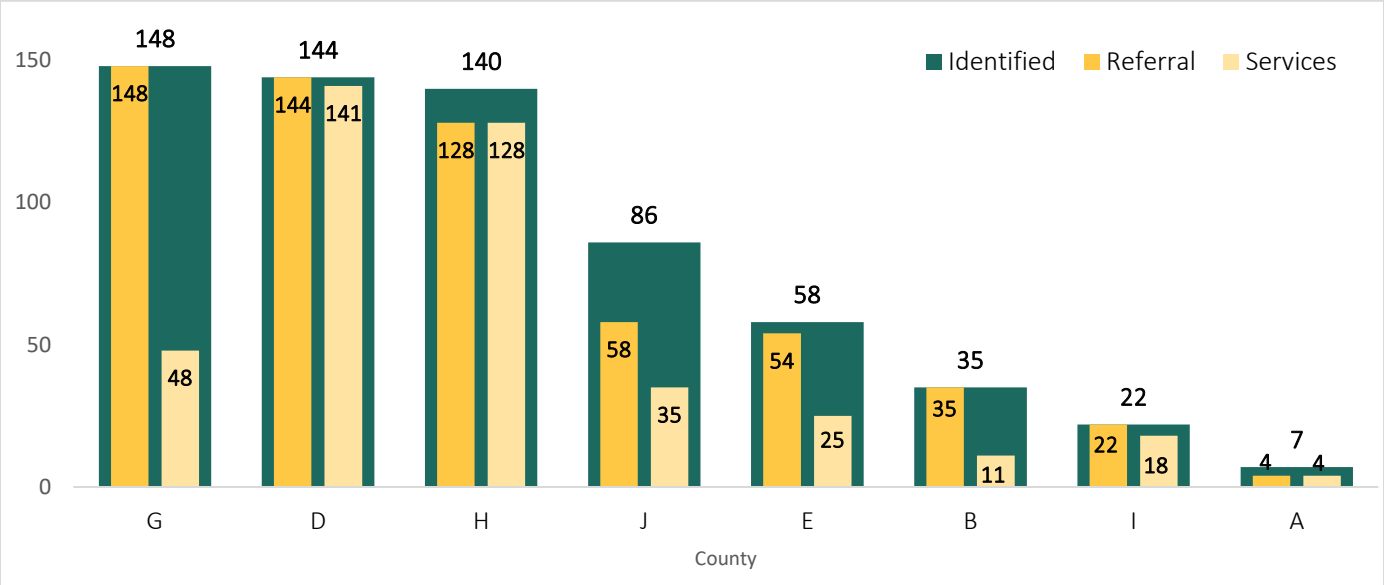


**This jail uses the K6 as their screening tool related to officer identification, which is why the K6 only is so low.*
Data Source: K6 Collections across jails 2017 and Jail Identification data across counties

Referral and Service

It was anticipated that those who were ***identified by the Jail*** *(Jail SMI) would receive a follow-up mental health assessment or service.* Figure 10 below illustrates the relationship between identification by the Jail and subsequent referral and mental health assessment/service by county.

Figure 10: Follow-Up Referrals and Services Among Those Identified by Jails



Data Source: County-level Jail and Treatment Provider Data

In some counties there is near perfect concordance between the number of individuals identified, the number referred, and the number receiving a mental health service (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.

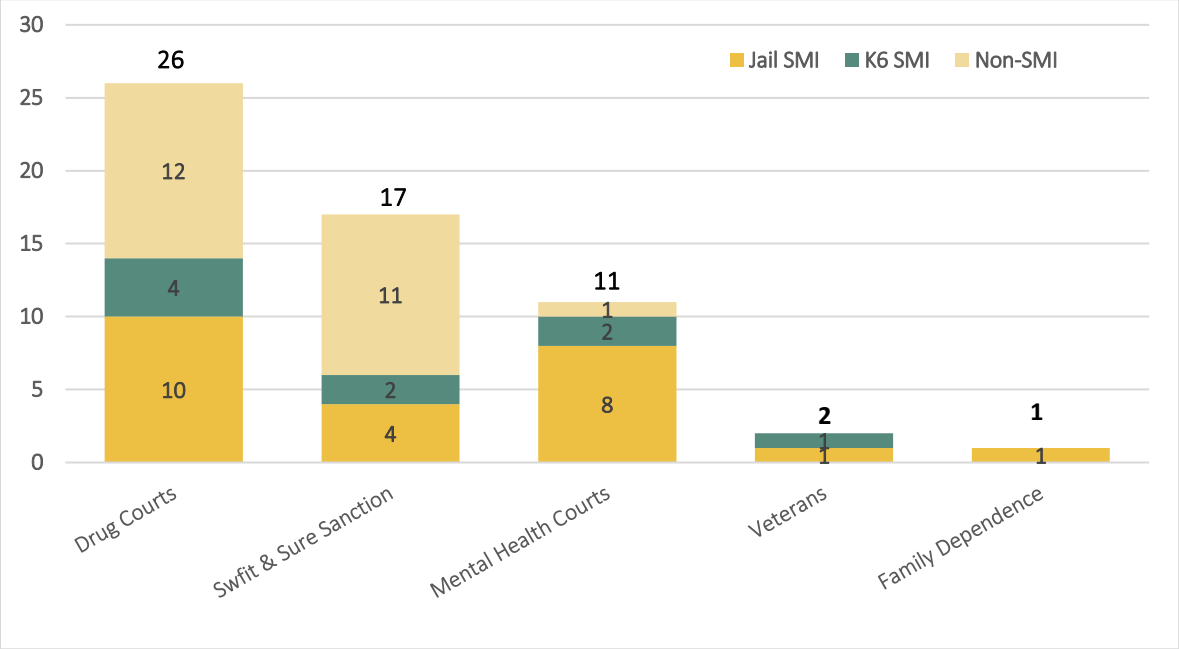
Courts

We drew a subsample of 1,160 individuals to examine the characteristics of the offense, court involvement and jail stay associated with the data collected at booking in 2017. Within this subsample there were individuals identified by the jail as having SMI (Jail SMI), those identified by the K6 (K6 SMI), and those who were Non-SMI.

Specialty Court Involvement

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

Figure 11: Individuals in Specialty Court by Mental Health Identification Type

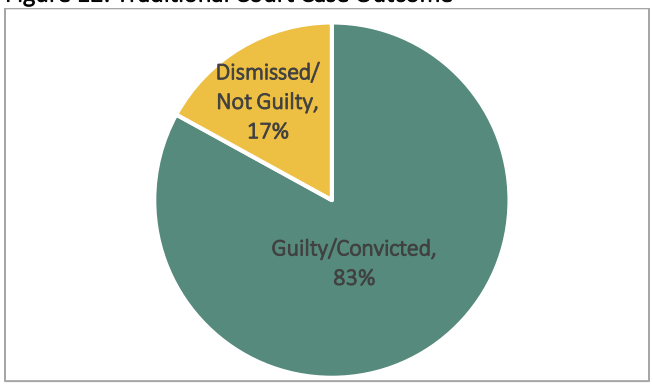


Data Source: SCAO; Sample Size 57

Traditional Court Processing

There are a total of 45 traditional courts across the eight counties. Of those courts, 39 report court data to the Judicial Data Warehouse (JDW) and six do not. Of the eight counties examined for court processing, seven counties had at least two courts reporting to JDW; one county had no courts reporting to JDW. Due to these non-reporting communities, the JDW contained only 59% of the cohort sample (n=684).

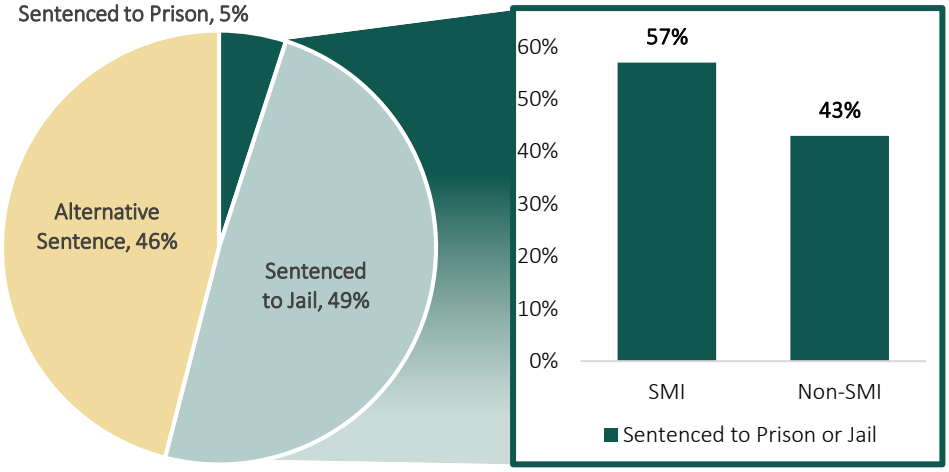
Figure 12: Traditional Court Case Outcome



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

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

Figure 13: Sentencing Outcome (a) by SMI-status



Examples of Alternative Sentence include fines, community service, and probation.

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

Individuals with SMI were more likely to be sentenced to jail or prison (57%) than Non-SMI (43%)[16]. There was a significant difference in the proportion of individuals sentenced to jail or prison by county[17]: County G (31%), County C (47%), County A (52%), and County E (57%) sentenced fewer individuals to jail or prison compared to the remaining six counties. This was likely related to county size, as urban jails sentenced fewer individuals to jail/prison (42%) compared to rural (64%) and metropolitan (69%) jails[18]. Examples of Alternative Sentence include fines, community service, and probation.

Intercept 3: Jail-Based Services

Organization and Funding of Services within Jails

Mental health services within jails are generally a function of how service delivery is organized and funded. Configuration of who provides services – and how those services are paid for – vary by county. In general, there are often strained relationships between the jail and the CMH organizations. In the pre-award period, in half of the counties, mental health services were supported solely by the jail, with little or no interaction with CMH. During the grant period, all of the counties moved toward a collaborative care model with improved communication and coordination of services between the jail and CMH. In fact, in three counties, this grant marked the first time CMH organizations were permitted to provide services within the jail.

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 encompasses varying configurations organizational structure and type of services available. Some jails have full treatment capability (i.e., psychiatric beds or mental health units) while others facilitate medication continuity and crisis services only. Many of the jails use funds to contract third-party providers to deliver mental health services within the jail. These third-party providers range from a large corporation to an individual contracted for a few hours per week. Third-party providers are responsible for services in five counties; CMH is responsible in four counties; and a collaboration between CMH and a third-party provider is responsible in two counties.

It is important to note that the inclusion of third-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 the jail, third-party provider, and CMH staff. Our interviews with jail staff suggest that third-party providers are less interconnected with jail administrators and staff, the community, and with individuals with SMI. Additionally, third-party providers were often less willing to share treatment data with the jail or the evaluation team as there were no contractual agreements specifying who owned or had access to their data.

[16] $\chi^2(1, N=466)=4.4, p<.05$
[17] $\chi^2(7, N=466)=48.016, p<.001$
[18] $\chi^2(2, N=455)=30.7, p<.001$

Table 5 illustrates the varying funding and service structures across the ten counties, with special attention to county size (metropolitan, urban and rural). Choice of organizational configuration of funding and service delivery within a county may impact available resources and continuity of care.

Table 5: 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	CMH/ Third-Party	CMH/ Third-Party	Third-Party	Third-Party	CMH	Third-Party	CMH	CMH	Third-Party*	CMH

Data Source: Site Visits & Interview data
**County F was excluded from analysis due to insufficient data collection.*

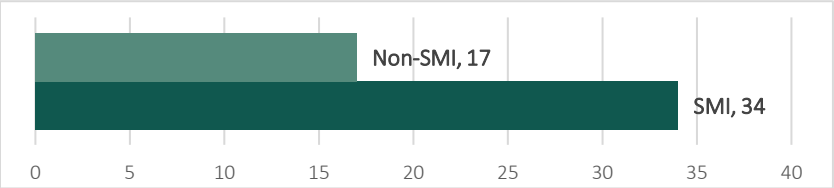
Compared to individuals in jails with third-party providers, individuals in jails with CMH providers are:

- 2.0 times more likely to be identified with mental health issues
- 2.4 times more likely to be referred to services
- 2.1 times more likely to receive a mental health assessment/service

Jail Length of Stay

In the subsample of 1,160 individuals associated with the target booking in 2017, we compared those with symptoms of SMI (K6 SMI & Jail SMI) and Non-SMI, on length of jail stay. Figure 14 and 15 illustrate longer stays for those identified as having SMI, compared to those without – even after controlling for offense type. This finding was consistent across all but one jail. The evaluation team is unable to explain this finding at this time, but has begun to examine possible contributing factors, including pre-trial risk assessments, variation in ability to post bail, or forensic center delays. Additionally, it could be hypothesized that medication dysregulation or behavioral issues within the jail might explain this variation.

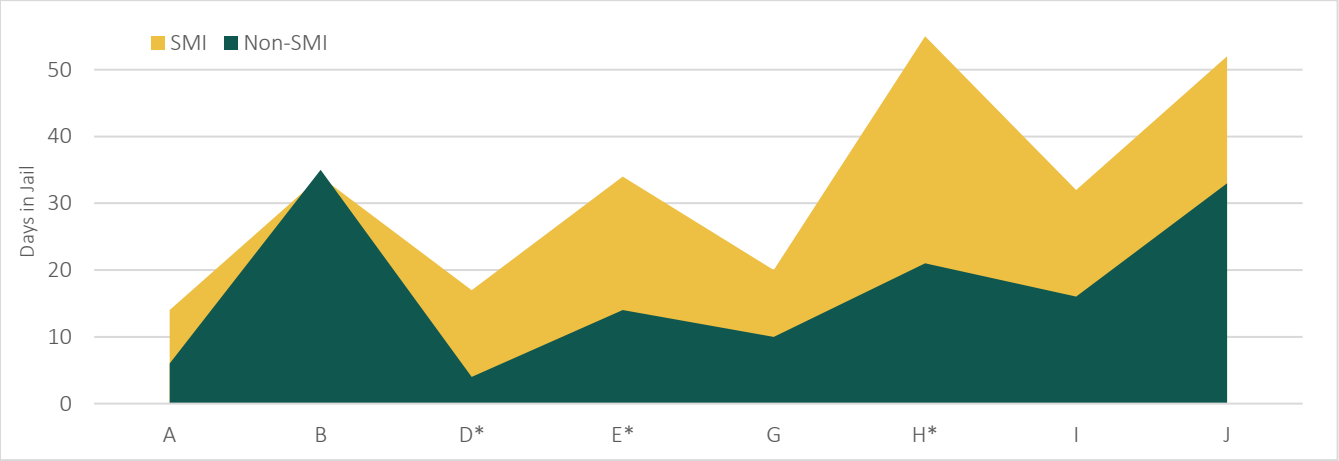
Figure 14: Days in Jail for Target Jail Stay by Mental Health Identification Type



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

Data Source: County Jails; Sample Size 1,160

Figure 15: Days in Jail for Target Jail Stay by Mental Health Identification Type by County



Data Source: County Jails; Sample Size 1,160. Two counties were omitted from this analysis due to insufficient sample collection.
**Days in Jail differed by Non-SMI/SMI*

Intervention Services within the Jail (Pilot Diversion Projects – Phase 1)

Jail intervention programs were a common strategy chosen by county stakeholders in the initial phase of pilot funding. **These services were meant to augment – and not replace – the usual configuration of mental health services within the jail.** However, similar to the CIT interventions in Intercept 1, there was quite a variation in the intervention models across sites. Table 6 illustrates these variations.

Table 6: Comparison of Jail Services Programs Across Pilot Sites

County	Type of Diversion		New Program	Model			
				Advocacy	Treatment	Supportive Services	
	Current	Future		Advocates for Early Release	Provides MH Services for the Jail	Discharge Planning & Referral	Discharge Follow-Up
A		X	X		X	X	X
B		X	X	X		X	X
C	X	X		X	X	X	X
D	X	X		X	X	X	X
E	X		X	X	X	X	X
F		X	X				
G		X	X*		X	X	X
H		X	X			X	X
I	X	X	X	X	X	X	
J	X	X	X	X		X	X

Data Source: County proposals to MDHHS; Interviews with County Stakeholders
**County G had an existing jail program but has expanded it to be available to formerly ineligible persons.*

Defining Diversion

It should be noted that although county CMH organizations are asked to report their 'diversion' activities, there is no generally accepted definition of what constitutes diversion. In this gulf, the evaluation team provided an operational definition so that project activities could be categorized accordingly. A ***current diversion*** is when an individual's current jail time is reduced due to some activity by jail or mental health staff. ***Future diversions*** are activities such as treatment within the jail or linkage to community resources that will promote reductions in subsequent jail time and recidivism. Both definitions of diversion are being used across the various sites within Michigan. However, statewide definitions should be standardized for more consistent data collection by MDHHS.

Evaluating Process and Outcomes Associated with Jail-Based Service

Nearly 7,000 individuals have received at least one jail diversion service from the pilot programs since 2015. For purposes of long-term evaluation (one-year post intervention outcomes), we focus on 1,267 individuals enrolled in the first year of the pilot program (April 1, 2015 – March 31, 2016).

The numbers served in each county varied, ranging from 35 to 701, depending on the type of program, existing services, and individual county objectives. Service intensity based on the number of contacts or length of stay also varied (low, moderate, or high) and descriptors are outlined in the full report on long-term outcomes (see Additional Reading section on page 23). Aggregate analyses of the data were often 'pulled' by the size of the largest county, where the sample of 701 individuals was over half of the total sample. Analyses were adjusted accordingly.

Evaluation design compared individual level outcomes in the year following the jail-based intervention to the year prior to the jail-based intervention. Program outcomes across counties was based upon the following indicators:

- Increase in mental health treatment engagement.
- Receipt of a mental health service within the regulated 14-day post incarceration period (continuity of care post jail).
- Reduction in proportion recidivating.
- Reduction in the total number of jail days served by the individual.
- Proportion of those who return to jail for a misdemeanor or violation (potentially divertible offenses).
- Success on both reducing recidivism and increasing treatment engagement.

The variation in program models – as well as the variation in the size, geographic location, and resource availability of counties – makes comparison of programs difficult. However, when looking across indicators and counties we can determine which programs are excelling in certain outcomes and how those successes cluster. Table 7 provides a snapshot of various outcomes; exemplars within each outcome indicators are highlighted.

Table 7: Examining Indicators of Success Across Eight Counties*

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

**Counties H & I was not included in the implementation, baseline, or long-term evaluations due to a later or earlier – pre-evaluation start date.*
Data Source: Aggregate and integrated data using primary data collected from sites, Medicaid, County Jail Records, MDOC data, 2016-2017

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

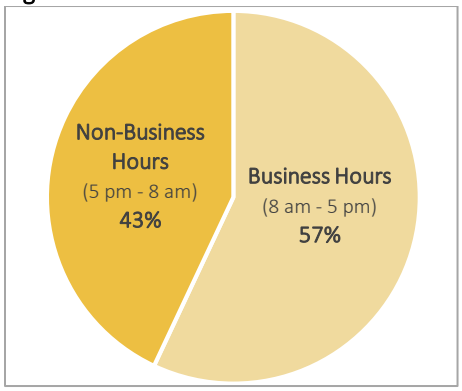
Intercept 4: Reentry

For purposes of this report, reentry includes discharge planning within the jail and at jail release, mental health and substance abuse treatment engagement upon the individual's reentry to the community. This reentry intercept does not examine those individuals who were sentenced to prison and did not reenter the community.

Time of Jail Release

Time of jail release was examined to determine what time of day individuals were released from jail and if this release time coincides with standard business hours for treatment providers, and thus easier access to services for those re-entering. **43% of individuals are released during non-business hours; no significant differences existed between SMI and non-SMI individuals**, and the proportion of those released during non-business hours differed significantly by county[19]. It is noted that jail release time is often unexpected and can be impacted by the results of court hearings and/or payment of bond.

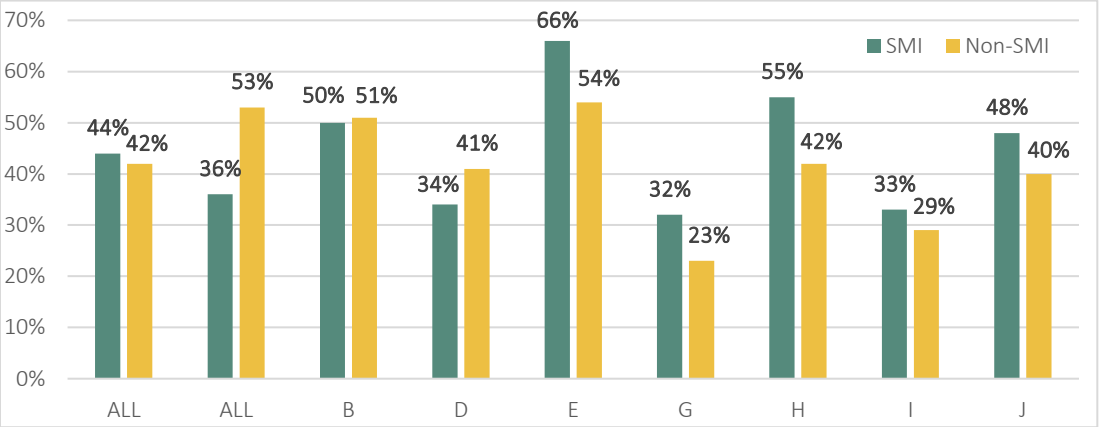
Figure 16: Jail Release Time



Data Source: County Jails; Sample Size 1,160

[19] $\chi^2(7, N=1,108)=60.3, p<.001$

Figure 17: Jail Release Time During Non-Business Hours Across Counties by Mental Health Identification Type

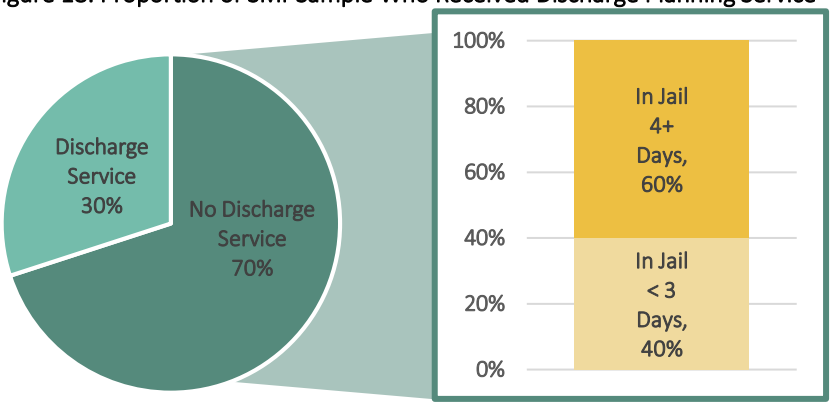


Data Source: County Jails; Sample Size 1,160

Discharge Planning

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

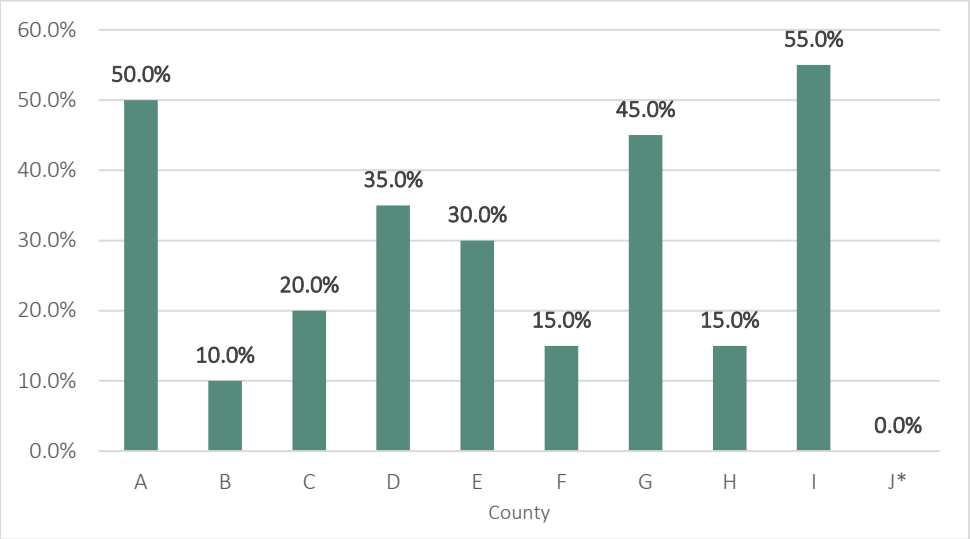
Figure 18: Proportion of SMI-Sample Who Received Discharge Planning Service



Data Source: Individual CMH and/or Jail files regarding Discharge Services; Sample Size 160

30% of individuals with SMI received discharge planning services. Of the 70% who did not receive discharge planning services, 60% had been in the jail for 4 or more days

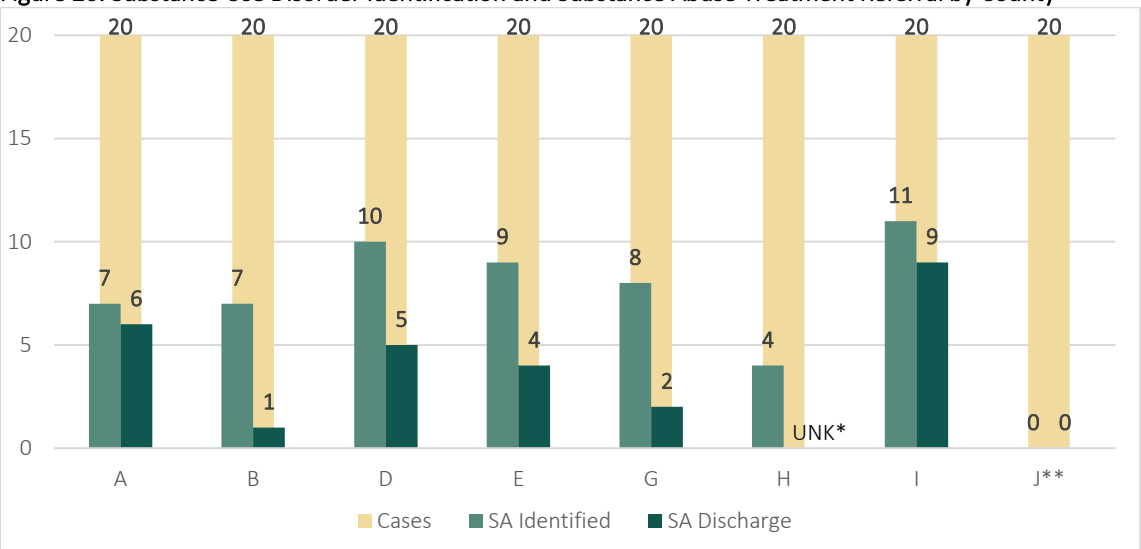
Figure 19: Proportion of SMI-Sample Who Received Discharge Planning Service by County



Data Source: Discharge Services; Sample Size 160
**A change in data systems used to track services & the largesse of jail population to sample size (N=20) may have contributed to this result.*

The proportion of individuals who received discharge services differed by county[20], and documentation of services also varied. In some counties, services may be under-reported as stakeholders reported that some discharge services were delivered but not documented.

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



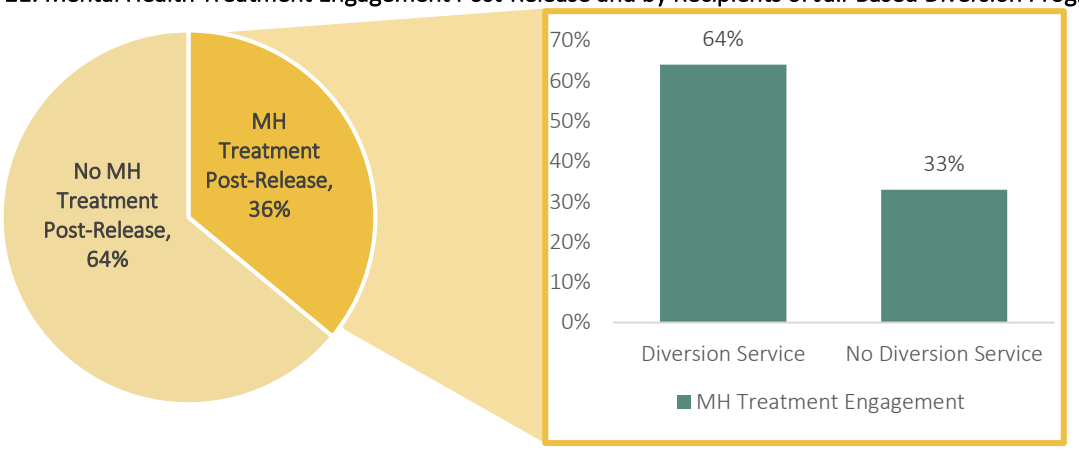
Data Source: Discharge Services; Sample Size 160
**UKN= unknown, no available data.*
***A change in data systems used to track services & the largesse of jail population to sample size may have contributed to this result.*

There is a difference by county[21] in the proportion of individuals identified with SUD who received a corresponding service: a higher proportion of individuals in County A (30%), and County I (45%) counties received substance abuse referrals for community-based treatment.

[20] $\chi^2(7, N=160)=26.7, p<.001$
[21] $\chi^2(7, N=140)=18.9, p<.01$

Treatment Engagement Post Release

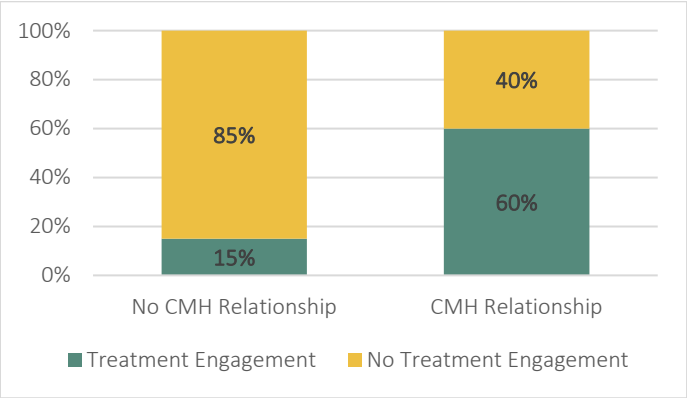
Figure 21: Mental Health Treatment Engagement Post-Release and by Recipients of Jail-Based Diversion Program Services



Data Source: Medicaid; Sample 1160; 31% of sample not found in Medicaid; 803 individuals included.

Individuals who received jail-based diversion services were more likely to engage in treatment (64%) compared to those who did not receive jail-based diversion services (31%)[22].

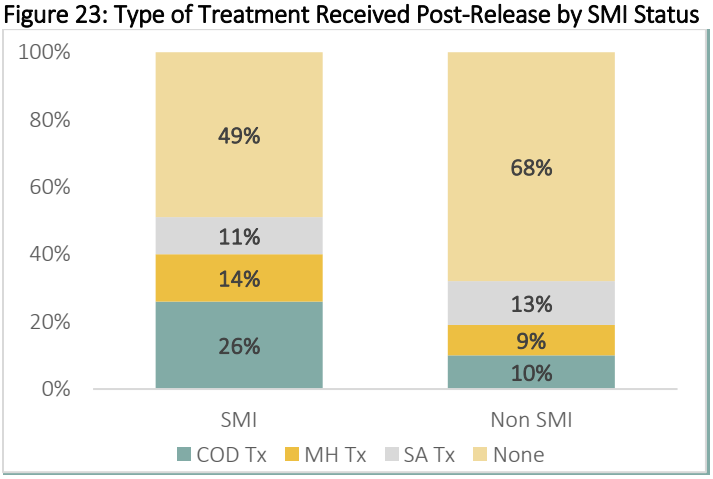
Figure 22: Mental Health Treatment Engagement in the 14-Month Post-Release Period by CMH Status



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

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

Figure 23: Type of Treatment Received Post-Release by SMI Status



The type of services individuals received significantly differed by SMI: 26% of individuals with SMI received treatment for a co-occurring mental health and substance use disorder (COD) compared to 10% Non-SMI. Though individuals were not identified in the jail, 9% of the Non-SMI group received mental health services within the community, compared to 14% of those identified within the jail (SMI).

Data Source: Medicaid; Sample 1160; 31% of sample not found in Medicaid; 803 individuals included.

[22] *$\chi^2(1, N=802)=27.8$, $p<.001$*

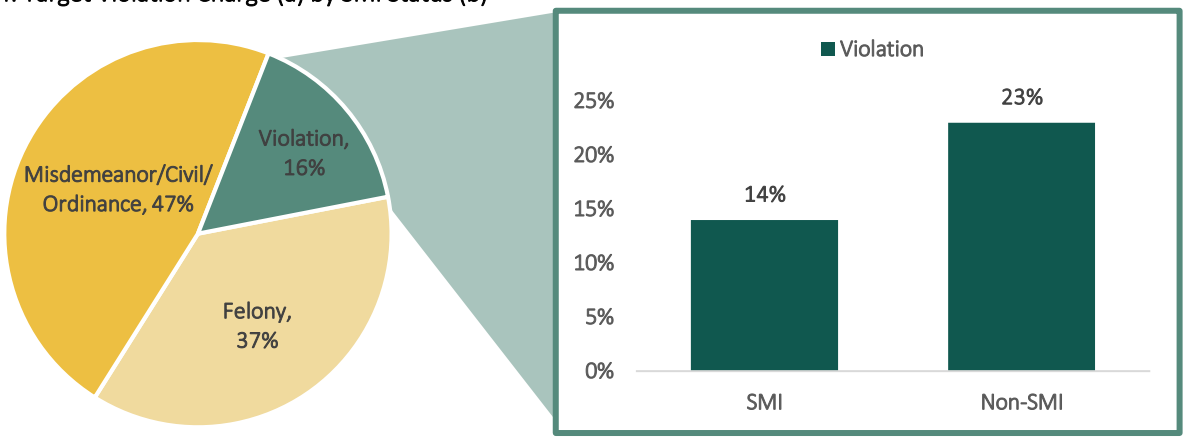
Intercept 5: Community Corrections

In this section, the impact of probation and parole violations on the target offense, as well as collaboration between Community Corrections and CMH treatment providers is examined. For purposes of this report, divertable offenses are defined as misdemeanor, civil ordinance, and/or violation offenses.

Impact of Probation and Parole Violations on Target Offense

Target offenses were examined to determine the proportion of individuals who had a violation. 63% of individuals were charged with a 'divertable' offense: 47% with a misdemeanor, civil, or ordinance offense and 16% with a probation or parole violation. A larger proportion of Non-SMI individuals were charged with a violation (23%) compared to individuals with SMI (14%)[23].

Figure 24: Target Violation Charge (a) by SMI Status (b)

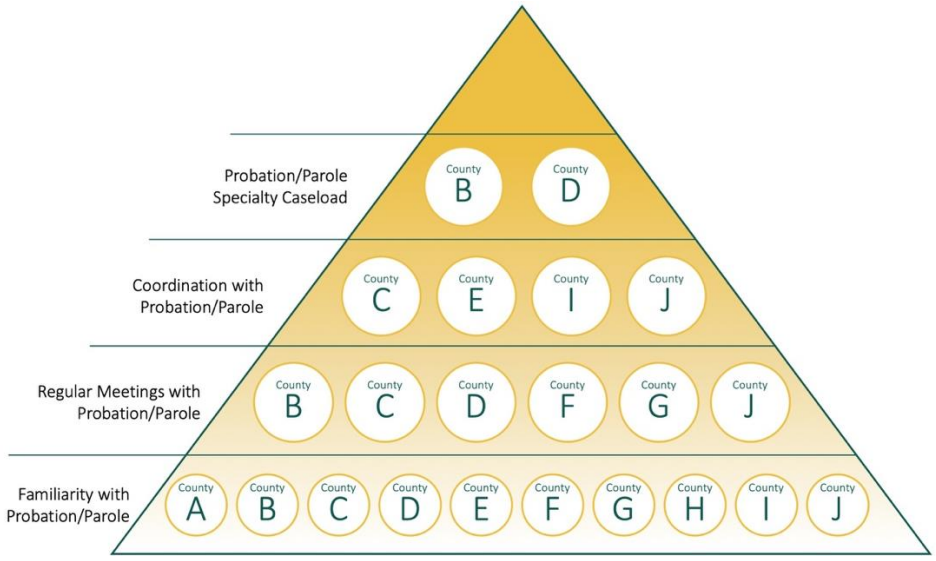


Data Source: County Jails; Sample Size 1,160

Level of Collaboration with Probation and Parole

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

Figure 25: Collaboration between CMH and Probation/Parole by County



Data Source: Interviews with CMH and jail stakeholders

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

[23] $\chi^2(2, N`=1,107)=15.3, p<.001$

Conclusions

Lessons Learned

To date, there are many observations and data points that inform the path forward. The evaluation team has identified opporutnities to decrease the number of individuals with behavioral health issues from entering county jails that are applicable at both state and county levels.

Practices within Counties Leading to Desired Outcomes

Figure 26 outlines *specific practices* within counties that have been empirically demonstrated to improve outcomes, including: reducing recidivism or jail stays, increasing treatment access/continuum of care, and enhancing knowledge and skills for officers. While outcomes may vary across sites, all of the outcomes are achieved through best practices and align with the goals of the MMHDC. No single county incorporates all of these empirically validated practices and most counties have varying configurations of one or more of these practices.

A future CBHJ report will examine the *collective outcomes of the system-based intervention strategy* across the SIM. This 2020 report will illustrate which county's collective strategy is empirically validated when it is compared with the baseline system-level data reported upon in January 2019. Until that time, the evaluation team endorses the practices outlined in Figure 26 as those that will lead to improvements.

Figure 26: Empirically Derived Actionable Practices

Intercept 0 Community Services	Intercept 1 Law Enforcement	Intercept 2 Initial Detention/ Initial Court Hearings	Intercept 3 Jails/Courts	Intercept 4 Reentry	Intercept 5 Community Corrections
Individuals with **co-occurring substance use and mental health disorders were over 2 times more likely to recidivate** than those with a only mental health disorder. **Delivery of integrated treatment is hindered** by separate mental health and substance use funding and data systems.	Fidelity to the CIT Model improves officer knowledge and skills and changes behavior. In the month after CIT training, **officers were 38 times more likely to use the Crisis Center**; the increase was sustained 18-months later.	Across all jails, use of a standardized mental health screen at booking **improved the identification of mental health issues**; officer only identification varied from 3% -33%. Across all jails, **47% of individuals booking in were charged with a 'divertable' offense.**	Training corrections officers in de-escalation techniques **decreased forcible cell removal by 50%.** Individuals receiving an in-reach or diversion service in jail were **twice as likely to receive a mental health service in the community.**	Improving discharge services (currently, **only 30% of individuals with SMI received a discharge service**) and discharging during business hours (**44% of those with SMI are released from jail during non-business hours (5 pm – 8 am)**) will enhance continuity of care.	Enhancing the relationship between county-level CMH and parole/probation officers may decrease the number of individuals incarceration for probation/parole violations. Currently **four of ten counties** report such a relationship.

Recommendations for State and Counties

In previous reports, we have provided comprehensive recommendations for state and county administrators. For example, recommendations in the 'Implementation Process Report' (Kubiak et al, 2016 – See Additional Reading section on page 24) focus on factors effecting implementation, as well as recommendations for system change. These recommendations remain relevant, and many have become objectives for the MMHDC. Figure 27 highlights the most salient recommendations across the state and county systems. These recommendations are focused on producing direct impact on practices at the county level that will support improved identification, referral and service delivery that will decrease incarceration for those with SMI and/or SUD.

Figure 27: Recommendations for State and Counties Empirically Derived Actionable Practices

Intercept 0 Community Services	Intercept 1 Law Enforcement	Intercept 2 Initial Detention/ Initial Court Hearings	Intercept 3 Jails/Courts	Intercept 4 Reentry	Intercept 5 Community Corrections
Address structural funding and data barriers to **increase accessibility to integrated mental health and substance use treatment**. Explore changes to existing policies and practices to **attain effective transition of Medicaid coverage from jail to community**.	**Identify and reduce barriers to data collection** across law enforcement agencies. Explore how to **define "diversion" within dispatch and law enforcement systems**. **Develop sustainable law enforcement training plans** within counties and encourage fidelity to CIT model.	**Implement a standardized mental health screen at jail booking** to augment identification of mental health issues. Develop strategies to **add standardized screening tools to jail management system** across counties. **Improve collaboration between courts and CMH** to increase pre- and post-booking diversion.	**Explore length of stay differences between individuals with and without SMI**, including uniform risk assessment, implications of CIT training, and behavioral indicators such as tickets and incident reports.	**Reduce after hours jail releases** for individuals identified with SMI. Increase in-reach and discharge planning strategies to **improve continuity of care for individuals with mental health and/or substance use disorders**.	Build and strengthen relationships between CMH and Probation/Parole to **reduce violations that result in recidivism including: specialized caseloads, formal collaboration and case consultation, and mental health training**.

Facilitating County-Level Change

In addition to these practices, to ensure county level change efforts two ingredients are necessary: 1) funding or other resources that bring stakeholders to the table, and 2) external faciltiation of the process and data collection. Funds available from MDHHS acted as a catalyst for engagement between the criminal/legal system in the county and the CMH provider. Individuals or systems that had not collaborated previously are now partnering with a shared mission. Of equal importance, the evaluation team acted as 'consultants' to the project and 'facilitators' of the process, often supplying technical assistance resources. For example, the evaluation team's monthly phone calls with stakeholder groups in each county often facilitated communication across sytems, and the CBHJ provided county stakeholders with tools to monitor data collection, process maps of the actions within the county, and data which was utilized by county stakeholders to modify their actions. These efforts were valuable in facilitating data driven change and encouraging positive momentum across all points of the SIM.

Additional Reading

Additional reports and publications by the WSU CBHJ can be found online at behaviorhealthjustice.wayne.edu/reports-publications-resources. This report reviews and condenses data from the following CBHJ Reports and Publications (including publications upcoming and under review:

Reports

- Statewide Jail Diversion Pilot Program Implementation Process Report – April – September 2015.
- Diversion Pilots: Long-term Outcomes – Aggregate finding across sites for those served between April 1, 2015 and March 31, 2016.
- Diversion Pilots: Planning for the Future with Baseline Data – Aggregate findings across sites for those served between April 1, 2015 and September 30, 2015.
- Mental Health Jail Diversion: Using a Cohort Sample to Evaluate Diversion Across the Sequential Intercept Model – Report on Stage 1 Statewide May – August 2017.
- Baseline Activity Across Sequential Intercepts by Diversion Pilot Programs—Using a Cohort Sample to Evaluate Diversion Report on Stage 2 Activities from March 2017 – April 2018.

Publications

Comartin, E., Swanson, L., & Kubiak, S. (2019). **Mental health crisis location and police transportation decisions: The impact of Crisis Intervention Teams training on crisis center utilization**. Journal of Contemporary Criminal Justice, 35(2), 241-260. doi.org/10.1177/1043986219836595

Kubiak, S.P., Comartin, E. Ray, B. & Tillander, L. (2018). **The effect of systems collaboration on the individual outcomes of mental health court participants: A multi-site study**. International Journal of Law and Psychiatry, 60, 64-72. https://doi.org/10.1016/j.ijlp.2018.08.004

Kubiak, S.P., Comartin, E., Hanna, J. & Swanson, L. (in press). **Identification, referral, and services for individuals with serious mental illness across multiple jails**. The Journal of Correctional Health Care.

Kubiak, S.P., Shamrova, D., Comartin, E. & Milanovic, E. (2019). **Enhancing knowledge of adolescent mental health among law enforcement: Implementing youth focused Crisis Intervention Teams training.** Evaluation & Program Planning, 73, 44-52. https://doi.org/10.1016/j.evalprogplan.2018.11.006

Kubiak, S.P., Comartin, E., Milanovic, E., Bybee, D., Tillander, E., Rabaut, C., Bisson, H., Dunn, L., Bouchard, M., Hill, T. & Schneider, S. (2018). **Countywide implementation of Crisis Intervention Teams: Multiple methods, measures and sustained outcomes**. Behavioral Science and the Law, Special Issue on Diversion, 35(5/6), 456-469 (Invited Paper). https://doi.org/10.1002/bsl.2305

Kubiak, S.P., Roddy., J., Comartin, E. & Tillander, E. (2015). **Cost Analysis of Long-term Outcomes of an Urban Mental Health Court**. Evaluation and Program Planning, 52, 96-102. https://doi.org/10.1016/j.evalprogplan.2015.04.002

Comartin, E., Kubiak, SP, & Ray, B. (2015). **Short and long-term outcomes of mental health court participants by psychiatric diagnosis**. Psychiatric Services, 66(9), 923 -929. https://doi.org/10.1176/appi.ps.201400230

Ray, B., Kubiak, S.P., Comartin, E. & Tillander, E. (2015). **Mental Health Court Outcomes by Offense Type at Admission**. Administration and Policy in Mental Health and Mental Health Services Research,42, 323-331. https://doi.org/10.1007/s10488-014-0572-2

Kubiak, S., Tillander, E. and Ray, B. (2012). **Assessing the role of legal actors across eight mental health courts**. MSU Journal of Medicine and Law, 17, 301. https://heinonline.org/HOL/LandingPage?handle=hein.journals/jmdl17&div=16&id=&page=

Under Review

Comartin, E., Nelson, V., Hambrick, N. & Kubiak, S. (under review). **The impact of private, for-profit mental health services within county jails**.

Comartin, E., Burgess-Proctor, A., Putans, A., Hicks, M. & Kubiak, S. (under review). **Assessing the efficacy of mental health jail diversion programs: A multi-site study.**

Comartin, E., Nelson, V., Smith, S., & Kubiak, S. (under review). **The criminal/legal experiences of individuals with mental illness along the Sequential Intercept Model: An eight site study.**

In Progress

Willis, T., Comartin, E., & Kubiak, S. (in progress). **Recidivism & treatment engagement of individuals with serious mental illness who have multiple contacts with law enforcement officers.**

Hicks, D., Comartin, E., & Kubiak, S. (in progress). **Coordinating mental health care upon community reentry: Results from a county jail.**

Hedden, B., Comartin, E., & Kubiak, S. (in progress). **Racial disparities in access to, and utilization of, jail- and community-based mental health treatment.**

Hicks, M., Putans, L., Comartin, E., Burgess-Proctor, A., & Kubiak, S. (in progress). **Mental health diversion programs impact on women of color.**