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**Statewide Mental Health Court Outcome Evaluation
Aggregate Report
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**Prepared for:
Michigan Department of Community Health**

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EXECUTIVE SUMMARY

Nationally, the number of people with serious mental illness (SMI) in jails ranges from 6 to 36 percent. Some refer to jails as the last mental health hospital as individuals with SMI revolve in and out of jails. As one solution to this social problem, jurisdictions are finding ways to divert such individuals from prosecution or sentencing by engaging them in treatment services. The mental health court (MHC) offers an alternative to traditional criminal court processing; it is post-booking diversion program that utilizes treatment and services available in a given community to stem the frequency of mentally ill offenders' contact with the criminal justice system. Studies of MHCs have consistently found that they can be successful in reducing re-offending and increasing treatment utilization.

In 2008, the Michigan Department of Community Health (MDCH) and the State Court Administrative Office (SCAO) developed the Michigan Mental Health Court Grant Program as a mechanism to jointly fund a statewide MHC pilot program during fiscal year 2009. In 2011, MDCH contracted an external evaluation of the pilot program encompassing eight MHCs: Berrien (Unified Trial Court); Genesee (25th Probate Court); Grand Traverse (86th District Court); Jackson (4th Circuit and 12th District Courts); Livingston (53rd District Court); Oakland (6th Circuit Court); St. Clair (72nd District Court); and Wayne (3rd Circuit Court).

The evaluation encompasses the three-year pilot period of January 2009 to December 2011 and relies on multiple sources of data to assess the processes and outcomes of each court. Questions related to court processes were: How are courts similar to and different from each other? What are mechanisms for referral and admission? How strong is the collaboration or integration between the court and mental health staff? Did participants successfully complete? Data used to assess these process-related questions included surveys, site visits, interviews, and court observation. Based on site visit and interview data, the research team created a process map illustrating each court's screening, admission, and decision-making processes. The process map and a report based on the data collection was submitted to each MHC for verification. Questions related to outcomes included: Did MHC reduce recidivism (i.e. time in jail, new arrests)? Did MHC increase participation in mental health treatment? Did high-intensity treatment such as hospitalization decrease as a result of MHC? Did specific individual or system level factors affect outcomes? Data collected to assess these outcomes came from five primary sources: MDCH-CMH Encounter/Service Data; SCAO – MHC database; jail data from each county; MDCH – Bureau of Substance Abuse and Addiction Services treatment data; and Michigan State Police – arrest and conviction data. To assess long-term outcomes, a comparison of three time periods was considered: 1) one year prior to MHC admission; 2) the period of involvement in MHC; and 3) one year following MHC discharge.

Using the Council of State Governments Justice Center list of ten essential elements of MHC as a guide, MHCs across Michigan were found to vary widely in terms of organization, policies, and practices. Differences between courts should not be construed as a 'right' or 'wrong' way of operating. Rather, each court is responsive to the needs of the particular county and uses the resources available to the best of its abilities. Because each MHC is unique, it is not possible to draw direct comparisons between courts. The intent of this evaluation is to illuminate the variety of MHC structures and processes across the state and utilize individual- and system-level factors, other than county of origin, to assess variations in outcomes.

There were 678 individuals admitted into the eight MHCs prior to December 31, 2011. The average age at admission was 35 years (range 18 to 64). Nearly two thirds of participants (63%) were males and 67% identified as Caucasian. The overwhelming majority of participants were unemployed (91%) at admission, and nearly 20% were homeless. Nearly 40% were admitted into MHC with a primary diagnosis of bipolar disorder, followed by depression (29%), schizophrenic/psychotic or delusional

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disorders (21%), and 12% representing other diagnoses such as developmental or personality disorders. Although 60% were identified as having a 'current substance abuse', other evidence shows that as many as 79% were substance involved. Participants were most likely to enter MHC on a felony offense (48%), while 43% were admitted on a misdemeanor, and 8% on civil cases.

The average length of stay in MHC was 276 days; among all 678 participants who were admitted, there were 187,043 MHC program days since 2009. Of the 450 participants discharged, 43% successfully completed all requirements of the MHC – a proportion within range of national averages. Age and offense type were the strongest predictors of success: Successful completers were more likely to be older than average (39 years) and have a misdemeanor/civil offense.

Treatment outcomes. Participants received the greatest number of services during MHC, and these were primarily low-intensity services (e.g., med reviews, case management). The proportion of participants requiring a high intensity service (e.g., hospitalization) declined from 31% pre-MHC to 15% post-MHC. Time to first mental health treatment after MHC admission averaged 16 days; upon discharge into the community the average was 41 days. While 95% of participants received mental health treatment during MHC, 72% of those discharged greater than one year received such services. Substance abuse treatment within the CMH system increased during MHC as compared to pre-MHC (45% compared to 53%) but declined post-MHC (28% of those discharged).

Recidivism outcomes. A primary indicator of MHC is recidivism, measured nationally by new arrests. Since admission into MHC, only 14% of participants were arrested and charged with a new offense – a much lower rate than national averages - particularly, since time between admission to MHC and one year post-MHC may have been as long as 2-years. Prior to MHC, 81% of participants spent time in jail, averaging 39 days. During MHC, 54% of participants spent time in jail, averaging 24 days. This represents a statewide saving of 10,074 jail bed days. To date, a reduction of 15,991 jail bed days is seen when comparing the pre-MHC to post-MHC periods for the 450 participants discharged. Among participants discharged one-year (n=236), long-term outcomes indicate 43% spent time in jail post-MHC and 4% were incarcerated in state prisons. Successful program completion strongly predicts the absence of recidivism.

Individual Factors Influencing Outcomes. Mental health diagnosis was found to have no effect on completion, treatment attainment or recidivism. However, the presence of COD predicted less favorable completion, more time in jail during MHC and higher proportion of new arrests/convictions. Similarly, those with felony offenses were less likely to complete, and when they did, they spent more time in MHC. Interestingly, those with felony offenses had significant reductions in jail days when comparing pre- and post-MHC periods regardless of completion status. Importantly, there was no difference in new arrest/convictions between those who entered with a felony versus a misdemeanor.

System-level Factors Influencing Outcomes. Outcome variations related to court type (felony, misdemeanor/civil, or mixed) were similar to those above, with courts focused on felony cases having the greatest reduction in jail days. Examining the level of integration between the courts and treatment staff (high vs. low), high integration courts had lower lengths of stay and less time to treatment. Although those in low integration courts were more likely to complete MHC, those in high integration courts were more likely to experience greater reductions in jail days and higher treatment participation.

Implementation and piloting of MHCs across Michigan has been successful, and many quantitative indicators as well as personal stories demonstrate positive outcomes. Based upon the body of knowledge amassed in this report, the following are areas for future consideration that may expand positive outcomes: 1) Enhance the level of integration between courts and treatment; 2) Consider matching risk level with length or intensity of court supervision; 3) Extend use of rewards to encourage longer length of stays and positive completion; 4) Increase attention to COD, integration of mental health and substance abuse treatment, and continuity of care post-MHC to support ongoing recovery.

XI. Conclusions and Recommendations

In 2008 the Michigan Department of Community Health and the State Court Administrative Office joined forces to initiate a proposal process for funding and evaluating mental health courts across the state. This report summarizes the outcomes associated with those mental health courts by aggregating participant data across courts and merging it with several secondary sources of administrative data. Primary data were also collected through surveys, interviews, and observations at each of the eight studied courts. In addition to a straightforward assessment of data across the entire sample of 678 participants, approaches were utilized to assess differences by individual (i.e., diagnosis, co-occurring disorders, and offense at admission) and system (i.e. integration level, court type) factors. Using this accumulation of outcome data, a summary of conclusions is provided below.

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Program Similarities and Differences: As Table 3 (Page 16) and Appendix B illustrate, there is wide variation among the MHCs across legal and clinical eligibility criteria (e.g., diagnosis; offense type), characteristics of participants, length of stay, organizational structure, size, and program requirements. Differences between courts should not be construed as a ‘right’ or ‘wrong’ way of operating a MHC. Rather, each court is responsive to the needs of the particular county and uses the resources available to the best of its abilities. Because each MHC is unique, it is not possible to draw direct comparisons between courts. The intent of this evaluation is to illuminate the variety of MHC structures and processes across the state and utilize individual- and system-level factors, other than county of origin, to assess outcomes.

A. General Outcomes Across All Participants: Highlighted below is a summary of findings among all participants admitted to the MHCs.

Participant Characteristics

- The typical participant is male, mid-30s, unemployed, dependent on others for housing, and has a problem with drugs/alcohol.
- Participants were just as likely to have a misdemeanor/civil case as a felony offense upon admission.

Program Outcomes

- The average length of stay in MHC is 276 days; across courts 678 participants spent 187,043 days in MHC since 2009.
- As of 12/31/11, 450 participants were discharged from MHC – 43% successfully.
- Age and offense type were the strongest predictors of success: Successful completers were more likely to be older than average (39 years) and have a misdemeanor/civil offense.
- One quarter (26%) of MHC participants were never screened for drug or alcohol use during MHC; 234 participants (35%) had a positive drug screen at least once.
- Over half (55%) of participants received some type of incentive during MHC and 41% received at least one program sanction.

Treatment Outcomes

- When comparing pre-, during and post-MHC periods, participants received the greatest number of services during MHC, and they were primarily low-intensity services.
- Time to first mental health treatment after MHC admission averaged 16 days.
- Time to first mental health treatment after MHC discharge averaged 41 days.
- Mental health treatment was received by 95% of participants during MHC, but by only 64% of participants post-MHC.
- The proportion of participants requiring high-intensity mental health treatment (e.g. hospitalization) declined from 31% pre-MHC to 15% post-MHC.

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- Nearly 80% of participants were identified at admission with a current substance abuse problem or had received a formal substance abuse treatment service in the year prior to admission.
- Of the 406 participants screened as having ‘current substance abuse’ at admission, 65% (n= 263) received a substance abuse treatment service in either the mental health or substance abuse treatment system during MHC.
- Utilization of substance abuse treatment within CMH increased during MHC participation, suggesting that the realization of the effect of substance misuse may have been heightened during MHC. Post-MHC, only 28% of all discharged participants received a substance abuse treatment service within CMH.

Recidivism Outcomes

- A reduction of 10,074 jail days is seen when comparing time spent in jail the year prior to MHC to the time during enrollment in MHC.
- To date, a reduction of 15,991 jail bed days is seen when comparing the pre-MHC period with the post-MHC period for 450 participants discharged.
- Since admission into MHC, 14% of participants have been tried and convicted of a new offense (of these, 4% are for felony offenses).
- Of those participants discharged, 5% (n=24) are incarcerated in state prisons.
- Successful program completion strongly predicts a lack of future recidivism (i.e. jail post-MHC, new charge, felony).

Long-term Outcomes: Discharged Longer than One Year

- Reduction in jail interface: 80% of participants spent time in jail the year pre-MHC compared with 43% in the year post-MHC.
- Arrest rates in the year post-MHC are lower than published findings from other courts: Overall, 16.5% were charged with a new offense after admission, but for those who successfully completed MHC, only 6.3% were charged with a new offense.
- 72% of participants engaged in mental health treatment in the year post-MHC
- There was a 50% reduction in the utilization of high-intensity mental health services in the year post-MHC compared to the year pre-MHC.

It should be noted that the outcomes reported above are very favorable in comparison to the published literature on MHC. For example, one year post-discharge arrest rates for successful completers range from 15% to 27%²⁷, whereas MHCs in Michigan average 6.3%. Moreover, treatment utilization post-MHC has been reported as 55%¹⁷ compared to 72% in Michigan.

- B. Individual-Level Factors Comparison:** In addition to the general outcomes above, the evaluation also sought to determine if there were differences in outcomes by certain factor specific to the individual such as diagnosis, presence of co-occurring disorders or the type of offense at admission.

Mental Health Diagnosis

- There were no differences in outcomes (i.e., presence of jail episode, reductions in jail bed days, reductions in high-intensity mental health treatment, or increases in low-intensity mental health treatment) across the four mental health diagnosis categories.
- Prior to MHC admission, participants diagnosed with schizophrenia/psychotic disorders were more likely to have had a jail episode and a longer stay in jail than participants with other diagnoses.
- Participants diagnosed with schizophrenia/psychotic disorders had a statistically significant drop in high-intensity service utilization from pre- to post-MHC.
- There were no significant differences by mental health diagnosis when considering successful completion; however, it is important to note that participants diagnosed as “other” had the greatest proportion of successful completers and those diagnosed with depression had the lowest.

MHCs should continue to consider participants with various mental health diagnoses, as well as developmental disabilities, since no differences were found across diagnosis categories on the key outcomes.

Presence of Co-Occurring Disorders (COD)

- Those with COD had longer program stays (301 vs. 234 days) and were less likely to complete successfully (41% vs. 53%) than those without COD.
- Those with COD were much more likely to spend time in jail during (54% vs. 28%) and post-MHC (28% vs. 21%) than those without.
- Those with COD were more likely to have new charges and convictions than those without COD.

Treatment of COD may be an important factor in the success of MHC participants. When defining COD very conservatively (i.e. any substance abuse treatment service prior to or during MHC) the presence of COD was found to be a significant predictor in unsuccessful completion, jail time during and post-MHC, and new convictions. These differences suggest that more attention to the screening, assessment, and treatment of COD during MHC may improve court outcomes.

Offense Type

- Those with a felony offense were far less likely to complete the MHC program when compared with misdemeanants.
- Those with a felony offense spent considerably more time completing MHC than those with a misdemeanor (473 days compared to 375 respectively).
- There were significant pre/post reductions in jail days for participants with felony offenses whether or not they successfully completed the program.

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- Long-term outcomes suggest that there is a decrease in jail days in the year post-MHC when compared with the year pre-MHC for those who enter with felony offenses and an increase for those with a misdemeanor/civil case.
- There is no statistical association between a new offense – or seriousness of a new offense – and the type of offense at admission.

Findings suggest that participants with a felony arrest have the greatest reductions in jail days between pre- and post-MHC periods. These reductions occurred irrespective of completion status, even though those with a felony were less likely to complete. Some of these reductions may be attributable to the greater number of jail days pre-MHC among those with felony offenses, but it is noteworthy that increases in jail days post-MHC were found for those with misdemeanor offenses. The increased supervision and case management that comes with MHC participation, coupled with little difference in the length of stay during MHC, may inadvertently create a greater level of surveillance for those with a misdemeanor. This increased surveillance for misdemeanants may put them at increased risk for sanctions or getting caught for behaviors that otherwise would have gone unnoticed.

C. System-Level Factors: As stated above, the evaluation sought to determine if there were either individual- or system-level factors that created differences in outcomes. System-level factors refer more to organizational-type factors of the court such as variation in the court type (felony, misdemeanor/civil, or mixed) or the level of integration between the court and the treatment system (low or high integration).

Court Type

- Participants in felony and mixed courts had reductions in jail days when comparing pre-MHC to during MHC, while participants in misdemeanor courts had increases.
- Comparison between pre-MHC and post-MHC jail days shows that felony court is the only court type to have significant reductions from 72 days pre- to 18 days post-MHC.
- Examining unsuccessful completers by court type, there were increases in jail days pre- to post-MHC for both the misdemeanor (18 to 59 days) and mixed courts (46 to 63 days); however, the felony courts still had an overall reduction of 80 days to 33 days.

When the courts were grouped by criminal offense type, the MHCs that exclusively accepted felony cases had the greatest reductions in jail days. The magnitude of these reductions is all the more evident when considering that the average number of jail days for those courts that only accepted misdemeanors increased post-MHC. Although this increase was not statistically significant, it suggests something about the effectiveness of the MHC process for various types of offenders.

Integration Level

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- Half the courts scored in the ‘High Integration’ range and half in the ‘Low Integration’ range.
- High Integration courts were more likely to serve those with more serious offenses (e.g. felony) and more likely to reduce re-arrest among these high-risk populations.
- The average number of days in MHC for a participant in a High Integration court was 275 compared to 314 days for those in a Low Integration court. Those who completed a High Integration court averaged slightly over a month longer in MHC than those in a Low Integration court.
- Those in the High Integration courts average 8.3 days to first treatment encounter during MHC while those in Low Integration courts average 14.3 days.
- Among both levels of integration, participants who successfully completed MHC had significant reductions in the average number of jail days in the post-MHC period. However, among those who failed to complete MHC, those in High Integration courts still had reductions in jail days.
- High Integration courts have greater reductions in jail days during MHC, and these reductions are retained in the year post-MHC.
- In comparing those MHCs with and without a mental health provider on the team, it was found that teams with a mental health provider had a greater proportion of successful completions and greater reductions in jail days post-MHC. (Note: The term provider is used to identify a staff member from community mental health contracted to provide direct service to MHC participants i.e., case manager, clinical supervisor, or administrator).

MHCs that are highly integrated took on more serious offenders, but were also more likely to have greater reductions in jail days during and post-MHC. These reductions were for both those who were successful and unsuccessful in MHC. For those in the Low Integration courts, reductions were only found among those who successfully completed the court. The most important element of integration was the presence of a mental health provider on the treatment team (i.e. case manager, clinical supervisor, or administrator from the mental health provider contracted to provide direct service to MHC participants).

D. *Recommendations for Enhancing MHC Outcomes:* One of the unique aspects of this report is not only that data are analyzed from multiple MHCs, but also from individual as well as organizational and procedural differences across participants and courts. This approach to the analysis allows for a more complex and multifaceted appraisal of the short and long term outcomes.

While MHCs have similarities in terms of the essential elements, there were acute differences in how these elements played out. For example, while all of the observed courts used a non-adversarial team approach, they differed in terms of the criminal justice, mental health, and community stakeholders who were a part of this team, as well as each group’s level of involvement in decisions about MHC participants. Courts are not structured as a ‘one size fits

all' and thus are more able to assess unique differences among participants, as well as the resources available within their communities.

Implementation of MHCs across Michigan has been successful, and many quantitative indicators, as well as personal stories, demonstrate positive outcomes. Based upon the body of knowledge amassed in this report, the following are areas for future consideration that may improve outcomes long-term.

1. Maximize integration efforts with treatment at all levels of court administration and functioning

A primary goal and an 'essential element' of MHC is the collaboration between two systems: courts/criminal justice and mental health treatment. Analyses in this evaluation demonstrate that this is more than a theoretical tenet; there is evidence to support that MHCs with greater integration between the courts and treatment community have better participant outcomes.

Based on the six-point integration measure used in this evaluation, courts that scored 'high' had participants with shorter lengths of stay, greater reductions in jail days, and less time to treatment – even though these courts were more likely to serve felony offenders. The most predictive item in the scale was the presence of a mental health provider on the court treatment team. Another indicator of integration is an active community advisory board, which is a component in three of the eight courts.

Efforts to maintain high levels of collaboration and cooperation between mental health and court constituencies should remain a primary goal statewide. Maintaining community advisory boards and a clinical presence on the court treatment teams may be desirable for all MHCs.

2. Matching level of supervision/court intensity with offense level

Participants with felony offenses were more likely to experience reductions in jail days when comparing pre-/post-MHC jail days – irrespective of completion status. In other words, any 'dosage' of MHC was effective in reducing jail days for felony offenders, although a greater decrease was found among those who successfully completed. This was not the case for those who entered the court with a misdemeanor/civil case. Those who entered with a misdemeanor offense and successfully completed the program had a reduction in jail time. However, the evidence suggests that those with misdemeanors/civil offenses as a whole experienced an increased number of jail days in the year post-MHC as compared to the year pre-MHC. When examining long-term outcomes, those with misdemeanor offenses averaged 17 jail days in the year pre-MHC and 30 days post-MHC. While much of the decline for felony offenders may be attributed to the greater number of jail days pre-MHC (related likely to the seriousness of offense), it is nonetheless disconcerting that individuals with lesser offenses actually experienced an increase in jail days after some dosage of the MHC intervention.

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One factor to consider is length of MHC. The average of 276 days may incentivize those with felony offenses, while it may be much more intensive than the typical sanction for someone with a misdemeanor offense. In fact, the length of stay (LOS) for successful completers with a felony offense, as compared to those with a misdemeanor, averaged only three months longer. However, for non-completers, the LOS was exactly the same, irrespective of offense type. Considering the likely variation in sentencing between misdemeanor and felony offenses, it is striking to see little difference in program length of stay.

What the examined data do not reveal is criminal history. Incomplete data in this field within the SCCM database did not allow examination of felony histories among participants with a misdemeanor target offense. When interpreting difference by offense level, criminal history should be taken into account and could be assessed by using risk assessment tools. It was noted during interviews that only one court currently collects risk scores and that none of the courts are currently considering risk scores when considering individuals for admission to the MHC.

Nevertheless, some questions remain. Is it possible that those with low-level misdemeanor offenses are under court supervision far longer in MHC than they would have been without MHC? Is this increased surveillance resulting in more sanctions that might not otherwise be there? Enhancing court outcomes may require more use of 'matching' principles or using criminal justice risk assessment tools that examine risk/needs to determine length of court supervision and MHC involvement.

It is difficult to find comparisons in the literature on such a phenomenon since historically the majority of MHCs served misdemeanants only. Moreover, evaluations rarely examine outcomes by type of court or offense. However, recent research on Drug Courts has found that focus on high-risk/high-need offenders reduces crime twice as much as those serving less serious offenders^{46 47}. Furthermore, the focus on this higher risk population yields a nearly a 50-percent greater cost-benefit to their communities⁴⁸.

3. Increasing successful completion rates

Similar to other national studies^{27 49}, this evaluation found that those who successfully completed MHC in Michigan experienced less recidivism and higher treatment utilization post-MHC. Therefore, one goal would be to increase the proportion of participants with successful completion. The successful completion rate across the eight MHCs in the state was 43%, meaning that 57% of participants experience a negative termination. This negative termination rate is within the 14% to 60% range of success reported in other studies^{35 38 39}, but on the higher end of the continuum.

Increasing successful outcomes may be a delicate balance between adjusting program requirements (e.g. LOS for lower level offenders as discussed above) and enhancing community resources and individual motivation. In both mental health and substance abuse treatment there are tenants and mechanisms for matching level of need with level of services. Some

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research, in treatment, as well as criminal justice sanctions, has indicated that when there is an inappropriate matching to a higher than needed service, there are fewer positive outcomes. In MHC there is a need to match participants with appropriate levels of treatment, as well as appropriate levels of supervision. Therefore, adjusting program requirements to more appropriate match the participant's criminal risk may be necessary. For example, increasing LOS for those with higher risk and decreasing LOS for those with lower risk. Success in this delicate balancing act would likely improve outcomes.

Individual-level predictors of completion were age, living situation, employment, substance use, and offense type (note: when considered simultaneously, only age and offense type were significant). Those that were employed or living independently at admission were more likely to complete than those who were unemployed or dependent on others for housing. Although it is difficult to say, a lack of community supports or resources available to the court to support housing and employment initiatives may contribute to treatment failure. Some courts offered greater ancillary services and demonstrated broader community supports than others, and certainly there is variation in success rates across courts. However, it is not merely the presence or absence of resources that contributed to outcomes but rather the combination of these system- and individual-level factors. One strategy is the employment of peer support specialists on the MHC team. Peer support specialists are individuals with SMI who are recipients of services in the CMH system and have reached stability in their recovery. They are trained, certified, and employed in a variety of roles, with the opportunity to provide a unique 'insider' perspective to other individuals with SMI. In addition, this opens up employment opportunities for successful graduates, perhaps incentivizing successful completion of the program. Although some courts are using this strategy, more widespread use across courts may be advantageous.

Finally, individual personality characteristics and life circumstances are also factors in moving a participant to successful completion status. Enhancing motivation at an individual level can be successful in engaging individuals in treatment and increasing length of stay. One evidence-based method for enhancing motivation and engaging individuals with SMI and/or SUD into treatment is motivational interviewing⁵⁰. Motivational interviewing is also an important component in the evidence-based IDDT Model for treatment of COD⁵¹.

4. Enhancing compliance and motivation through the use of rewards and sanctions

Although all courts employed the use of sanctions and rewards to extinguish negative behaviors and encourage positive behaviors, it was difficult to assess the success of these strategies due to the limited reporting of them in the SCCM database. When used effectively, a system of rewards and sanctions can positively affect criminal behavior⁴⁵ as well as treatment engagement and completion.

Research on the effective use of rewards and sanctions, also referred to as contingency management, has documented positive effects when used in drug courts in increasing length of stay and treatment compliance⁵². Contingency management approaches use a structured set of

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incentives to modify behavior by either giving rewards or sanctions – or taking away rewards/sanctions. Examples of giving rewards can be praise, token gifts, or certificates of accomplishment. Sanctions can be a writing assignment, increasing reporting times, or jail. Examples of taking away a reward may be a monetary fine, revoking a license, or taking away earned privileges. Taking away a sanction might be reducing reporting days or treatment levels.

Principles attached to the use of rewards and sanctions include the certain implementation of the scheduled reward/sanction and that rewarding positive behavior more frequently than sanctioning negative behavior is more effective. However, based on the data in SCCM, the ratio of incentives to sanctions falls short of the ratios suggested for successful behavior change (4:1 rewards to sanction). This could be lack of reporting or absence of data, but more conscious efforts to develop and record incentivizing systems may improve outcomes.

Moreover, some courts rely heavily on jail as a sanction despite the goal of decreasing jail stays and the negative effects of incarceration on persons with SMI. Although the data do not allow full assessment of which jail days during MHC were used as sanctions versus new offenses, the small number of new offenses (14% of the entire population) and the moderate reduction in jail days during as compared to pre-MHC, suggests that jail is a commonly used sanction. The use of jail as a sanction might be more limited if the menu of sanctions increased. In other words, there is a need for graduated sanctions that would offer a more comprehensive array of options to incentivize positive behavior and a similar array of options to sanction negative or unwanted behavior. If this more comprehensive array of options was available, and the incentive/sanction ratio favored incentives, jail might be used less frequently.

5. Improving dual diagnosis capabilities of the court/team

Although there is a variation in how and when substance use disorders are assessed across courts, thus making it difficult to definitively capture the prevalence of COD, it is clear that the majority of participants were misusing drugs and/or alcohol or had a COD. The presence of COD, defined as receiving any substance abuse treatment before or during MHC, predicted unsuccessful completion, more jail days during MHC, and poorer recidivism outcomes.

However, there are indications that enhanced treatment for COD may improve outcomes. For example, gaps between who was identified as having a substance abuse problem and who received related services could be closed (only 65% of those identified with a substance use disorder received a related treatment during MHC). Moreover, of the 339 (50%) participants who had at least one positive drug screen during MHC, 234 (69%) received substance abuse treatment. Based on interviews with program staff, only three reported offering integrated mental health and substance abuse treatment services, but there was no indication of any participant receiving the CMH preferred Integrated Dual Disorders Treatment (IDDT).

Enhancing staff involved in MHC to provide the multiple components of IDDT, including motivational interviewing, 'staging' both substance abuse and mental health treatment, dual

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recovery support groups, and a multidisciplinary team would be a beneficial addition. One advantage of the MHC is the presence of the treatment team as a vehicle for collaboration among the mental health, substance abuse, and criminal justice providers. Operationalizing this vehicle outside of an MHC program is often an obstacle to this level of collaboration.

6. Enhance treatment retention post-MHC

The data demonstrate that participation in MHC greatly increases the number of mental health treatment services – particularly low-intensity services – as compared with the year pre-MHC. However, in the one year post-MHC, there is a reduction in the number and amount of services provided. On one hand a reduction in overall service utilization could be a positive outcome in that functionality of the participant has improved. However, that nearly a quarter of those discharged do not engage in any service – even low-intensity services (i.e. medication reviews)– may affect longer-term outcomes of MHC.

It should be remembered that the post-MHC service utilization across Michigan MHCs is higher than reported in the research literature. However, efforts to enhance the continuum of care between MHC involvement and discharge may elongate stabilization gains made during MHC. Community outreach and transition planning with new providers may enhance engagement over time.