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# **Evaluating the Recidivism Rates for Parolees Enrolled in M-COIT, a Community Mental Health/ Substance Abuse Treatment Program**

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### **Abstract**

This paper focuses on an evaluation of recidivism rates of parolees with severe and persistent mental illness enrolled in a mental health/ substance abuse treatment program (M-COIT) at a community mental health center in southeastern Michigan. The two partners in the study were a community mental health center located in a city bordering the southern part of Detroit and Eastern Michigan University located in Ypsilanti, Michigan. The purpose of the study was to identify the recidivism rates and factors that affected these rates for parolees who participated in the M-COIT Program. This was a retrospective medical record review. The practical participatory evaluation was stakeholder driven; the organization's staff initiated the evaluation and participated directly in the process from start to finish, including setting objectives and expectations, instrument development, data collection, analysis and interpretation, and reporting of outcomes. Results reported are for the parolees who participated in the program from 2004 to 2006. Implications for public health are addressed.

## Overview

The chief executive officer of a non-profit community mental health center, located in a Downriver city bordering Detroit, Michigan, was interested in identifying the recidivism rates and factors that affected these rates for parolees who participated in the outpatient mental health and substance abuse treatment program (M-COIT) operated by the agency, and in identifying interventions that needed to be continued, modified and/or enhanced. The M-COIT (Mental Health/Substance Abuse Corrections Outreach Intensive Treatment Program) located in Wayne County, Michigan, is a multi-disciplinary, outpatient mental health and substance abuse treatment program for parolees with severe mental illness and/or substance use disorders.

Mental illness as a public health issue negatively affects an individual's overall health and well-being. According to Healthy People 2020, mental illness refers collectively to all diagnosable mental disorders; mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning (USDHHS, 2012). The National Institute of Mental Health (2012) reports that an estimated 26.2 percent of Americans ages 18 and older, about one in four adults, suffer from a diagnosable mental disorder in a given year; six percent suffer from a serious mental illness. The prevalence rates of many of the mental disorders among inmates are higher than the rates for these conditions among the U.S. population as a whole (Feucht & Gfroerer, 2011; NCCHC, 2002). Sixty to eighty percent of individuals under the supervision of the criminal justice system have a substance use related issue (Feucht & Gfroerer, 2011).

“Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25 percent of all years of life lost to disability and premature mortality”

(USDHHS, 2012). Mental illness is associated with such chronic medical diseases as cardiovascular disease, diabetes, and obesity (CDC, 2011). Although rates for asthma among inmates are higher than for the total U.S. population (NCCHC, 2002). The prevalence rates for diabetes and hypertension are lower for inmates than the U.S. population, perhaps because these inmates are a relatively young population (NCCHC, 2002). A more serious threat to the public's health is the high prevalence rates of certain communicable diseases, HIV/AIDS, sexually transmitted diseases, Hepatitis B and C, and Tuberculosis infection and disease. These are significantly higher among inmates and those released than among the total U.S. population (NCCHC, 2002).

Participatory evaluation is applied social research that involves a partnership between a trained evaluator and practice-based decision makers, organization members with program responsibility or people with a vital interest in the program, primary users (Cousins & Earl, 1992). Practical participatory evaluation fosters evaluation use with the implicit assumption that evaluation is geared toward program, policy, or organizational decision-making (Cousins & Whitmore, 1998). Cousins (2001) defines practical participatory evaluation in which primary users of evaluation data participate directly in the evaluation process from start to finish, including technical activities as instrument development, data collection, processing, interpretation, and reporting. Practical participatory evaluation represents a pragmatic problem-solving approach where the primary concern is the creation of meaningful evaluation knowledge that will be useful in supporting program decision making (Sylvestre, Cousins, Sundar, Aubry, & Hinsperger, 2008). Involvement of staff will increase the likelihood that the outcomes of the study will be used to improve the effectiveness of the program and enhance organizational learning (Kopczynski &

Pritchard, 2004) and ownership of outcomes (Hudson, Hardy, Henwood, & Wistow, 1999).

In this paper, the authors first describe Assertive Community Treatment, the evidence-based practice on which the M-COIT Program is modeled, and the M-COIT Program itself. Secondly, the authors discuss the participatory evaluation process, results regarding recidivism rates and associated factors, lessons learned, and implications for public health practice.

**Assertive Community Treatment:** The evidence-based practice model for M-COIT is Assertive Community Treatment, which provides comprehensive mental health services in the community utilizing an interdisciplinary treatment team based on consumers' needs (Dixon, 2000; Lamberti, Weisman, & Faden 2004; Morrissey, Meyer, & Cuddleback, 2007; Osher & Steadman, 2007).

In an ACT Program, the interdisciplinary team provides intensive treatment through supportive and cognitive-based psychotherapy, psychiatry, and case-management services and facilitates dual-diagnosis treatment, psychotropic medication management, educational/vocational assistance and promotes community re-engagement (Allness & Knoedler, 2003). Staff are to be available 24 hours a day, seven days a week, with an average of three contacts per week with the clients (Allness & Knoedler, 2003). The original intent of the ACT Model was to treat individuals with severe and persistent mental illness in the community to prevent repeated psychiatric hospitalizations (Dixon, 2000, & Morrissey et al., 2007). Morrissey et al. (2007) report that the ACT model needs to be modified with extra interventions that specifically target reduction of criminal behavior, and that there is a definite need for ACT-like interventions for mentally ill offenders, because as a group, individuals with severe mental illness are incarcerated more often than they are hospitalized. Forensic ACT (FACT) is the emerging designation for

ACT teams that focus on preventing psychiatric hospitalizations, jail detention and recidivism for those individuals with severe mental illness who are involved with the criminal justice system (Lamberti et al., 2004; Morrissey et al., 2007; Osher & Steadman, 2007).

**M-COIT Program:** The M-COIT Program is a certified ACT program adapted to meet the needs of the parolees who are severely and persistently mentally ill, the majority of whom have co-occurring substance-use disorders. M-COIT provides intensive case-management, psychotherapeutic, psychiatric, nursing, and referral services. The goals of M-COIT are to assist parolees with severe mental illness who were discharged from Michigan's prison system in adjusting to community living and maintaining a crime-free life style. The premise is that parolees who comply with treatment will have lower recidivism rates, have reduced inpatient psychiatric hospitalizations, and be productive members of society. For many parolees, participating in intensive mental health and substance use/abuse services is a parole condition, and they risk violating parole if they do not participate.

To be admitted into M-COIT, parolees need to meet a criterion as being severely and persistently mentally ill. This includes, but is not limited to, a severe DSM-IV-TR Axis I diagnosis, a history of psychiatric hospitalizations, the present and/or historical usage of major psychotropic medications for the stabilization of a profound mental illness, and referral from prison, a parole officer or parole board. Further consideration is given to individuals with significant chemical dependency histories as defined by substance abuse inpatient treatment histories, as well as legal and diagnostic data. Almost all of the parolees in M-COIT have some form of chemical dependency (primarily crack, alcohol, marijuana, and heroin).

Parolees enrolled in the M-COIT Program are required to participate in mandatory, weekly mental health and substance abuse didactics (education), weekly group psychotherapy, monthly psychiatric and medication reviews, individual psychotherapy, and be in contact with nurses and case-managers, on an outpatient basis. Individuals in need of inpatient substance abuse services are referred to one of three residential substance abuse treatment sites with M-COIT contracts. The length of the program is the term of the individual's parole, which is generally between 18 and 24 months. This is the amount of time for which the funder will pay for services. Once a parolee completes parole and is still in need of services, M-COIT staff refers him or her to a treatment program within the Agency or another community agency, as appropriate.

M-COIT meets the fidelity requirements of the ACT standards, and its adaptations comport with the four elements that Lamberti (2007) and Morrissey (2007) identified to distinguish a forensic ACT program from a traditional ACT program. These four elements are: 1) the goal of the program is to prevent arrest and incarceration; 2) requirement of all participants admitted to M-COIT to have criminal-justice histories; 3) acceptance of the majority of referrals from criminal justice agencies; and 4) the development and incorporation of supervised residential treatment components for parolees with co-occurring substance use disorders (Lamberti et al, 2007; Morrissey et al., 2007).

### **Evaluation process**

This evaluation study was a participatory process that involved stakeholders as partners with the external evaluator in the study design, data analysis, and reporting. The key component of participatory evaluation was stakeholder involvement (Cousins & Whitmore, 1998; Israel, Eng, Schulz, & Parker, 2005; Plottu & Plottu, 2009); Sylvestre, Cousins, Aubry, & Hinsperger, 2008).



If stakeholders are involved, this increases the likelihood that the evaluation results will be used.

In this study, the stakeholder was the organization, with the CEO as the driving force for the evaluation of M-COIT. The CEO wanted to identify the recidivism rates of the parolees and to identify factors contributing to these rates for program improvement. The internal evaluator was M-COIT's Program Coordinator, and the external evaluator was a faculty member from Eastern Michigan University in Ypsilanti, Michigan. Before the commencement of the study, the CEO, Deputy Director for Programs, the Program Coordinator, and the faculty member met informally to discuss the study and to clarify roles. The CEO and the Deputy Director were to develop overall objectives for the evaluation and serve as a resource during the evaluation process. The Program Coordinator and external evaluator would collaborate on the data collection process, analysis, reporting of results, and joint authorship of papers. Resolving differences and concerns was not specifically addressed at the preliminary meeting, but it was implied the internal and external evaluators were to work together and not expect the CEO to resolve them. This was important because of the personal (spousal) relationship between the CEO and the external evaluator.

Prior to the commencing the study, the CEO informed the Agency's Board of Directors about the study and that his wife would be the external evaluator. No compensation would be provided to the external evaluator and that he would apprise the Board of progress on a regular basis. At this point, the CEO was in control of the agenda. His objective, as stated in the beginning, was to identify factors that contributed to recidivism rates, new conviction rates, and inpatient psychiatric hospitalization rates for parolees who participated in M-COIT. The information

would be shared with funders and be used for program improvement. Once the Board of Directors approved the study, the CEO, Deputy Director for Programs, Program Coordinator, and the external evaluator met to finalize the objectives of the study and the data collection process. After the initial meeting, the evaluators met on a regular basis.

Data collection included a retrospective medical record review of parolees who were discharged from the M-COIT from 2004 through 2006 and were not enrolled in M-COIT during the study period that commenced in 2007. These years were selected because there needed to be an interval of at least one year between discharge from M-COIT and assessment of recidivism status. According to Austin and Hardyman (2004), most arrests occur during the first year out of prison. The data collection tool was designed to collect demographic data (age, gender, education, race), the number of contacts the consumers had with members of the ACT team, the type of contact (individual and group), psychiatric diagnosis, past and current history of substance use, past treatment for mental illness and substance abuse, discharge status from M-COIT, and other factors.

Another source of data was the state of Michigan's online offender database, the Offender Tracking Information Service (OTIS), to ascertain the incarceration status of the individuals under study. This database lists demographic data about the offenders, their status (prisoner, parolee, probationer, absconder, or discharged), and the type of sentences (active and inactive) (Michigan Department of Corrections).

The external evaluator developed the first draft of the data collection tool based on the literature

review, discussions with the Program Coordinator, and forms that the Agency used to collect data on all consumers enrolled in its various programs. After both evaluators agreed on the data collection tool, the external evaluator submitted a request to the University's Human Subjects Review Committee (UHSRC) for approval. Upon approval from the UHSRC, in March of 2007, the external evaluator started collecting data from 2004, 2005 and 2006 years' program data. Data was scattered throughout the record, so after reviewing several records, the evaluator redesigned the tool to follow the sections of the medical record for ease of data retrieval. Once agreement was reached regarding revisions, the external evaluator continued with data collection.

Data collection was a slow and time-consuming process because the medical records were voluminous, the external evaluator was unfamiliar with the records and had limited time for the project. For the time period under study, agency providers manually documented each contact from the medical record. Many parolees had more than 200 contacts, and some had more than 500 contacts with M-COIT staff, which contributed to the substantial size of the medical record. The external evaluator spent approximately three hours per record collecting data. To assist and expedite the process, the CEO assigned the Agency's Quality Improvement (QI) Assistant to assist with the data collection because she was familiar with the records. The external evaluator instructed the QI Assistant in the use of the tool and reviewed each form after the QI Assistant finished collecting data from the medical record. The number of contacts a parolee had with M-COIT staff was an important variable because one of the criteria for ACT is the number of contacts a consumer has with the ACT program team, which is to be at least three or more contacts per week (Allness & Knoedler, 2003) and the effect of this factor on recidivism rates.

The Program Coordinator reviewed several records that the evaluator completed on ascertain if there was consistency in data retrieval. No parolees' names, addresses, nor medical record numbers were written on the surveys to maintain confidentiality. The forms were coded with a number that was cross-referenced to a list of names that was kept separate from the completed forms.

The external evaluator inputted and analyzed the data with a statistical analysis program. Discussions were ongoing between the evaluators regarding data analysis and interpretation of the results. For example, information about the parolees' inpatient psychiatric hospitalizations was not consistently documented in the medical record; therefore, these rates were not calculated and not reported in this paper.

### **Results**

In this section, we describe the characteristics (gender, age, race, education, and employability) of the 74 parolees who were discharged from M-COIT, in calendar years 2004 through 2006, (see Table 1), and report the results of cross tabulation analysis.

The percent of women enrolled in M-COIT is higher than the percent of women in prison, which is approximately four percent (MDOC, 2007). The mean age of the consumers was 40.1 years, which is higher than the prison population's mean age of 36 years (MDOC, 2007). High school graduates included a general equivalency diploma and/or had education beyond high school.

Special training or skills was used as a proxy for employability. Criminal history was measured in two ways: one was the number of sentences per consumer and the other was the type of most recent offense. Sung and Rickter (2006) refer to criminal history as number of adult arrests. The

mean number of sentences was 3.27 (n= 70). The OTIS system reports the number of sentences with which a prisoner is charged and not the number of arrests. The number of arrests may be higher, if the offender had been arrested for a misdemeanor and jailed in a local jurisdiction that is not included in the Michigan Department of Corrections database. The most recent offenses for which the parolees were serving a sentence prior to release and enrollment in M-COIT are listed in Table 2.

Approximately 93% (69, n=74) of the parolees had a co-occurring disorder of some form of substance abuse; only 16.4% (12, n=73) were sentenced for drug offenses. Forty (54.1%, n=74) had a thought disorder (various forms of schizophrenia), and 34 (45.9%, n=74) had a mood disorder (e.g., bi-polar and major depression) as their primary Axis I diagnosis. The average length of stay in M-COIT was 48.93 weeks, ranging from .29 weeks to 153.29 weeks. The mean number of contacts was 4.5 per week, and 71.6% (53, n=74) had at least three or more contacts per week. One year after discharge from M-COIT, 36.9% (n = 65)<sup>3</sup> returned to prison. This is lower than the 42.5% parolees who were re-incarcerated in Michigan in 2006 (Bureau of Justice Statistics, 2007). Of those who returned to prison, only three were charged with a new sentence of a felony. In Michigan, 38.8% were imprisoned with a new sentence (Bureau of Justice Statistics, 2007).

Cross tabulation analysis was used to identify relationships between the dependent and independent variables. The dependent variable was whether or not a parolee returned to prison within one year of discharge from the M-COIT Program. The independent variable was a

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<sup>3</sup> There was missing data on 4 of the prisoners and 5 died either while they were in M-COIT or within one year of discharge.

dichotomous variable, whether or not a participant had three or more contacts per week with the M-COIT team, controlling for age, education, race, gender, employability and mood disorder. Characteristics that can affect a parolee's return to prison are age, gender, education, race, type of mental disorder, employment-related skills, substance abuse, criminal history, (Austin & Hardyman, 2004, Belenko, Foltz, Lang, & Sung, 2004; Sung & Rickter 2006), residence, and family relationships (Austin & Hardyman, 2004). The premise was that the more contacts the parolee had with the ACT team, the greater the likelihood the parolee would not recidivate. If a parolee had three or more contacts per week with the team, this was coded as 1, and if there were fewer than three contacts, it was coded as 0. First, the relationship between the dependent variable and the individual independent variable was analyzed, excluding the primary independent variable of interest, three or more contacts per week, to ascertain if there were statistically significant relationships between them. Secondly, the relationship between the dependent variable and the variable, three or more contacts per week, controlling for the other variables, individually was analyzed. Pearson's Chi Square was used to test for statistical significance among the relationships because cross tabulation analysis takes into consideration all tabular data (Pollock, 2003). The p value of .05 was used to determine statistical significance. Parolees' ages were grouped into two categories, 30 years and younger and 31 years and older. Education was categorized as high school education or higher (including general equivalency diploma or GED) or not a high school graduate. Race was transformed into a dichotomous variable, white and nonwhite. Employability measure was defined through the consumer's self-report as having or not having special training or skills. Mental disorders were grouped as thought or mood disorders. The number and percent of parolees who returned to prison, number of weekly contacts, and control variables are included in Table 3.

Individuals who had three or more contacts per week with the M-COIT team had a higher rate of return to prison than those with fewer than three contacts, 43.8% (21, n=48) and 17.6% (3, n=17), respectively. This was not a statistically significant relationship at the  $p < .05$  level. In analyzing the relationship between number of contacts and return to prison, controlling for the other independent variables, there were statistically significant relationships when we controlled for age and type of mental disorder at the  $p < .05$  level. There were no statistically significant relationships between returning to prison, the number of weekly contacts, controlling for the other variables. (See Table 3). There is a statistically significant relationship between three or more contacts, parolees under age 30, and return to prison,  $\chi^2 (1) = 6.429, p < .05$ . The relationship between parolees with thought disorders and number of contacts and return to prison is not statistically significant. The relationship between parolees with mood disorders and number of contacts and return to prison is statistically significant at the  $p < .05$  level (See Table 3).

### **Discussion and Lessons learned**

As indicated above, the recidivism rates for 2004 through 2006 appear to be lower for the parolees who participated in M-COIT than that for the state of Michigan. One year after discharge from M-COIT, 36.9% (n = 65) parolees returned to prison. The premise was that if parolees had three or more weekly contacts with the M-COIT team, they were less likely to recidivate. In reviewing the data, it appears that the opposite occurred. The only statistically significant relationships with return to prison within one year of discharge, and number of contacts with the MCOIT team, were younger parolees and those with mood disorders.

Baillargeon et al. (2009) reported that parolees with comorbid disorders (psychiatric and

substance use) have a twofold greater risk of parole revocation as a result of a parole violation and nearly a threefold greater risk for revocation as a result of a new offense. Approximately 93% of the parolees participating in M-COIT have co-occurring psychiatric and substance abuse disorders. Individuals who have co-morbid psychiatric disorders have multiple service needs, resulting in more frequent contacts with the M-COIT team. Having contact with the M-COIT team that includes parole officers and case managers may increase the likelihood that parolees' technical violations are identified at a higher rate than those who have less contact with the team. In their study, Balillargeon et al. (2009) state that reincarceration rates may be partly attributable to more frequent and focused surveillance by case managers and parole officers. Our results indicate that there is a need for more in-depth analysis.

Developing a trusting relationship is a key component of a participatory evaluation process, not only among the management staff, but also with line staff. Although line staff were informed about the study, they were not involved in the preliminary discussions regarding the purpose and objectives of the evaluation study. There needs to be a formal mechanism to address staff concerns, which the evaluators did not do. There is a need to involve all staff from start to finish (Cousins, 2001).

The Agency learned how time consuming it is to conduct an evaluation study and that it consumes indirect resources. Even though the external evaluator was not paid, the CEO allocated staff time to assist in data collection, and clerical staff assisted in retrieving records on-site and off-site and filing them. The Program Coordinator is a therapist in the M-COIT Program; therefore, time dedicated to this project was time away from treatment and productivity. Indirect



Agency costs were not calculated. The outcomes affirmed the need for intensive resources to meet the multiple service needs of the parolees. Finally, the external evaluator learned that internal communication is extremely important among all parties and that evaluators need to be more assertive in that regard.

### **Implications for Public Health**

Inmates and parolees have higher rates of mental disorders, substance use, asthma, and communicable diseases. Once released from prison, many do not have access to primary care because of their ineligibility for Medicaid services, limited or no funds, or no usual source of medical care. Lack of access to medical care is a major problem because disease conditions may go untreated until an individual is very ill and treatment will then be costly, as well as presenting the potential to spread communicable diseases, if left undiagnosed and untreated. With limited budgets and overcrowded correctional facilities, states are discharging prisoners earlier into the community where there are scarce resources to care for both the public and mental health needs of the individuals. There is a need to develop systems to coordinate services among the correctional, the public health, and mental health sectors to address the needs of the individuals and to protect the public's health.

### **Summary**

This evaluation study was a participatory process and the stakeholder, organization was involved from the initiation of the study, forming objectives, designing the data collection tool, assisting in data collection, analyzing and interpreting results. Results were reported to the Board of Directors and funders and disseminated at a conference. The authors described the Assertive Community Treatment, the evidence-based practice on which M-COIT is based, the Agency's M-COIT Program, its goals, the target population, the type of study, analysis, and

outcomes. The primary focus of this paper was on the participatory evaluation process of an academic-agency partnership to identify the recidivism rates of parolees who were treated for severe and persistent mental illness and substance use disorders in a community mental health agency in Wayne County, MI. Overall, the recidivism rates were lower than the state of Michigan's; however those consumers who recidivated had a greater number of contacts with M-COIT providers. There is a need to explore, in more depth, the reasons for this.

## References

- Allness, D. and Knoedler, W. (2003). *National Program Standards for ACT Teams*. National Alliance for Mental Illness.  
<http://www.nami.org>
- Austin, J. and Hardyman P. (2004). The risks and needs of the returning prisoner population. *Review of Policy Research*, 21 (1), 13-29.
- Baillargeon, J., B. A. Williams, J. Mellow, A.J. Harzke S.K. Hoge, G. Baillargeon & R.B. Greifinger (2009). Parole revocation among prison inmates with psychiatric and substance use disorders. *Psychiatric Services*, 60(11), 1516–1521.  
doi: 10.1176/appi.ps.60.11.1516
- Baker, E., White, L.E., and Litchveld, M.Y. (2001). Reducing health disparities through community based research. *Public Health Reports*, 116 (6), 517-519.
- Belenko, S., Foltz, C., Lang, M. & Sung, H. (2004). Recidivism among high risk drug felons: A longitudinal analysis following residential treatment. *Journal of Offender Rehabilitation*, 40 (1/2),105-132.
- Bureau of Justice Statistics ( 2007). News Release. Two-thirds of former state prisoners rearrested for serious new crimes. <http://www.ojp.gov/bjs/pub/press/rpr94pr.htm>
- Centers for Disease Control (2011). CDC Report: Mental illness surveillance among adults in the United States. [http://www.cdc.gov/mentalhealthsurveillance/fact\\_sheet.html](http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html)
- Cornwall, A., & Jewkes, R. (1995). What is participatory research? *Social Science Medicine*, 41(12), 1667-1676.
- Cousins, J. B. (2001). Do evaluator and program practitioner perspectives converge in collaborative evaluation? *The Canadian Journal of Program Evaluation*, 16(2), 113-133.
- Cousins, J. B., & Earl, L. M. (1992). The case for participatory evaluation. *Educational Evaluation and Policy Analysis*, 14(4), 397-418.
- Cousins, J. B., & Whitmore, E. (1998). Framing participatory evaluation. *New Directions for Evaluation*, 80, 5-23.
- Dixon, L. (2000). Assertive Community Treatment: twenty-five years of gold. *Psychiatric Services*, 51 (6), 759- 765.
- Feucht, T.E. & J. Gfroerer (2011). Mental and substance use among adult men on probation or parole: Some success against a persistent challenge. *SAMHSA Data Review*, 1-16.  
Available at <http://oas.samhsa.gov>
- Hudson, B., Hardy, B., Henwood, M., & Wistow, G. (1999). In pursuit of inter-agency collaboration in the public sector. *Public Management: An International Journal of Research and Theory*, 1(2), 235-260.
- Israel, B., Eng, E., Schulz, A.J. and Parker, E.A. (2005). Introduction to methods in community-based participatory research for health. In B. Israel, E. Eng, A.J. Schulz, and E.A. Parker (Eds.), *Methods in community-based participatory research for health* (pp. 3-26). *San Francisco: Jossey Bass*
- Kopczynski, M. E. and Pritchard, K. (2004). The use of evaluation by nonprofit organizations. In J.S. Wholey, H. P. Hatry and K.E. Newcomer (Eds.), *Handbook of practical program evaluation* (pp. 649-669). San Francisco: Jossey Bass
- Lamberti, J.S., Weisman, R. and Faden, D. (2004). Forensic Assertive Community Treatment: Preventing incarceration of adults with severe mental illness. *Psychiatric Services*, 55 (11): 1285-1293.

- Michigan Department of Corrections (nd.). Offender Tracking Information System.  
<http://www.state.mi.us/mdoc/asp/otis2.html>
- Michigan Department of Corrections (2007). *Michigan Prisoner Reentry Initiative (MPRI), Mental health reentry and Targeted case management*. Program Summary.
- Michigan Department of Corrections (2009). *2009 Statistical Report*. Retrieved from:  
<http://www.michigan.gov/documents/corrections/>
- Morrissey, J. , Meyer, P. & Cuddleback, G. (2007). Extending Assertive Community Treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43 (5), 527-544.
- National Commission on Correctional Health Care (NCCHC) (2002) *The Health Status of Soon-To-Be-Released Inmates: A Report to Congress*, vol. 1
- National Institute of Mental Health (2012) The numbers count: Mental disorders in America.  
<http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-inamerica/index.shtml>
- Osher, F., Steadman, H. & Barr H. (2003). A best practice approach to community re-entry from jails with co-occurring disorders: the APIC Model. *Crime and Delinquency*, 49 (1), 79-96.
- Petersilia, J. (November 2000). When Prisoners Return to the Community: Political, Economic, and Social Consequences. *Sentencing and Corrections, Issues for the 21<sup>st</sup> Century*. US Department of Justice, Office of Justice Programs.
- Pollock, Phillip H. (2003). *The Essentials of Political Analysis*. Washington, DC: CQ Press.
- Plottu, B., & Plottu, E. (2009). Approaches to participation in evaluation: Some conditions for implementation. *Evaluation*, 15(3), 343-359.
- Ryan, K., Greene, J., Lincoln, Y., Mathison, S., Donna M. Mertens, & Ryan, K. (1998). Advantages and challenges of using inclusive evaluation approaches in evaluation practice. *American Journal of Evaluation*, 19(1), 101-122.
- Sung, H. and L. Rickter (2006). Contextual Barriers to Successful Reentry of Recovering Drug Offenders. *Journal of Substance Abuse Treatment*, 31, 365-374.
- Sylvestre, J., Cousins, J. B., Sundar, P., Aubry, T., & Hinsperger, V. (2008). Engaging stakeholders in the planning of a collaborative multi-agency evaluation: The HousingPlus Collaborative Communities Project. *Studies in Educational Evaluation*, 34, 212-217.
- U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at [www.healthypeople.gov](http://www.healthypeople.gov)

Table 1: Parolees' Demographic Characteristics, 2004-2006

Variable	N	Percent
Gender	74	
Male	61	82.4
Female	13	17.6
Age	74	
< 30 years	11	14.9
> 30 years	63	85.1
Race	73	
White	31	42.4
African American	40	54.8
Other Minority	2	2.7
Education	74	
< 12 years	24	32.4
≥ high school graduate	50	67.6
Special skills- self report	65	
Yes	32	49.2
No	33	50.8

Table 2: Most Recent Offense Before Enrolling in M-COIT

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Violent	25	33.8	34.2	34.2
	Property	29	39.2	39.7	74.0
	Drug offense	12	16.2	16.4	90.4
	Public disorder	5	6.8	6.8	97.3
	Other offenses	2	2.7	2.7	100.0
	Total	73	98.6	100.0	
Missing	9	1	1.4		
Total		74	100.0		

Table 3: Number of Parolees who Returned to Prison, Weekly Contacts, and Control Variables

Variables	N	#RTP	< 3 weekly contacts	≥ 3 weekly contacts	X <sup>2</sup>	DF	Sig.
Age							
<30 years	10	6	0	6	6.429	1	p ≤ .05
≥30 years	55	18	3	15	1.089	1	p ≥ .05
Mental disorder							
Thought	33	12	2	10	.589	1	p ≥ .05
Mood	32	12	1	11	3.720	1	p ≤ .05
Education							
< high school	20	8	1	7	1.111	1	p ≥ .05
≥ high school	45	16	2	14	2.548	1	p ≥ .05
Gender							
Male	54	19	2	17	3.620	1	p ≥ .05
Female	11	5	1	4	.244	1	p ≥ .05
Race							
White	28	7	0	7	2.545	1	p ≥ .05
Nonwhite	36	17	3	14	1.648	1	p ≥ .05
Employability							
Yes	28	10	1	9	1.207	1	p ≥ .05
No	29	11	2	9	1.368	1	p ≥ .05