LA CRISP RICMS Cohort 2 Final Report for the Los Angeles Justice, Care, and Opportunities Department

Submitted to the California Board of State and Community Corrections

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BUILDING KNOWLEDGE TO IMPROVE SOCIAL POLICY

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Overview

Los Angeles County has the largest jail system in the world, housing over 14,000 people daily in 2021.[1] In an effort to divert people from incarceration as well as support formerly incarcerated individuals when they are released, LA County's Board of Supervisors established the Office of Diversion and Reentry – hereafter referred to as the Reentry Division – in September 2015. The office connects individuals with criminal legal system involvement with housing, employment, physical and behavioral health, and other supportive services that are intended to improve well-being and prevent future system involvement.

Evidence for coordinated reentry – or the coordination of services across multiple community providers – shows that it is a promising approach to support individuals with mental health or substance use disorders who are released from correctional facilities to access services. Recognizing the role that community-based organizations can provide in securing access to services, the Reentry Division built a countywide system of programs that aim to increase access to housing, health, mental health, substance use disorder, employment, and other services intended to reduce justice system involvement. One such program is the Reentry Intensive Case Management Services (RICMS) program. Through a network of 29 community-based providers located across Los Angeles County, RICMS links individuals with prior criminal legal system involvement to community health workers – most of whom have lived experience, or a family member with lived experience with the criminal legal system, housing instability, or mental health issues. The community health workers provide care coordination and navigate clients to a wide array of services and supports throughout LA County for about one year.

This report describes findings from a process and outcomes study of RICMS based on analysis of administrative records and management information system data for individuals enrolled in the program between April 2018 and March 2021, a survey of program staff and managers in April 2022, and semi-structured interviews with program managers, staff and participants conducted between June 2019 and August 2022.[2] The study used a non-experimental approach to compare the health and criminal legal system outcomes of individuals who enrolled and participated in RICMS with those of a matched comparison group who enrolled but did not participate in the program. Though propensity score matching is a powerful analytic tool, it cannot determine with certainty whether a causal relationship exists between the program and observed outcomes. It is possible that unobserved characteristics may influence the patterns of who participates in the program and who does not. However, in the absence of a randomized controlled trial, this exploratory quasi-experimental analysis provides some initial information about the differences in outcomes that could be due to participation in the program.

Overall, the results suggest that RICMS is a promising program to improve the life experiences of its clients, especially in reducing future contact with the criminal legal system. More specific findings include:

- **Location of enrollment appears to have important implications on participation in the program.** Clients reach RICMS through a variety of referral sources including within LA

[1]Vera Institute of Justice (n.d.).

[2]The study defines enrollees as individuals entered into the CHAMP management information system for the RICMS program. Participants are those who received services from a community health worker for at least 30 days after enrollment and had a care plan recorded in CHAMP.

County and City of Long Beach jails. Most individuals enrolled in RICMS after returning to live in the community after release, but some individuals enrolled in RICMS while still in jail. Of those enrolled while they were in jail, 13 percent participated in RICMS while 30 percent of those who enrolled while living in the community did.

- **Participants and nonparticipants, across both enrollment locations, had similar demographic profiles.** The majority were men. with more than 40 percent identifying as Hispanic and 29 to 41 percent identifying as Black. The groups had similar levels of County mental health outpatient service and inpatient treatment use. Participants who enrolled while in the community were more likely to live in the South Los Angeles service planning area. The groups differed most in their recency of contact with the legal system. Participants who enrolled while living in the community after release had less recent contact with the criminal legal system than non-participants who enrolled after release and than participant and non-participants who enrolled while in jail.

- **Over half of RICMS participants were enrolled in the program for 6 months or less, regardless of their enrollment location.** Individuals enrolled while in the community tended to participate for longer periods of time than those enrolled while in jail. Participants interviewed consistently spoke about the importance of their connection with their community health worker, some even described them as "family."

- **Multiple contextual factors created barriers to program implementation and participation.** Inaccessibility or unavailability of housing was a pervasive issue; stable housing supports facilitate connections with employment, substance use recovery, and positive physical and mental health. Communication between the jail-based staff and RICMS program staff was not consistent by provider or staff member so collaboration to support individuals as they prepare for and return to the community was not consistent and sometimes challenging. Exacerbating the challenge to coordinate with individuals in jail was that the Los Angeles County Sheriff's Department placed restrictions on staff attempting to access the jail population in person. The COVID pandemic prompted providers to adjust their service delivery approaches.

- **RICMS is a promising program that appeared to reduce contact with the criminal legal system during the first two years of follow-up and to reduce the use of emergency room services for those who enrolled while living in the community.** Because the pool of individuals who enrolled while in jail (1,619) is so much smaller than the number of individuals who enrolled in the community (13,429) the non-experimental analyses are focused on the latter group.

    - Across nearly all the criminal legal system outcomes measured – including arrest, incarceration, convictions, and probation revocation – the participant group had statistically significant better outcomes than the comparison group. RICMS program participants were less likely to experience convictions, arrests, incarcerations, and probation revocations than the comparison group. They also spent fewer days in jail at both one- and two-years after program enrollment.

    - RICMS program participants were also less likely to visit the emergency room than comparison group members at both time periods.

Though the nonexperimental matched comparison group analysis should be interpreted with some caution, taken together, this study finds that this kind of case management structure that employs persons with lived experience as community health workers is a promising approach for individuals with legal system involvement. Relationships between participants and community health workers – and the supports they provided – was central to the success of participants. An upcoming cost study will further explore these findings and document the total costs of the RICMS program.

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Acknowledgments

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The Authors

Introduction to the Program

Los Angeles County has the largest jail system in the world, housing over 14,000 people daily in 2021.[1] In recent years, the LA County jail has seen an increase in the number of individuals with complex clinical needs, in part due to a lack of affordable housing and difficulties in navigating and accessing physical and behavioral health services in the community.[2] In an effort to divert people from incarceration as well as support individuals after their interaction with the criminal legal system, LA County's Board of Supervisors established the Office of Diversion and Reentry – referred to as the Reentry Division in this report – in September 2015.[3] The department's goal is to divert people from incarceration and support individuals when released. With funding from the Safe Neighborhoods and Schools Act (Proposition 47) – administered by the California Board of State and Community Corrections – and the California Community Corrections Performance Incentives Act of 2009 (SB 678), the Reentry Division has since launched a number of programs that are intended to improve well-being and prevent future system involvement.

Evidence for coordinated reentry into the community – or the coordination of services across multiple community providers – shows that it is a promising approach to support individuals with mental health or substance use disorders who are released from correctional facilities to access services.[4] Recognizing the role that community-based organizations can provide in securing access to services, the Reentry Division built a countywide system of programs that aim to increase access to housing, health, mental health, substance use disorder, employment, and other services intended to reduce involvement in the criminal legal system. This system of services includes the Reentry Intensive Case Management Services (RICMS) program.[5] Through a network of community-based providers located across Los Angeles County, RICMS links individuals with prior criminal legal system involvement to community health workers who provide care coordination and help clients navigate their way to a wide array of services and supports.

MDRC leads the RICMS evaluation as part of the Los Angeles County Reentry Intensive Services Project (LA CRISP), a multiyear, multi-study evaluation of the Reentry Division reentry services. The study was executed as part of a Proposition 47 grant to Los Angeles County.

To evaluate RICMS, the LA CRISP research team conducted a process study, an outcomes study, and a cost study. This report presents findings for the process and outcome studies.[6] The remainder of this introductory section briefly describes RICMS. The RICMS implementation study findings are described in the next section, followed by a presentation of the findings from an outcomes study of the RICMS program one year and two years after clients enrolled, depending on the time of

[1]Vera Institute of Justice (n.d.).

[2]Hunter and Scherling (2019).

[3]In 2022, the Los Angeles County Board of Supervisors consolidated various efforts – including the Office of Diversion and Reentry – to support communities that are system-impacted within the new Justice, Care, and Opportunities Department (JCOD).

[4]Umez, De la Cruz, Richey, and Albis (2017); Corrigan et al. (2017).

[5]The Reentry Division also developed an Interim Housing program for individuals in early recovery from substance use disorders with the goal of providing a safe housing environment that equips clients with the support that contributes to sobriety. Some RICMS clients were referred to this program. See Appendix E to learn more about this program and its implementation.

[6]Findings from the cost study will be published separately when that analysis is finished.

enrollment. The final section concludes the report with recommendations for local, state, and national policies and practices.

Study Design

The research team used qualitative and quantitative methods to examine the program models, program goals, program implementation, and client outcomes. The process study for this report examined how the RICMS program activities align with the logic model (shown in Figure 1) and how the program was implemented, including what services were provided and the role of the Reentry Division and coordinating agencies and contracted providers in delivering and coordinating services. The theory of change underlying RICMS assumes that the centralized coordination of reentry services and connection to individuals with similar lived experiences lead to improve health and well-being outcomes and reduced criminal legal system contact. The outcomes study assessed whether the program achieved its proposed goals. To this end, the evaluation measured the level of RICMS participants' use of county physical health care, mental health care, and substance use disorder treatment services, as well as criminal legal system outcomes of RICMS participants. The outcomes study uses a matched comparison group nonexperimental design to assess whether the services may have resulted in improved client outcomes. See Appendix A for information about data sources and methodology.

The study examines administrative data for individuals enrolled in RICMS between April 2018 and March 2021. Interviews with program staff and program participants, conducted between June 2019 and August 2022, provided qualitative information about program implementation. A survey of program managers and direct service staff was administered in April 2022.

Program Snapshot

Program Structure and Staffing Model

RICMS was delivered by 29 community-based providers that were contracted by the Reentry Division. See Appendix Table A.1 for more information.[7] Each provider has a team that comprises a program manager and one or more community health workers (CHWs) who work directly with clients.

A key component of the RICMS model is the role of CHWs, who conduct outreach to engage clients, identify their needs, and help them access needed services. CHWs each maintain a caseload of approximately 30 clients who are enrolled when they are living in the community plus a "jail caseload" (also referred to as pre-release caseload) of up to 60 individuals who are pending release.[8] As part of their contract with the Reentry Division, RICMS providers committed to hiring CHWs who have "lived experience" with the criminal legal system – which means they have been personally affected by the

[7]After the launch of this study, four RICMS providers stopped providing program services bringing the total number of providers to 25. This report focuses on the 29 providers since that was the number for most of the study period.

[8]These individuals are enrolled before or during release from jail. Information about the individuals in jail is sent in advance to the community provider in the area where they will be released to facilitate recruitment and enrollment. To date, the CHWs have not had the opportunity to interact much with the individuals before they are released.

legal system (for example, having been arrested or incarcerated) or affected through others close to them (for example, having family members or close friends who have been arrested or incarcerated).

Connection with the Los Angeles County Reentry System

The Reentry Division established a referral pipeline for RICMS from the County's Correctional Health Services team that provides pre-release health services to individuals in the LA County jail. The Reentry Division also educated other County agencies about RICMS to encourage referrals into the program, such as from the INVEST workforce program and from the Probation Department's Resource Utilization Unit.[9] The Reentry Division also established an Interim Housing program to supplement housing resources for RICMS providers which is described in Appendix E of this report. The Reentry Division provides technical assistance and training to help providers connect with programs and resources across the county. (See the next section, "Program Implementation and Participation Patterns," for further discussion of the Reentry Division's role in program monitoring and technical assistance.)

[9]The Los Angeles County Innovative Employment Solutions Program (INVEST), funded through California Senate Bill 678, is designed to address the complex range of employment and supportive service needs an individual on felony probation may have and support them in pursuing their employment and career goals. It is the subject of a separate MDRC evaluation.

Program Implementation and Participation Patterns

This section describes how the RICMS program was implemented and presents program participation patterns for people enrolled in RICMS between April 2018 and March 2021, with a minimum follow-up period of one year from the time of enrollment. The implementation study examined how the RICMS program was implemented and managed, including service provision and coordination with other agencies. This component of the research seeks to answer the following overarching research questions:

- What organizational factors, policies, and other external factors may have shaped the design, implementation, and outcomes of RICMS?
- Who was served by RICMS and what were their service needs?
- What is the service delivery system of RICMS and how is RICMS implemented?
- What is the client experience of RICMS and does the program meet clients' needs?

The implementation study draws on analyses of administrative management information system data from Los Angeles County Department of Health Service's management information system, known as CHAMP, along with surveys of staff at each community-based provider. Qualitative data include interviews with a subset of staff from the community-based providers, the Reentry Division staff, and program participants, and analysis of official planning and program documents shared with the research team. See Appendix A for more information about the implementation research data sources and methods.

Context of Program Implementation

When interviewed, staff working within RICMS programs described multiple contextual factors creating barriers to program implementation and participation. These factors also represented opportunities for improvement of client engagement with the program. Below, these factors are described.

Release Process

While CHWs were expected to make efforts to communicate with individuals that were referred from the jails before their release date, the research team found that the extent of this communication varied by provider and staff member. During interviews, CHWs reported that release dates from the jails were unpredictable and were not communicated directly by the jail, which meant it could be hard to know when to begin preparing to engage an individual in planning for reentry. For example, it was common for a referred client to have a release date scheduled in the jail data system for months out, but to be suddenly released without communication to the CHW. Another reported challenge was the Los Angeles Sheriff's Department's restrictions on CHWs being able to access potential clients in the jail facilities. However, some CHWs described instances of successful collaboration with medical case workers inside of jails to set up phone calls or meetings, though interviewees reported that medical case workers could be hard to reach. Other CHWs described how they developed alternative strategies to reach these clients, such as sending letters or setting up a process to receive collect calls. CHWs described a stronger coordination process with the referrals they received from the California Department of Corrections and Rehabilitation, since their staff actively coordinated with CHWs around an established release date that was communicated by the correctional

agency and unlikely to change suddenly. Staff who were interviewed reported that because of these challenges, they tended to focus their efforts on engaging clients who came from referral sources other than the county jails. As one CHW described, individuals referred from sources other than jails were more engaged. Especially for individuals referred before their release date, staff who were interviewed shared that lack of contact information was a common reason they were unable to successfully engage clients. Staff described making efforts to reach other points of contact such as family members or, in some cases, going to seek the individual at a location where they were known to spend time.

COVID

The pandemic prompted organizations to change the ways that they approached service delivery and internal operations. While many internal operations went remote in March 2020, some staff and program managers interviewed described their organizations as having "boots on the ground" — that is, staff who were working in the field to provide services directly to clients in need. One staff member added, however, that most of staff who were active in the community during the heights of the pandemic did contract COVID. Many of the sites tried to continue in person service delivery throughout the pandemic, closing temporarily when a staff member became sick. As one program manager summarized their organization's COVID policies being remote: "[we work] remote where we can… [but] pretty much the show goes on." This seemed to reflect the ways many RICMS sites approached adapting to the pandemic.

Housing Availability

Service providers and clients consistently brought up the unavailability and inaccessibility of housing in LA County. Lack of housing presented challenges to service delivery, as many providers interviewed suggested that access to housing was often necessary for a client to succeed in various domains like employment, substance use recovery, and facilitating physical and mental health, as well as pro-social behaviors associated with reentry (for example, "staying out of trouble," or not being exposed to social environments that could encourage negative patterns or habits). One client shared:

> "Because I was in jail, my kids were taken away. The court won't give me my children without having housing. Housing won't give me housing because I don't have my children. So that's like a loop, ... I'm struggling right now." -

One CHW explained a challenge of housing application process:

> "I have a client right now. It took him over a year to get his housing. We went through one of the emergency housing vouchers. We duplicated proof of income three or four times. We duplicated homeless history just as many, if not more. That means where the client has lived so they don't fall out of the qualification of homeless three times for a year, one year continuously, no couch surfing, things like that.
>
> And the client finally got his Section 8 voucher. Helped the client find a beautiful apartment, filled out the application. The manager loves the client, the owner loves the client. Ready to move in. We sent the voucher back to the housing authority. He needs $3,500 to move in. Okay?
>
> Now $3,500 was needed. That is just as taxing, as depressing as you can get after you've been through all this, and the client will say they don't want you to get housing. 'How can I get housing when I can't get this money? Where do they expect me who's been homeless for the last 15 years to get this money? Am I just supposed to have this money?' So if the Reentry

> Division had a flex fund, had something that I could tap into to help this client get this money, it would save a lot."

Incidentally, the Reentry Division developed the Interim Housing program, using Proposition 47 funds, for individuals in early recovery from substance use disorders with an immediate need for housing. RICMS clients have access to this program.

Gaps in Services

CHWs described that some clients may be uncomfortable with the types of services offered, such as shared housing arrangements, due to concerns about their safety or lack of autonomy offered in those spaces. In other situations, CHWs described particular neighborhoods or areas as being unsafe for certain clients to live in due to their history in that area. In order to adequately serve clients, programs need to be able to help them navigate complex circumstances while maintaining a sense of safety and alignment with their unique needs.

Trust

Staff described that some clients may not be ready to engage with RICMS or referral services available through RICMS. CHWs described the efforts they had to undertake to earn trust of clients, many of whom were distrustful of County systems due to experiencing harm or trauma in the criminal legal system, expectations that anything they shared with the CHW would be reported, or due to disappointment with other agencies that had failed to help them or adequately understand their needs. As one CHW explained:

> "People who've been incarcerated have a good degree of distrust, and suspicion of other people, especially people coming from, 'the system.' So, generally, when I first meet someone, I give them a chance to talk. I tell them who I am, what I do. And let them know I'm here to only help them for what they want to do, not what I want to do. And I ask them, 'How can I help you?' And that's how I start by giving them the permission or giving them an opportunity to express their need and their desires."

Clients Served by RICMS

RICMS was designed to have a "no wrong door" approach to enrollment, allowing clients to engage with the program at varying points after interaction with the criminal legal system. During the study period, RICMS enrolled adults who were charged with or convicted of a crime, and who were identified as having mild to moderate mental health and/or substance use disorders who agreed to enter the program.

Referrals to RICMS

Clients reached RICMS through a variety of referral sources, including from within the LA County and City of Long Beach jails, other reentry programs led by the Reentry Division, the Department of Probation, the California Department of Corrections and Community Rehabilitation, and from the recruitment efforts of RICMS providers within the communities they serve. (See Figure

2: Los Angeles County Reentry Services System Flow.)[10] All client information was entered into CHAMP at the point of enrollment.

Recruitment approaches varied among providers depending on the kinds of partnerships they established, their level of outreach in the community, and the programs their organizations offered beyond RICMS. For example, some CHWs described having strong partnerships with medical or substance use disorder organizations that send them referrals, while others described visiting local social service offices to do direct outreach by speaking with potential clients. Multiple CHWs also described establishing recruitment relationships with local probation offices and receiving referrals from individual probation officers who had knowledge of their organization in the community.

Once a client was referred to RICMS, providers were expected to make at least five contact attempts within 30 days to reach the client. For clients who were recruited from within LA County jails, Correctional Health Services staff enrolled clients into RICMS before their release, and then the Reentry Division staff distributed these referrals to providers located in the community where the client would be released. These clients were considered part of a "jail caseload," which was monitored by provider staff so that service planning could be continued after the client's release. However, as noted earlier, CHWs met challenges doing so.

As it turns out, location of enrollment – in jail or in the community – appears to have important implications on participation in RICMS services. Individuals enrolled while they were living in the community were more likely to participate in RICMS than those enrolled while they were still in jail (See Table 1). While the exact reason for this difference is not known, the challenges associated with the communication with individuals while in jail, as described earlier, is a likely one source. Of the 1,619 clients who enrolled while they were in jail, only 211 (13 percent) became participants, whereas 4,089 of the 13,429 clients (30 percent) who enrolled while in the community became participants. This important finding motivated the study team to analyze data for these two referral streams separately.

Characteristics of RICMS Clients

Table 2 presents characteristics of RICMS clients who participated in RICMS services and RICMS clients who were enrolled but ultimately did not participate in RICMS for both the jail and community referral streams. The majority of RICMS participants were men. Overall, more than 40 percent of participants identified as being Hispanic; about 30 percent identified as Black. Over one-third of RICMS participants had used County mental health outpatient services at some point in the two years prior to RICMS program enrollment, and 8 percent received inpatient treatment from the Department of Mental Health. Participant characteristics at the two enrollment locations were fairly similar.

Both groups differed most in terms of their recency of contact with the legal system: on average, nonparticipants had more recent contact with the legal system. For instance, around one-third of participants had a conviction for a felony within two years prior to RICMS enrollment for the

[10]Note that RICMS previously accepted referrals from the California Department of Corrections and Rehabilitation (CDCR) who were being released on parole from state prisons. Due to issues related to eligibility under Prop 47 grant funding, the Reentry Division no longer accepts referrals from CDCR.

community group, compared with half of nonparticipants in the community group. On average, nonparticipants were more likely to have been arrested or convicted in both groups. Nonparticipants also spent more time incarcerated than participants. See Box 1 for more detailed examples of RICMS client backgrounds.

Case Management Services and System Navigation

After a client was enrolled into RICMS, CHWs completed a comprehensive assessment of client needs which is used to form a care plan which includes service goals. Due to challenges communicating with individuals enrolled in jail, this typically did not happen until after someone was living in the community. The service domains included in client care plans are physical health, mental and behavioral health, housing, transportation, benefits enrollment, and employment. Care plans also included needs related to identification and legal documentation as well as other service needs such as fulfilling court mandates. Staff reported that they used an initial conversation to identify the client's primary goals and motivations and then built out the care plan over time.

Staff at RICMS providers described their approach to serving clients as meeting them "where they were at." As a general philosophy or style of engagement, meeting a client "where they were at" meant acknowledging that client progress was often not linear, and that setbacks can and do happen. When a setback happened (for example, relapse or reincarceration, an emotionally or physically distressing situation, or losing access to housing), staff emphasized the necessity of having a nonjudgmental reaction and disposition. This phrase was also meant literally, as in physically meeting them where they were located or otherwise working to remove any barriers for them that could make it hard to meet in person. One CHW summarized meeting a client "where they were at" as follows:

> "We're not here to judge the client. We're here to help them no matter how many times they fall, it doesn't matter. As long as we're there to help you get up. Getting up is gonna have to be a struggle. But at the end of the day, we'll do it together and it's gonna, you're getting up, but you're gonna go down again, but we're here."

Role of Lived Experience in the Community Health Worker Client Relationship

As RICMS providers are committed to hiring CHWs with lived experience with the criminal legal system, MDRC spoke with CHWs and program participants about how they perceived and understood the role that lived experience may play in both service delivery and the development of relationships between CHWs and clients. While not all CHWs have lived experience with the criminal legal system, most respondents to the staff survey reported some shared experience whether personally or through family or others close to them. See Appendix Table B.1. The staff survey found that 71 percent of CHWs and other staff directly serving a client caseload had experienced someone close to them being incarcerated, and 52 percent had direct experience with incarceration. The study team also examined whether CHWs and other staff carrying caseloads of RICMS clients were demographically similar to clients.[11] The study found that staff share some demographics in terms of racial and ethnic identity (41 percent of clients and 48 percent of staff reported their racial identity as Black, and 43 percent of clients and 55 percent of staff reported their ethnic identity as Hispanic) but that they were

[11]Some program managers reported that they carry a caseload of clients in addition to their managerial duties.

not representative in terms of gender identity (64 percent of direct service staff and 27 percent of clients reported their gender identity as female).[12]

The majority of CHWs interviewed agreed that lived experience (specifically with incarceration and addiction) enhanced their capability to empathize with and read and understand clients' experiences and the contexts that clients were in and navigating through. Some CHWs noted that their own experiences allowed them to pick up on subtle behaviors, patterns, or attitudes that their clients displayed that they may not have noticed or placed as much importance on had they not had lived experience in similar situations. As one CHW noted regarding their own lived experience:

> "It helped me connect with people who probably would not have accepted this type of help before because they were able to connect with me because of my previous experience. I had a client before who thought, 'How did you get this job?' And so when I told her a little bit about my history, she was floored. She couldn't believe I had been to prison and that I have an office job and that I was a case manager. And I told her, 'You can do the exact same thing I'm doing.' So when I told her about my story, all her walls fell down and I was able to kind of get in and help her."

CHWs disclosed their lived experience to clients strategically. While many CHW interviewees shared that they were upfront with their clients about their relatable personal histories, others withheld disclosing some or all their lived experiences to clients until they felt it would serve a strategic function. For example, one CHW described how sharing their own experiences with incarceration has helped them work with clients were uncooperative:

> "From my personal experience, when I have a client who's like, 'You don't know what I've been through,' and I allow them to vent and I allow them to let me know that they're frustrated, I feel like it's the most rewarding feeling to be able to be like, 'Listen, I spent the majority of my 20s in prison. So yes, I do know how it feels.' You know what I mean? And I feel like sometimes when a client hears that and they see the position I'm in and I'm rocking a county badge....I used to transfer drugs across the border. Nine years ago, you would never tell me I would be in this position. And when I have the chance to tell a client who's desperate for help but does not know the steps, and I let them know like, 'Check this out whatever you want in your life, it is possible.' And then I give them a brief description of what I've been through, that's the most rewarding thing. So I feel like it does help when you have those clients who wanna be difficult and, 'You don't know how it feels to...you know, no one wants to hire me.'"

CHWs lived experiences were important tools for establishing trust and rapport with clients. The relationships between CHWs and their clients were fortified and deepened through the intentional sharing of such experiences. For clients, believing that their CHW truly and meaningfully understood where they were at felt very important to them. This mutual understanding facilitated a level of trust that many clients didn't have with other system actors or service providers, and for some clients, a

[12]Race and ethnicity both describe people's identities, but in different though sometimes related ways. Race often tends to be distinguished based on physical characteristics, especially skin color. Ethnicity is often distinguished by cultural characteristics including but not limited to language, history, religion, and culture. However, these concepts are often conflated in how they are used or presented. In this report, we have generally presented race and ethnicity separately. In the RICMS program's client data and in the staff survey conducted by MDRC, clients and staff could indicate multiple races, and separately indicate whether they identified as Hispanic/Latino.

level of trust that they couldn't even locate within their own social networks of family and friends. As two RICMS participants explained:

> "I think they connect with me because some of them have been in similar...they might not have done time or anything like that, but they've dealt with the system and they know. They have some experience with the system and how the system can deter you from moving forward. How the system can put up roadblocks to prevent you from moving forward, especially with a record, you know. They're able to relate in finding jobs, you know having an income, things like that. The addiction, having a drug addiction, having alcohol addiction. They're able to relate in those ways, you know. And I think that makes them better caseworkers because they're not just giving us words or self-serving. They're giving us part of their experience as well in the way they go by trying to help us."

> "I feel that the other case worker that I had, she kinda related to me with certain, like, personal things that I've went through, but...how do you say? Like, [the CHW], since the first day she met me, she was worried about my well-being when I told her that I just wanna be a good mother to my baby when my child comes. And I know that she's a mother herself, and she wanted to help me because she knows the struggle as a woman, as a mother, you know."

Engagement in RICMS

Based on analysis of the management information system records (see Table 1), only 30 percent of community-enrolled clients participated in RICMS, meaning that they received services for least 30 days after enrollment and had a care plan recorded in CHAMP; 13 percent of individuals enrolled in jail met this participation threshold. Once enrolled into RICMS, clients received case management services for up to 12 months and in some circumstances, some participated longer than 12 months if they needed more support. Staff periodically reviewed caseload assignments to assess whether clients were successfully meeting their goals and conducted case reviews at 6 months to determine whether clients needed more time to address the needs documented in their care plan.

Figure 3 shows the number of months that participants were enrolled in the RICMS program (regardless of enrollment stream).[13] Just over half (53 percent) of participants were enrolled in the program for 6 months or less, around one-third (34 percent) were enrolled for 7 to 12 months, and 14 percent were enrolled for over 12 months.

Furthermore, individuals who were enrolled while living in the community, participated for longer periods of time, on average, than individuals who were enrolled while in jail. Participants who were enrolled while in the community spent an average of 51 more days as an active RICMS participant than participants who were enrolled while in jail. The median community enrollment participants spent 190 days in the program — 39 more days than the median jail enrollment participant (as shown in Table 1).

[13]Participants are those who received services from a community health worker for at least 30 days after enrollment and had a care plan recorded in CHAMP. Participants were considered enrolled in RICMS until their CHW exited them from CHAMP. This happened when they achieved their goals, declined further services, stopped responding to CHW outreach attempts, moved out of the county, or were reincarcerated.

Types of Services and Supports

As described above, RICMS providers used various approaches to connect clients to services, which may be offered in-house at their organization, through a referral into other County programs, or by making referrals to other community-based organizations. The types of services and approach to meeting service needs varied among providers depending on the resources they could offer within the organization, what other resources were in their geographic region, and the boundaries established by staff in attending to client needs. Box 2 describes the persistence clients described as important for them to navigate these services. Described further below are services and supports that were commonly described by clients and CHWs.

Housing

While RICMS is designed to meet a core set of service needs, the types of services and approach to meeting service needs varied among providers depending on the resources they could offer within the organization, what other resources were in their geographic region, and the boundaries established by staff in attending to client needs.

When asked which services were hardest to access, nearly all CHWs interviewed named housing as the greatest challenge. Access to affordable housing is in particularly high demand in Los Angeles County but varies in availability depending on each local jurisdiction. Staff observed that housing availability has improved over time, though staff in some service planning areas, such as the San Gabriel Valley, reported having fewer options to meet housing needs. To help alleviate some of the housing pressure, the Reentry Division developed the Interim Housing program for individuals in early recovery from substance use disorders and with an immediate housing need. Program slots were made available to all Reentry Division programs, but RICMS clients account for almost all referrals.

Physical and Mental Health Services

Clients spoke of their physical and mental health status as presenting challenges to navigating reentry. These challenges were sometimes described as conditions, like learning disabilities, limited physical mobility due to injury, or mental health issues like depression or anger. However, challenges were compounded by other factors, such as a client's socio-economic status and access to insurance or financial assistance. For example, one client was unable to afford getting the monthly shot he needed to manage a chronic condition once he was released and ended up missing two doses before an RICMS program offered help. “I went almost two months without [my] injection. At what point do I continue to become damaged, irreparable damage?” Clients mentioned the ability to access medical services within one organization being very beneficial. Furthermore, to effectively connect clients to behavioral or mental health services, CHWs described the value of being able to “make a warm handoff” within the organization or connect the client with a specific person the CHW knows. This approach was particularly helpful for clients who might feel hesitant to try therapy due to fear or social stigmas.

Substance Use Disorder Treatment

Histories of substance use were another theme that emerged from client interviews. Most of the clients who discussed their relationship to substance use had experiences characterized by phases of recovery punctuated by relapses. Some of these clients struggled with addiction to multiple substances, including alcohol and illicit drugs. Their struggles toward recovery were compounded by other factors, such as their housing status or socioeconomic status. For example, one client explained that as she was experiencing homelessness, one of her only options for housing was with a friend who

offered her a place to stay. Unfortunately, she described that friend as playing a major role in facilitating her alcohol relapse.

Court-Mandated Programs

During interviews, clients and CHWs often described the services available within the provider organization as being important motivators for clients to engage with case management more broadly. For example, Watts Labor and Community Action Center provided access to free court-mandated classes in anger management and domestic violence. For one client this benefit was described as significant in reducing their financial burdens and alleviating stress.

Crisis Response

Some CHWs shared anecdotes about helping clients during times of acute distress or urgency. This looked like dropping what a CHW was doing to pick up a client in an emergency or providing legal aid when a client was facing eviction, providing assistance in case a client who was employed had a transportation issue that could get in their way of getting to work.

Social Support

Social networks, when they're available, can represent a crucial external resource clients leveraged to navigate challenges associated with reentry. In some cases, a client's strong social ties with friends or family allowed them to gain access to crucial information and resources like job leads or transportation shortly after release. For example, one client was able to quickly buy a car from a close family member for $1,000. Access to such resources so soon after release appeared to have powerful downstream impacts. The client who was able to purchase a car right after being released from prison was then able to find stable employment independently. At the time of the interview, the client was enrolled in a vocational training program for solar panel installation. While it is impossible to know what might have happened under different circumstances, it is reasonable to assume that without quick access to reliable transportation via a social network, this client may have had a much harder time tapping into the career track identified at the time of the interview, as one of the job requirements was owning a car.

The utility of strong social ties and networks was not only demonstrated through direct access to resources, but also in access to social and emotional support during and after incarceration. One client had family and friends who visited her regularly during her long prison sentence. She emphasized how crucial that social-emotional support was for her well-being during and after her incarceration. Additionally, many people in her immediate social network had experience being incarcerated and navigating reentry. One close relative was even a social worker who had experience helping formerly incarcerated individuals. This client was able to tap into her social network's knowledge to find programs and services upon release that worked well for her:

> "I've learned about it through my sibling having been in the… jails and stuff…. We've been involved, incarcerated and stuff, since before 18."

Ultimately, strong social ties and social networks constituted an important resource that some clients possessed and leveraged to navigate challenges associated with reentry. These clients were able to independently access resources and information that other clients who lacked these social ties leaned on CHWs for. Despite the strength of some clients' social networks, the majority of participants MDRC interviewed did not have robust social networks to leverage like the ones above. In some cases, clients had extremely frayed social networks to the point where they had very little if any family or friends to whom they felt they could ask for help with accessing resources, information, or social and emotional

support. For these clients, the CHWs they worked with appeared to fill an important social void; CHWs for them represented one of the few (and in one case the first) social ties that was characterized by unconditional support. See Box 3 for further discussion of client perspectives on the quality of their relationship with CHWs.

One of the major strengths of RICMS was that the CHWs provided essential social support and capital to participants who had little if any people in their lives to rely on unconditionally. This form of support seemed both implicitly and explicitly essential to clients identifying and reaching their various goals following release. It also seemed to enhance the enthusiasm with which participants engaged with the RICMS program.

Referrals for Services

The organizations operating RICMS have a range of other services they offer and therefore CHWs have varying levels of ability to leverage resources within their organizations. Often, seeking external service referrals to help clients was necessary. When surveyed about providing referrals to services inside or outside their own organization, staff reported that they most frequently refer clients to other organizations for things like children's service, physical health services, and substance use disorder treatment. Services that providers most frequently connect clients with inside their own organization include mental health treatment, employment, and education.

Table 3 shows service referrals made within the one-year follow-up period after enrollment for RICMS participants who enrolled between May 2020 and March 2021 by enrollment location.[14] Referrals fall into two categories: (1) those for services that are intended to be on-going such as a series of employment workshops and (2) those that are more point-in-time assistance such as securing basic necessities like clothing. For those enrolled in the community, the most commonly documented referrals to ongoing services were for housing services (35 percent) followed by employment services (19 percent) and mental health services (18 percent). The most commonly documented one-time service referral types for those enrolled in the community were assistance with food (23 percent), assistance with other basic necessities (18 percent), and assistance with other supportive services not categorized in CHAMP (30 percent).

Referrals for those enrolled from jail indicate some different priorities with housing (28 percent), substance use disorder services (17 percent) and mental health services (14 percent) as the top referrals. The most commonly documented one-time referrals for these individuals were social services (22 percent), basic necessities (18 percent) and other supportive services not categorized in CHAMP (18 percent).

A caution when interpreting these referral numbers: the documented referrals in CHAMP may represent a floor or minimum rather than an exact accounting. In other words, *at least* the percentage of participants shown in Table 3 were referred to the services shown, *but possibly more* received referrals to these services. As shown at the bottom of Table 3, 84 percent of all RICMS participants

[14]CHAMP was updated in May 2020 to enable systematic recording of service referrals. Prior to this update, CHAMP could only record service referrals that had been made in case notes. With CHAMP's updated service referral tracking, providers could distinguish between referrals for ongoing services and those services meant to be a one-time support. Furthermore, these data were recorded in ways that could be more easily counted.

had at least one documented service referral. Based on qualitative interview data and the staff survey, nearly all RICMS participants should have received referrals to some type of service. One potential reason why this may not be the case is that in some instances, staff may not always be using the service referral functionality in the CHAMP system and may be documenting some services in case notes. Still, even with this potential undercounting of service referrals, these data give a sense of the relative frequency with which RICMS participants are referred to different service types.

In interviews, program managers and staff also described leveraging other funding sources outside of RICMS to help clients with additional needs, such as transportation. Providing clients with bus passes, for example, was a common practice. Many CHWs personally provided their clients with rides to various appointments and obligations.

In interviews, CHWs described tailoring their approach to connecting clients with services to their level of engagement, explaining that some clients were more likely to reach out proactively and pursue goals independently while other clients might need more hands-on assistance to navigate towards their goals. Feedback shared by clients and staff members suggests that the relationship, once established, contributes to clients' satisfaction with services and sense of connection to the program. (See Box 3 for further exploration.) To provide support, CHWs interviewees discussed the importance of being perceived by their clients as dependable and consistent. This meant that it was important for clients to trust that they would always answer or return their calls, that CHWs would follow up consistently, and among other things, that CHWs could be depended on when urgent needs arose.

> "So, I think a big thing is following through. That's number one. Never promise anything that you yourself cannot deliver. So even though I can say, 'This is how the housing works,' or, 'This is how this program works,' I can explain that to you, but I'm not the one running that program, I'm not the one funding that program. I can't tell you for sure this is going to happen. All I can say is this is usually the process, and this is how you usually get there. If I tell you, 'Hey, I've got some clothes,' because I know I've got them here, and I'm like, 'Yeah, here's some socks,' you know, then I know that's on me. But I can't say, 'Oh, yeah, we're gonna get you those socks. I'm gonna find you this week,' if I don't know that I'm gonna be able to pull that off. Because I don't wanna ever add to mistrust. I don't want them to ever feel a sense of like, 'Wow. You're just like everyone else. You're giving me a bunch of crap.'"

In interviews, CHWs emphasized the importance of holistic approaches to client engagement, where the services provided, and the nature of the CHW-client relationship expand past the horizon of reentry goals and services. For example, checking in about medical history (last doctor or dentist visit), or personal relationships (with children, family, and so forth) were seen as ways to look at the "whole person." One CHW summarized:

> "We deal with the whole person. We don't want you to just think better, we want you to feel better and look better while you're going through this change. So we deal with the mental, the emotions, the body."

As important as it was to be perceived as being available and dependable, however, CHWs also talked about the importance of establishing boundaries with their clients, which they felt ultimately facilitates trust and rapport. Some CHWs were very adamant about a clear "9 to 5" timeframe of availability for their clients, and only engaging with clients after they were "off the clock" in case of absolute emergencies.

Program Monitoring and Quality Assurance Practices

The Reentry Division conducted training and quality assurance to ensure that the network of RICMS providers implemented the program according to established policies and procedures. Each RICMS provider was assigned a Reentry Division program manager. Program managers at the local provider and the Reentry Division representative met once or twice monthly to review CHW caseloads and discuss case management strategies, monitor care plans in CHAMP, and to help address gaps in service needs. The Reentry Division program managers also conducted in-person site visits at RICMS agencies to assess the effectiveness of service provision.

The Reentry Division arranged training for CHWs and program managers, with topics including program procedures, effective case management practices, and other professional development topics. Provider staff who were surveyed found the training valuable, with 90 percent or more of staff survey respondents rating each training session they attended as being helpful or very helpful. Providers also helped CHWs learn the job through on-the-job training. Nearly all staff interviewed felt they received enough training and professional development opportunities.[15] CHWs interviewees also described the importance of learning from their peers. Before the pandemic, the Reentry Division also hosted quarterly peer learning events with all RICMS providers to provide ongoing training and technical assistance as well as to foster collaboration and share best practices. The in-person meetings were discontinued during the COVID-19 pandemic and were conducted virtually instead, with less frequency. Peer learning events were well-received by provider staff, who frequently mentioned them in interviews as valuable opportunities to build relationships, identify resources, and share tips.

To support data quality assurance and monitor compliance with CHAMP data-entry requirements, the Reentry Division conducted training with providers, developed materials to inform staff members of system changes, and reviewed individual cases with providers. Program managers who were interviewed also described reviewing data in CHAMP with CHWs to ensure they recorded program activities. Staff members' feedback on CHAMP indicates that improvement has been made over time. Staff members who were interviewed in 2019 (before changes were implemented to CHAMP) reported lower satisfaction than staff interviewed after 2021 as the system has gained features that are more useful for staff members in their workflow.

[15]One training that occurred was on "risk need responsivity" (or RNR) model. The RNR model assumes that the risk and needs of an individual should determine the strategies appropriate for addressing an individual's criminogenic factors, or those factors that have a direct link to future criminal activity and can be changed. This training occurred only one time and the concept of applying the RNR model did not seem to take a strong hold among the providers.

Program Outcomes

The theory of change underlying RICMS assumes that the centralized coordination of reentry services and connection to individuals with similar lived experiences lead to improved health and well-being outcomes and reduced criminal legal system contact. To begin unpacking whether this theory translates into positive change for RICMS participants, the evaluation took a non-experimental approach to comparing the health and criminal legal system outcomes of individuals who enrolled and participated in the RICMS program with those of a matched comparison group who enrolled in the RICMS program but did not participate. This approach amasses less confidence about estimates of program effectiveness than, for example, a well-implemented randomized controlled trial. However, conducting a randomized controlled trial to test the efficacy of RICMS was not possible at the time of this evaluation as the program had the capacity and desire to serve everyone who was interested and eligible.[16] In the absence of a randomized controlled trial, the exploratory quasi-experimental analyses provide some initial descriptive information about the differences in outcomes that could be due to RICMS.

Research questions for the outcomes study include the following questions about participants, when compared with similar individuals enrolled in but not participating in RICMS:

- Do participants' county-provided emergency healthcare utilization rates differ from those of nonparticipants?
- Do participants' county-provided in-patient and outpatient healthcare utilization rates differ from those of nonparticipants (hospital and primary care services, mental health services, substance use disorder treatment services)?
- Do participants experience fewer re-arrests, new reconvictions, and incarcerations than do nonparticipants?
- Among clients on probation supervision, do participants experience fewer revocations than do nonparticipants?

Analysis Approach

The outcomes analysis used propensity score matching to construct matched comparison groups.[17] Drawing on the full sample of individuals enrolled in RICMS with enrollment dates between April

[16]Randomized controlled trials of services are particularly appropriate when there is there is excess demand for services that cannot be met by the program. That is, when programs are oversubscribed, with more potential clients interested in services than the program's capacity and resources to serve all those interested. When this happens, and the benefits of the services for clients are not yet known or evaluated, a randomized controlled trial can be implemented as a fair and unbiased way to determine who receives services among those interested and eligible. See Finkelstein and Taubman (2015) for a discussion of excess demand and service rationing as they relate to randomized controlled trials.

[17]The propensity score is a conditional probability that estimates the likelihood of something (in this case, participating in RICMS) based on a set of factors or characteristics (in this case, an RICMS client's demographic characteristics at program entry, prior uses of county services, and prior interactions with the criminal legal system). To create the propensity score, we performed a series of logistic regressions to estimate the likelihood of a someone who enrolled in RICMS participating in the program given a set of case characteristics (covariates) such as age, race,

2018 through March 2021 this approach used background characteristics including demographics, prior criminal legal system involvement, and previous receipt of county services to construct participant and non-participant groups that were as similar as possible. The propensity score matching approach based on available background characteristics is a non-experimental design that yields stronger evidence than simply comparing outcome levels of unmatched groups. A potential limitation of analyses that rely on propensity score matching is whether there may be unobserved characteristics or unmeasured factors (e.g., those for which we do not have data) which could predict membership in the research groups (i.e., participant or nonparticipant) or on the outcomes. The research team had a rich data set containing multiple Los Angeles County agencies' records for RICMS clients, including demographic information and their histories with various government services and systems (the same systems and agencies from which our outcome measures are derived) dating back several years.[18] However, these data are not exhaustive, and it is possible that unobserved characteristics are present which would threaten the validity of the results. For instance, the team did not have data on transportation or whether participants had children, which could be important factors in program participation.

The propensity score matching process was conducted separately for people who enrolled in RICMS prior to release from jail and for people who enrolled in RICMS while living in the community given the observed difference in RICMS service participation between clients enrolled while in jail and clients enrolled while in the community described earlier in this report (see Table 1, which shows that community enrollment clients were more than twice as likely to participate in RICMS services than clients who enrolled in the program while in jail). The sample sizes for these two groups were also quite different: among program participants, the number who enrolled in RICMS while in the community during our analysis period was 19 times larger than the number who enrolled while in jail (210 versus 4082, respectively). As such, the outcomes findings presented in the main body of this report focuses only on this larger group: participants who enrolled while in the community. Appendix C presents outcomes findings for the smaller group of individuals enrolled while in jail. Appendix C also presents unmatched descriptive outcomes for the unconditional, full sample of RICMS participants and nonparticipants as a reference.

The matching process yielded comparison group matches for 85 percent of RICMS program participants who enrolled while in the community, meaning that outcomes analysis conducted on the matched group reflect outcomes for the majority of participants served by the RICMS program.[19] Appendix A presents more detailed information about the propensity score matching process and results. It also presents findings from sensitivity tests, which provide additional information regarding the robustness of the estimated differences in the outcomes analysis and how likely findings are to change under different assumptions and parameters. Overall, the results of the sensitivity checks

gender, and prior interactions with county systems and agencies. The estimated coefficients from this model represent the relationship between specific characteristics and the likelihood of participating in RICMS. These coefficients can be multiplied by individual case characteristics to create a propensity score for each client. We estimate these scores for clients who did participate in RICMS services and those who did not. Those who did are referred to as participants and those who did not are referred to as the comparison pool.

[18]One exception to this was substance use disorder services from Los Angeles County Substance Abuse Prevention and Control which were not available for time periods prior to program enrollment due to agency limitations on what data can be provided for researchers.

[19]The match rate for participants who enrolled in RICMS while in jail was 99 percent.

showed consistency with the outcomes analysis which did not diminish the team's confidence in the findings for clients enrolled while in the community. Had the sensitivity test results shown changes in observed differences once the tests were applied the team would have less confidence in the findings.

Outcomes were examined for a one-year period following RICMS program enrollment for all RICMS clients in the study sample. Outcomes over a two-year follow-up period are shown for RICMS clients with enrollment dates prior to March 2020. Differences in outcomes were estimated using linear regressions.[20]

One- and Two-Year Outcomes for Community Enrollment Clients

This section presents service use outcomes for substance use disorder, mental healthcare, and primary care and hospitalization are presented, followed by criminal legal system outcomes. Outcomes for the RICMS participants and the "comparison group," or those who did not participate are presented for clients who enrolled while living in the community.[21] The "estimated differences" columns in each table shows the estimated differences between the participant and comparison research groups' outcomes, which might be attributable to RICMS. Means for each of the research groups are presented unadjusted by the regression model for ease of comparison to the descriptive full unrestricted sample outcomes for all RICMS clients shown in Appendix C.[22] The estimated difference is regression-adjusted to account for slight differences in covariates between the RICMS program participant and comparison research groups and thereby improve the precision of the estimates.[23] Therefore, the estimated difference in outcomes in the tables may appear larger or smaller than the simple difference between the research groups' means for these outcomes. due to the regression adjustment. The number of asterisks in the tables indicates whether an estimated difference in outcomes is statistically significant.[24]

Substance Use Disorder Treatment

There were no statistically significant differences in admissions to County-provided substance use disorder services between the RICMS program participants and the comparison group members. As shown in Table 4, among both research groups, around 7 percent of clients were admitted to County-provided substance use disorder services during the first year after RICMS enrollment. By

[20]Generalized linear regression models were also run on binary outcomes and produced similar results.

[21]See Appendix C for outcomes findings for clients who enrolled in RICMS while in jail.

[22]The full unrestricted sample in Appendix C includes the 15 percent of RICMS community enrollment program participants for whom no matching comparison was found among non-participants. It also includes all comparison members, including those comparison members who did not match to a matched RICMS program group member.

[23]See Appendix A for a list of covariates and discussion covariates selection.

[24]The threshold for statistical significance used in this study is a p-value below 0.10. A p-value is the probability for obtaining a difference at least as extreme as the calculated difference between groups in a situation where there is no real difference between groups. For example, a p-value of 0.10 indicates that there is a 10 percent chance of observing a difference at least as extreme as the one observed when there is no real difference between groups. The p-values associated with each difference are represented in exhibits using asterisks, where "*" indicates a p-value less than 0.10, "**" indicates a p-value less than 0.05, and "***" indicates p-value less than 0.01. No asterisk indicates that the difference between groups is not statistically significant. That is, in a situation where there is no real difference between groups, the chance of observing a difference at least as large as the one observed is greater than 10 percent. See Wasserstein and Lazar (2016) for additional discussion of statistical significance.

the end of the two-year period, around 10 percent of both research groups had been admitted to County-provided substance use disorder services.

Mental Health Treatment

RICMS program participants were more likely to receive services from County Department of Mental Health providers than comparison group members. However, caution should be taken in interpreting these findings, as sensitivity checks showed that the outpatient mental health service measures may be sensitive to unmeasured bias (see Appendix A). As shown in Table 5, RICMS participants were 5 percentage points more likely to receive mental health services during the first year after enrollment.[25] By the end of the two-year follow-up period, the difference between groups was 3 percentage points. Specifically, this difference in the receipt of mental health services was driven by RICMS participants being more likely to receive *outpatient* mental health treatment. By contrast, at the of the second year, RICMS participants were *less likely* to have received *inpatient* mental health treatment.

Primary Care and Hospitalization

RICMS program participants were less likely to visit an emergency room than comparison group members. To examine whether the RICMS program group members differed from comparison group members in receipt of primary care and hospital services, the analysis measured primary care visits, inpatient hospital admissions, and emergency room visits. Table 6 shows that RICMS program participants were less likely to visit the emergency room than comparison group members: RICMS participants were about 4 percentage points less likely to be admitted to an emergency room during the two-year follow-up period than their comparison group counterparts.

Criminal Legal System Contact

RICMS program participants were less likely to have interactions with the criminal legal system than comparison group members. They were less likely to experience an arrest, be incarcerated in jail, have a new conviction, or have a probation revocation. As shown in Table 7, during the first year after program enrollment, around 72 percent of program participants did not experience an arrest or incarceration in jail, compared with 66 percent of comparison group members, an estimated difference of 6 percentage points. These differences persisted into the second year. On average, RICMS participants spent 8 fewer days in jail during the one-year follow-up period than comparison group members who did not participate in the RICMS program and 13 days fewer by the end of the two-year follow-up period.

Though neither of the research groups were likely to experience new convictions during either the first or second year after RICMS enrollment, RICMS participants experienced slightly fewer new convictions than comparison groups members. The difference in having a new conviction between the research groups was 3 percentage points during the first year and grew to 4 percentage points by the

[25]Outpatient care does not require a patient to stay at the hospital for care. Inpatient care requires a patient to stay in the hospital for care.

end of the second year. This difference in convictions was primarily driven by differences in misdemeanor convictions.

To examine differences in probation status (whether an RICMS client was on probation supervision) and probation system interactions between RICMS participants and comparison group members, the team measured yearly probation status, revocations, terminations, and extensions. RICMS program participants on probation experienced fewer probation revocations than comparison group members on probation. As shown in Table 7, 19 percent of the comparison group had their probation status revoked during the two-year period after their enrollment in RICMS, compared with 11 percent of RICMS participants. Comparison group members were also more likely to have probation terminated (a 1 percentage point difference between the groups).

These differences observed in arrests and incarceration are greater in both magnitude and statistical significance than most recidivism effects recorded in the literature for comparable reentry programs. A synthesis of 53 studies on reentry programs found that, on average, reentry programs reduce recidivism by 6 percent, compared with the 17 percent difference seen in the RICMS program.[26] A meta-analysis of 9 reentry programs a separate study of 12 reentry programs across the United States found small and statistically insignificant differences in rearrest rates between program participants and comparison group members—between 30 and 65 percent of the observed differences in the one-year arrest and one-year incarceration rates in the RICMS analysis. [27] One of these two studies also measured reincarceration rates, and found no statistically significant differences in reincarceration rates for the reentry program participants.[28] Two caveats in making comparisons to these three prior studies are that 1) the target population in these studies varied somewhat from that of RICMS and 2) the researchers used various research designs in their analyses.[29]: Therefore, a strictly "apples-to-apples" comparison is not possible. Still, these studies provide valuable information for contextualizing the RICMS findings in the broader research literature.

[26]Ndrecka (2014). RICMS differences in percentage points stated earlier were converted to percent difference for comparison purposes. Furthermore, measures were inverted (e.g., our "no arrest" measure with rate of 72 percent was converted to an "arrested" measure with corresponding rate of 28 percent) for calculating the percent difference, as these papers and much literature in the field rely on percent calculation (rather than percentage point differences) relative to measures like arrests (rather than "no arrest").

[27]Berghuis (2018); Lattimore and Visher (2013).

[28]Lattimore and Visher (2013).

[29]For instance, many of the programs in these other studied served only on people who were being released from prison, and in many cases only men. By contrast, RICMS serves men and women, and a wider population of people with criminal legal system involvement than just people returning from prison, including also people who have been released from jail and people with criminal legal system contact but not recently released. In terms of study design, Lattimore and Visher's work used a nonexperimental design, Berghuis relied only on randomized controlled trials in their meta-analysis, and Ndrecka's meta-analyses included both randomized controls and nonexperimental design studies.

Conclusions and Recommendations

The RICMS program is founded on the premise that coordination of reentry services and connection to individuals with similar lived experiences could lead to improved health and well-being outcomes for participants and reduce their criminal legal system contact. The findings from this report have implications for local, state, and national organizations thinking about service structures for individuals with criminal legal system involvement.

Community Health Workers and RICMS participants interviewed as part of this study both indicated the value of the workers' lived experience and how it facilitated stronger connections between the staff and participants. This relationship appears to be central to engaging participants and connecting them with the services and supports they need to be successful. However, CHWs' success to connect clients to needed services depends on the social service delivery system in the County. Los Angeles County has a high level of fragmentation of services due to the complexity of its governance and social service delivery system. Clients living in service areas with fewer community resources may experience greater barriers as CHWs have fewer options available or there may be long wait lists for in-demand services like housing. The Reentry Division was able to address some housing gaps by funding interim housing programs for RICMS, which shows how integrating services can help bolster the success of an individual program. While program managers and CHWs expressed the value of peer learning and relationship building amongst the 29 RICMS providers, the support the network offered all CHWs appears limited. Some CHWs tended to view themselves as securing successful service connections on their own or within their individual organization without the support of the Reentry Division as a coordinating body. The different approaches to building a network of service referral options are likely to result in variation across providers depending on their unique culture, approach, and set of resources within their organization.

Regardless of the challenges to connect clients to needed services, the quantitative findings suggest that this kind of case management structure is potentially successful for individuals with criminal legal system involvement. The results of the matched comparison group analysis indicates that RICMS is a promising program for reducing future contact with the criminal legal system and emergency medical services for those who enrolled while living in the community.[30] Findings regarding reduced contact with the criminal legal system among the participant group were consistent across measures of arrest, incarceration, convictions, and probation revocations. The magnitude of these differences is similar in scale to those of more comprehensive reentry programming.[31]

That said, a substantial number of those enrolled in RICMS, regardless of their enrollment location (jail or in the community), did not actively engage in services. It is hard to know the reason for this, though, without future study. One possibility is that individuals who enrolled ultimately decided they did not need the services that RICMS staff were offering which could suggest an opportunity to target enrollment efforts differently. Another factor in the low take-up of services could be the limited connections between the jails and the RICMS program staff, particularly as it relates to having up-to-date information about release dates and contact information. This suggests an

[30]Individuals enrolled in RICMS while in the community are those that did not enroll while in jail or while being released from jail.

[31]See Barden et al. (2018) and Redcross, Millenky, and Rudd (2012), for example.

opportunity to strengthen the relationship and system of communication between jail-based staff and RICMS staff to better support the individuals preparing for and being released.

An upcoming cost study will further explore these findings and document the total costs of the RICMS program. To support further learning about the reentry landscape in Los Angeles, and how lessons from this county can inform efforts across the country, the research team is conducting additional impact, outcomes, implementation, and cost studies of other reentry programming in Los Angeles County managed by JCOD.

Appendix A:

Data Sources and Methods

Data Sources

The implementation study relies on multiple qualitative and quantitative data sources:

Semi-Structured Interviews with Program Staff. The study team interviewed a total of 27 Community Health Workers (CHWs) and 14 program manager program staff across 13 of the 29 RICMS providers in 2021 and 2022. See Table A.1 for a list of all RICMS providers. Interviews lasted approximately 1 hour each and took place over Zoom or in-person. Topics included:

- Staff lived experience
- How staff build relationships with participants
- Client interactions
- General experiences working as a CHW
- Organizational characteristics of agency
- Integration of service delivery systems
- Performance management
- Broader policy and social context that agencies are embedded in

Semi-Structured Interviews with Program Participants. The study team interviewed a total of 26 individuals who participated in one of 10 RICMS providers 2021 and 2022. The team selected participants from these providers in particular to reflect diversity in location of providers (service planning areas), common referral sources, and variety of other services provided. Interviews lasted approximately 30 minutes and took place primarily in-person. Topics included:

- Experiences with release from prison or jail
- Goals and needs after release
- Service receipt and participant satisfaction
- Participant's relationship with staff

Staff Survey. A survey was fielded to RICMS program managers and Community Health Workers in April 2022. Surveys were sent to staff at every RICMS provider. A total of 94 staff responded which represented 27 of the 29 RICMS providers. The survey asked program staff to provide information about their roles and responsibilities, their backgrounds, how they support clients and connect them to services, and trainings or procedures that guide their activities.

CHAMP. The Comprehensive Health Accompaniment and Management Platform (CHAMP) is a case management system operated by the Los Angeles Department of Health Services. It tracks client enrollments, consent forms, assessments, demographic characteristics, needs, goals, and referrals to services.

The outcomes study relies on two data sources: RICMS case management data and administrative records from several Los Angeles County agencies:

InfoHub. The LA County Chief Information Office (CIO), which sits in the LA Chief Executive Office, manages InfoHub, an administrative data repository that merges service-use data from multiple county information systems. Of the many county service systems that provide data to InfoHub, the CIO provided data from six LA County agencies for this report: the Department of Mental

Health (DMH), Substance Abuse Prevention and Control (SAPC), the Department of Health Services (DHS), the County Sheriff's Department, the Superior Court, and the Department of Probation.

Qualitative Analysis

Interviews were recorded and transcribed. The files were imported into Dedoose, a web-based, mixed-methods analysis software package, to systematically code the data in a multistep process; program staff and program participant transcripts were analyzed separately.[1] The development of the coding scheme involved several stages. First, structural code based on the topics that were intentionally included in most interviews (that is, following the semi-structured questions and topical probes of the protocols), were created a priori reflecting the theory of change.[2] These broad codes (for example, "CHW and client relationship" or "reentry system integration") essentially served as an indexing device. They were used to evaluate the consistency of the interviews (how commonly the code was covered) and the richness of data collected (the extent to which topics were covered in the interviews). Second, a more detailed coding structure, which included subcodes under structural codes as well as additional codes for emerging topics, was created based on the coding team's review of the first level codes. This was an iterative process, as some codes were identified in advance, but many were data-driven and developed during the process to accommodate new and emerging themes.

Propensity Score Matching Process

The outcome analysis used propensity score matching to create comparable research groups out of the pool of RICMS participants and nonparticipants.[3] A propensity score is a conditional probability that predicts the likelihood that an individual will receive a treatment based on characteristics or factors such as race, gender, or the extent of their prior contact with the criminal legal system. Each participant and nonparticipant receives a propensity score predicting how likely they would be — based on a set of personal factors — to participate in the RICMS program. Participants are then matched to nonparticipants with similar propensity scores to create two groups: the participant group and the comparison group. This process ensures that the research groups are substantially similar with regards to their propensity to participate in RICMS, increasing confidence in any effects on measured outcomes estimated during the outcomes analysis phase.

Propensity scores were created separately for people who enrolled in RICMS while in jail and people who enrolled while in the community. This was done given the observed difference in service participation between the two groups, which showed that those whole enrolled while in the community were double as likely to participate in services than those enrolled while in jail (see Table 2). Results are presented separately for these two groups.

To create the propensity scores, the analysis team used logistic regression to assess whether a series of characteristics and factors were predictive of an individual participating in the RICMS

[1]http://www.dedoose.com/.

[2]Saldaña (2009).

[3]The study defines participants as individuals who received services from a community health worker beyond initial enrollment for at least 30 days and had a care plan recorded in CHAMP. Nonparticipants are those entered into the CHAMP management information system for the RICMS program but do not have services recorded for 30 days or have a care plan.

program. In selecting covariates, the team followed the research literature on propensity score matching which indicates that covariates known to be predictive of research group assignment (in this case, participant or nonparticipant) or outcomes should be included in the model.[4]And that including additional covariates thought to be predictive of research group or of outcomes is likely not harmful. Therefore, covariates were selected based on findings from past research regarding predictors of criminal legal system involvement for justice-involved people.[5] In addition, wherever possible, we included measures of previous occurrences of key activities or services usage prior to RICMS enrollment corresponding to outcomes.[6] Multiple imputation was conducted for missing covariates. Below are the variables that were used as covariates:

- Gender
- Age
- Race[7]
- Ethnicity
- Month and year of enrollment
- Indicator for whether the client enrolled in RICMS before or during the COVID-19 pandemic (measured as on or after March 16, 2020)
- Probation status at time of enrollment
- Service Planning Area
- Ever convicted of a misdemeanor in the two years prior to enrollment
- Ever convicted of a misdemeanor in between two and seven years prior to enrollment
- Ever convicted of a felony in the two year years prior to enrollment
- Ever convicted of a felony in between two and seven years prior to enrollment
- Number of days between client's most recent conviction and their enrollment date
- Number of days client spend in jail in the two years prior to enrollment
- Number of days client spent in jail between two and eight years prior to enrollment
- Ever arrested in the two years prior to enrollment

[4]See Stuart (2010) and Guo, Fraser, and Chen (2020).

[5]For instance, a recent meta-analysis conducted by Goodley, Pearson, and Morris (2022) found that prior incarceration, prior convictions, prior arrests, a history of mental illness and being male were consistently shown to be associated with recidivism among adults convicted and sentenced to custody. This meta-analysis also found being Black to be a predictor, due to the institutional racism in law enforcement and the judicial system. A meta-analysis by Bechtel, Lowenkamp, and Holsinger (2011) found that age, jail incarcerations, prior conviction, prior felony, and prior misdemeanors were all predictive of re-arrest among people awaiting trial. In one of the few studies that exclusively focused on people released from jails, Sheeran (2020) found that gender, race, ethnicity, age at release, criminal record, risk score, and time served were found to significantly influence an individual's likelihood of receiving a new charge, conviction, or incarceration term within three years post-release. Lastly, a study by Lebenbaum, Kouyoumdjian, Huang, and Kurdyak (2022) found that among individuals released from provincial corrections institutes in Ontario, Canada, utilization of mental health services prior to incarceration were associated with higher rates of recidivism, higher rates of hospitalization, and lower rates of outpatient care.

[6]For instance, one outcome in the analysis was whether clients were admitted to emergency rooms. Therefore, we included in our model the number of emergency rooms visits that individuals had experienced in the two years leading up to RICMS enrollment.

[7]Race was missing for many cases in the initial data. As a first step to addressing this missingness, a comparison of race and ethnicity variable was conducted which revealed that in most cases when race was missing, ethnicity was indicated as Hispanic. Rather than impute race in this scenario, the research team combined race and ethnicity as a single race variable and indicated Hispanic as the race in these cases.

- Ever arrested in the years two to eight prior to enrollment
- Number of primary care visits in the two years prior to enrollment
- Number of ER visits in the two years prior to enrollment
- Number of inpatient hospital admissions in the two years prior to enrollment
- Ever received county-provided inpatient mental health services in the three years prior to enrollment
- Ever received county-provided outpatient mental health services in the three years prior to enrollment
- Ever flagged for substance abuse while receiving a county-provided mental health service in the three years prior to enrollment

The logistic regressions produced coefficients that represent the relationship between each predictor and the likelihood that a client would participate in RICMS. Clients' individual characteristics and factors are then multiplied by these coefficients to create a score between 0 and 1, where a score of 0 means that the client is estimated to be completely unlikely to participate in RICMS and a score of 1 means that the client is estimated to be certain to participate.

The research team used one-to-one nearest neighbor matching to match program participants to nonparticipants with similar propensity scores. This means that each program participant was matched to the closest unmatched score in the nonparticipant pool. The team ran the match without replacement, meaning that each client could only be matched once; once they were matched, the client was taken out of the selection pool. To ensure that program participants were only matched with nonparticipants with a somewhat similar likelihood of program participation, the research team used a caliper of 0.2. Using a caliper of this size prohibits our statistical computing software from matching two individuals together who have propensity scores greater than 0.2 units apart on the 0-1 scale. The caliper size was chosen based on recommendations in the literature and established MDRC practice.[8] The matching process produced a 99 percent match rate for the RICMS participants who enrolled while in jail and an 85 percent match rate for the RICMS participants who enrolled while in the community. In the jail enrollment group, 416 total participants and nonparticipants were matched, compared to 6,976 total in the community enrollment group. A larger sample size results in more statistical power, which means that we can be more confident that our community enrollment group effect estimates are accurate than we can our effect estimates for the jail enrollment group.

Any matched comparison group will differ slightly from the study sample which limits the ability to make causal inferences, however, it can provide an estimate of participant outcomes for the population of people enrolled in programs like RICMS who did not receive services.[9] See Tables A.2 for characteristics of the matched jail enrollment participants and Table 2 in the main report text for characteristics of all jail enrollment participants (including matched and not matched).

Program participants who enrolled while in the community for whom there was a match were more likely to have been convicted of a misdemeanor in the two years prior to enrollment compared to the full community enrollment sample (34 percent vs. 29 percent) and more likely to have been

[8]Austin (2011).

[9]A weighting approach based on propensity scores, in lieu of matching, was also given consideration. However, the team felt that a matching approach was clearer to understand, and more transparent in the sense that it is easy to compare the differences in characteristics of the resulting matched analysis sample with the characteristics of the overall unmatched sample, also presented in this report.

convicted of a misdemeanor in the years three through seven prior to enrollment (37 percent vs. 35 percent). Matched community enrollment participants were also more likely to have been arrested in the two years prior to enrollment (63 percent vs. 55 percent). On other measures, the matched and full sample of community enrollment participants were similar. See Tables A.3 for characteristics of the matched community enrollment participants and Table 2 in the main report text for characteristics of all community enrollment participants (including matched and not matched).

Matching Sensitivity Checks

To assess the strength of the matching process, the research team used a variety of visual and statistical sensitivity checks at each stage of the analysis. Each sensitivity check was conducted for the two enrollment streams separately. The team used three methods to assess covariate balance: means comparison, logistic regression, and an Average Standardized Difference (ASD) love plot. First, the team compared the covariate means for the two research groups in each stream to ensure that they were substantially similar. Table A.2 shows the covariate means for the jail enrollment group and Table A.3 shows the covariate means for the community enrollment group. The means for both analysis streams were substantially similar across the research groups.

Second, the team performed a logistic regression on the matched research groups to see if there were any statistically significant differences between them. In the jail enrollment group, there were no statistically significant differences in any of the individual covariates. In the community enrollment group, only two covariates were significantly different. The groups as a whole, however, were not statistically different.

Finally, the team constructed an ASD love plot for both streams after matching was done. The team used the cobalt bal.tab() function in R to produce balance statistics based on the treatment variable (participation in RICMS). The team then extracted the standardized difference statistics for each covariate and plotted them in relation to $x = 0$. In the jail enrollment group, all of the covariates fell between –0.05 and 0.05, except for two outliers. In the community enrollment group, all but one of the covariates fell between –0.05 and 0.05.

The team used several visual checks to assess the score assignment process. These include an examination of the region of common support using a histogram, a density plot of the slope of the probability distribution, line graphs of the quantile of probability, and a distribution plot of the propensity scores. See Figures A.1 and A.2 for the propensity score distribution plot for each enrollment group.

Participants and nonparticipants in the jail enrollment group had a similar distribution of propensity scores, even before matching. After matching, the plot shows nearly identical propensity score distributions for the matched treated units and the matched control units. There are only three unmatched treated units, which are those without similarly distributed units in the unmatched control pool. The plot for the community enrollment group shows similar score distributions for matched program participants (matched treated units) and matched nonparticipants (matched control units). As expected from a matching approach, the unmatched units are largely nonparticipants who were predicted to be highly unlikely to participate in RICMS and participants who were predicted to be highly likely to participate in RICMS. The distribution plot shows a strong match between the research groups.

Model Sensitivity Checks

The analysis team employed an iterative model building approach to test the strength of their model specifications and preempt overfitting. The team delineated three different models with a decreasing number of covariates, prioritizing covariates with the highest expected predictive power of both treatment and outcome. The research team first ran a linear regression on the full proposed model with all the covariates above. The team then ran linear regressions on the two reduced models and compared them to the original model. Each model showed only slight differences in the regression outputs; the direction and significance of each outcome were consistent across the three models.

In order to minimize the False Discovery Rate, the research team implemented the Benjamini-Hochberg (BH) Procedure on the outcomes, segmented by group and follow-up year. Under the adjusted p-values produced by the BH procedure, 10 of the jail enrollment outcomes were significant at the 0.1 level, including six one-year outcomes. Twenty-four outcomes for the community enrollment group were significant at the 0.1 level even after undergoing the BH procedure, including nearly all the criminal legal system outcomes where statistically significant differences has been observed in the main analysis. This provides support for the estimated differences for this group in the regression analysis.

The research team also conducted Rosenbaum's Bounds tests to assess the confidence in the results. These tests are designed to test the assumption of conditional independence implicit in propensity score analysis. They do this by determining how strong an effect an unmeasured confounding variable would need to have on treatment assignment to significantly influence the estimated causal effect. Two tests were used for continuous outcome variables: the Wilcoxon Signed Rank Test and the Hodges-Lehmann Point Estimate. Two tests were used for binary outcome variables: the Wilcoxon Signed Rank Test and McNemar's test.

The following results are for the community enrollment group. In year one, the criminal legal system outcomes were very robust, which the exception of 'no felony conviction within one year of follow-up,' which was sensitive to unmeasured bias. 'Probation status' was similarly sensitive to bias. The outcomes relating to arrests, incarceration, and probation term amendments were particularly robust. These patterns held for the two-year criminal legal system outcomes, except for the outcome 'probation status,' which became more robust in year two. Across both years, the primary care physical health outcomes were sensitive to bias, but the emergency services and inpatient hospital admission outcomes were robust against bias. All outpatient mental health outcomes were fairly sensitive to bias but inpatient mental health outcomes were not. Substance use disorder treatment outcomes were overall very sensitive to bias in the Wilcoxon Signed Rank Test, but the year two outcomes were robust according to McNemar's test.

Limitations

Data Sources

Data extracted from the CHAMP management information system may not reflect the full picture of client referrals and outcomes. CHAMP relies on information reported by program staff, which means that differences in the ways individual case managers enter data may influence the

accuracy or completeness of the data. Additionally, staff may not always be using the service referral functionality and may be documenting some services in case notes. This limits the level of detail our analyses can go into regarding services received by clients.

Another potential limitation is that outcomes analyzed in this study represent only data for Los Angeles County. For instance, outcomes data related to the criminal legal system included records from the Superior Court, Los Angeles Sheriff's Department, and Department of Probation. These records were limited to LA County, and arrests and convictions from other counties were not available for analysis. State prison admission and release data were also not available. Similarly, for primary care and hospitalization, mental health, and substance use disorder services and outcomes, the study captures only county-administered services and does not include information from private health providers or non-county agencies and organizations.

Propensity Score Matching

Though propensity score matching is a powerful analytic tool, it cannot determine whether a causal relationship exists between the program and observed outcomes. A potential limitation of analyses that rely on propensity score matching is whether there may be unobserved characteristics or unmeasured factors (e.g., those which we do not have data) which could predict membership in the research groups (i.e., participant or nonparticipant) or on the outcomes. The research team had a rich data set containing multiple Los Angeles County agencies' records for RICMS clients, including demographic information and their histories with various government services and systems (the same systems and agencies from which our outcome measures are derived) dating back several years.[10] However, these data are not exhaustive, and it is possible that unobserved characteristics are present which would threaten the validity of the results.

[10]One exception to this was substance use disorder services from Los Angeles County Substance Abuse Prevention and Control which were not available for time periods prior to program enrollment due to agency limitations on what data can be provided for researchers.

Appendix B

Staff Survey Responses

Appendix C

Supplementary Outcomes Analysis

Appendix D

Grantee Highlight

The Value of a Peer-Delivered Services Model

RICMS aims to remove barriers to successful reentry from jail, prison, or probation by connecting clients to a variety of services. A key component of the RICMS model is the role of Community Health Workers (CHW) who conduct outreach to engage clients, identify their needs, and help navigate them to needed services. A key component of the RICMS theory of change is the role of lived experience in the ability of the CHWs to establish a successful relationship. Using peer-delivered services in reentry programs has been shown to increase program engagement and retention rates and can improve the health and lives of individuals involved with the criminal legal system.[1]

The client-staff relationship is an essential component of the RICMS model. MDRC's qualitative research on the implementation of RICMS has shown that the positive and supportive nature of the relationships between CHWs and their clients is a primary driver of client engagement with and enthusiasm towards the model. Therefore, the relationship plays a major role in facilitating clients' successes in achieving their goals. A key component of the relationships that RICMS fosters is that CHWs share lived experience with many of the challenges and trajectories that clients are navigating. The kinds of lived experiences CHWs have include being personally impacted by the legal system (such as individuals who have been arrested and/or incarcerated) or impacted through others close to them (for example, having family members or close friends that have been arrested and/or incarcerated), as well as histories with substance use disorders and addiction, among others.

CHWs recognize that as clients reintegrate into society after incarceration, their mental and physical capacity to cope with stressors will vary, which is why in interviews with the research team, they all mentioned a similar motto: "Meet clients where they are at." CHWs accommodate clients by meeting them in locations where clients may be more comfortable or that are an easier commute for the client. Or may focus on attending to clients' immediate needs and will not push goals that the client is not interested in or ready to pursue.

One client described her CHW:

> "[RICMS CHW] listens to you and doesn't judge where you're coming from either, because it's really hard to feel like you're valid in a state of being displaced or whatever. And still feel supported without looking like you're not doing enough."

She then describes her relationship with her CHW, and without hesitation, says she feels validated with her CHW. Whereas other social service support agencies in her experience made her feel inadequate or "dumb," this RICMS provider is the complete opposite. This is a common theme heard from clients.

While each participant had unique needs and challenges, as well as unique resources they brought with them as they navigated difficult reentry contexts, a consistent theme that shined across all interviews was how the bond between participants and their CHWs helped them deal with and meet the myriad demands required of them by various institutions. CHWs also helped connect participants to a wide range of resources in the community, ranging from health to employment services. For participants however, what sets RICMS CHWs apart from past case managers or system actors they have worked with is the depth and richness of their bonds with their CHWs. On top of being case

[1]Umez, De la Cruz, Richey, and Albis (2017).

managers, CHWs appeared to offer crucial social support and a sense of understanding and non-judgment that, for participants, resulted in genuine enthusiasm in their participation and adherence to the program.

This video (https://youtu.be/8c4_i6XXTeQ) highlights the perspectives of RICMS CHWs regarding the important work they do in their communities, as well as demonstrates some of the strategies they employ to identify, engage, and work with clients to meet their reentry goals.

Appendix E

Interim Housing Supplement

To divert people from incarceration as well as support individuals after their interaction with the criminal legal system, LA County's Board of Supervisors established the Office of Diversion and Reentry – referred to as the Reentry Division in this report – in September 2015.[1] The department's goal is to divert people from incarceration and support individuals when released. With funding from the Safe Neighborhoods and Schools Act (Proposition 47) – administered by the California Board of State and Community Corrections – and the California Community Corrections Performance Incentives Act of 2009 (SB 678), the Reentry Division has since launched a number of programs that are intended to improve well-being and prevent future system involvement. Housing was identified as a priority solution given the strong intersection of homelessness and legal system involvement in Los Angeles County.[2] Therefore, the Reentry Division developed the Interim Housing program for individuals who are in early recovery from substance use disorders, with the goal of providing a safe housing environment that equips clients with the support that contributes to sobriety. The Reentry Division used Proposition 47 funds provide short-term housing to individuals with immediate housing needs. The first location – a 20-bed capacity for male clients – is operated by the community based nonprofit organization Christ Centered Ministries.[3] The Reentry Division made Interim Housing slots available to its other reentry programs, but Reentry Intensive Case Management Services (RICMS) accounts for almost all referrals.[4] This report describes program implementation and one and two-year outcomes of clients who enrolled in the Interim Housing program between April 1, 2020, and March 31, 2021. The study team interviewed two Christ Centered Ministries' staff and also analyzed interviews with other RICMS staff for additional information about housing needs and challenges faced by RICMS program participants.

About the Interim Housing Program

Among all RICMS staff interviewed between July 2019 and August 2022, affordable and accessible housing was noted as the biggest challenge they faced when supporting clients on their caseloads. Christ Centered Ministries, based in southwestern Los Angeles County, targets people who are experiencing homelessness and have mental health or substance use disorders. The house designated for the Interim Housing program contains shared bedrooms for clients, shared living space, and office space for staff to meet with clients. The house also includes a case manager on location who coordinates with RICMS community health workers to provide wraparound supports with a focus on substance use disorder treatment and recovery. This includes behavioral health services and connections to off-site inpatient and outpatient treatment. Clients can also attend support groups focused on recovery and maintaining sobriety. Clients are eligible to stay in the Interim Housing for up to twelve months and are expected to coordinate with RICMS community health workers to secure longer-term housing options as well as to access employment support, expungement assistance, and family reunification services.

[1]In 2022, the Los Angeles County Board of Supervisors consolidated various efforts – including the Office of Diversion and Reentry – to support communities that are system-impacted within the new Justice, Care, and Opportunities Department (JCOD).

[2]Shadravan, Stephens, Appel, and Ochoa (2020).

[3]Two additional interim housing sites have opened since, leveraging other funding sources.

[4]The RICMS program is described in more detail in the main text. Staff (known as community health workers) provide care coordination to their assigned clients and help them to navigate the wide array of services and supports needed. All clients were adults charged with or convicted of a crime, and who were identified as having mild to moderate mental health and/or substance use disorders. The RICMS program goal is to improve health and well-being outcomes and future reduce criminal legal system contact of its participants.

Multiple Christ Center Ministries' staff reported that the Interim Housing program was a valuable supplement to help them meet client's urgent housing needs, especially given the high rates of homelessness and housing insecurity in Los Angeles County.[5] However, the program has some limitations when examined as a complement to RICMS. Firstly, while the RICMS program serves the entire county, Interim Housing is concentrated in just two service provision areas of the county which limits client access to the program. Additionally, Interim Housing may not be suitable for all clients who need housing. Staff interviewees shared that many clients would prefer not to be in shared housing, whether due to safety issues, a desire for privacy, or a wish to maintain independence from the policies and programs attached to shared housing.

Client Characteristics, Program Participation, and Outcomes

The Interim Housing analysis of program participation and outcomes includes individuals who enrolled in both the RICMS and interim housing programs.

Table 1 shows the characteristics of the 56 interim housing clients who enrolled in the program between April 2020 and May 2021. Almost half of Interim Housing clients identified as Black and almost 40 percent as Hispanic. Most clients were between the ages of 25 and 44 years. The average length of time between check-in and check-out of Interim Housing was 145 days or just under 5 months and 93 percent of Interim Housing clients exited within one-year (not shown). Figure 1 shows the variation in length of stay for interim housing clients.

Table 2 shows the criminal legal system outcomes for Interim Housing clients at one- and two-years after the date of check-in to Interim Housing. Nearly three-quarters of clients did not have a new felony arrest (71 percent) or misdemeanor arrest (73 percent) in year one. By the end of year two, 61 percent of interim housing clients had not experienced a new felony arrest and 58 percent had not had a misdemeanor arrest. The level of no new felony convictions is consistently high across year one and two.

Conclusion

This descriptive analysis of a small number of Interim Housing participants limits the conclusions we can draw about the program. Namely, it is not possible to know whether a causal relationship exists between the program and the observed criminal legal system outcomes. This analysis is a good first look at the potential that housing – through the combination of the Interim Housing with RICMS programs – can have on its participants and their future contact with the criminal legal system. Additional research, including a more rigorous quantitative analysis with a bigger pool of participants, would help to better understand the effects of such programming on its participants.

[5]Los Angeles Homeless Services Authority (2022).

References

Austin, Peter C. 2011. "Optimal Caliper Widths for Propensity-Score Matching When Estimating Differences in Means and Differences in Proportions in Observational Studies." *Pharmaceutical Statistics* 10, 2: 150-161.

Barden, Bret, Randall Juras, Cindy Redcross, Mary Farrell, and Dan Bloom. 2018. *New Perspectives on Creating Jobs: Final Impacts of the Next Generation of Subsidized Employment Programs.* New York: MDRC.

Bechtel, Kristin, Christopher T. Lowenkamp, and Alex Holsinger. 2011. "Identifying the Predictors of Pretrial Failure: A Meta-Analysis." *Federal Probation* 75, 2: 78-87.

Berghuis, Maria. 2018. "Reentry Programs for Adult Male Offender Recidivism and Reintegration: A Systematic Review and Meta-Analysis." *International Journal of Offender Therapy and Comparative Criminology* 61, 14: 4655-4676.

Corrigan, Patrick W., Dana J. Kraus, Susan A. Pickett, Annie Schmidt, Ed Stellon, Erin Hantke, and Juan Lorena Lara. 2017. "Using Peer Navigators to Address the Integrated Health Care Needs of Homeless African Americans With Serious Mental Illness." *Psychiatric Services* 68, 3: 264-270.

Finkelstein, Amy, and Sarah Taubman. 2015. "Using Randomized Evaluations to Improve the Efficiency of US Healthcare Delivery." Cambridge, MA: J-Pal North America.

Goodley, Gary, Dominic Pearson, and Paul Morris. 2022. "Predictors of Recidivism Following Release from Custody: A Meta-Analysis." *Psychology, Crime, & Law* 28, 7: 703-729.

Guo, Shenyang, Mark Fraser, and Qi Chen. 2020. "Propensity Score Analysis: Recent Debate and Discussion." *Journal of the Society for Social Work and Research* 11, 3: 463- 482.

Hunter, Sarah B., and Adam Scherling. 2019. *Los Angeles County Office of Diversion and Reentry's Supportive Housing Program: A Study of Participants' Housing Stability and New Felony Convictions*. Los Angeles: RAND.

Lattimore, Pamela K., and Christy A. Visher. 2013. "The Impact of Prison Reentry Services on Short-Term Outcomes: Evidence From a Multisite Evaluation." *Evaluation Review* 37, 3-4: 274-313.
Lebenbaum, Michael, Fiona Kouyoumdjian, Anjie Huang, and Paul Kurdyak. 2022. "The Association Between Prior Mental Health Service Utilization and Risk of Recidivism among Incarcerated Ontario Residents." *Canadian Journal of Psychiatry*, DOI: 10.1177/07067437221140385.

Los Angeles Homeless Services Authority. 2022. "Greater Los Angeles Homeless Count." Website: https://www.lahsa.org/homeless-count/.

Ndrecka, Mirlinda. "The Impact of Reentry Programs on Recidivism: A Meta-Analysis" (doctoral thesis, University of Cincinnati, 2014), https://cech.uc.edu/content/dam/refresh/cech-62/school-of-criminal-justice/research/2011-2016/Mirlinda%20Ndrecka.pdf.

Redcross, Cindy, Megan Millenky, and Timothy Rudd. 2012. *More Than a Job: Final Results from the Evaluation of the Center for Employment Opportunities (CEO) Transitional Jobs Program*. New York: MDRC.

Saldaña, Johnny. 2009. *The Coding Manual for Qualitative Researchers*. London: SAGE Publications Ltd.

Shadravan, Sonya., Dustin Stephens, Oona Appel, and Kristen Ochoa. 2020. "Cross-Sectional Study of Homeless High Service Utilizers in Los Angeles County Jails: Race, Marginalization and Opportunities for Diversion." *Ethnicity & Disease* 30, 3: 501-508.

Sheeran, Alyssa M. "Examining the Influence of Individual and Neighborhood Characteristics on Jail Recidivism" (doctoral thesis, University of Wisconsin – Milwaukee, 2020), https://www.proquest.com/openview/bfb1d1f133064b95fb79ca2aa8bd8de3/1?pq-origsite=gscholar&cbl=18750&diss=y

Stuart, Elizabeth A. 2010. "Matching Methods for Causal Inference: A Review and A Look Forward." *Statistical Science* 25, 1: 1-20.

Umez, Chidi, Jan De la Cruz, Maureen Richey, and Katy Albis. 2017. *Mentoring as a Component of Reentry: Practical Considerations from the Field*. New York: The Council of State Governments Justice Center.

Vera Institute of Justice. n.d. "Care First L.A.: Tracking Jail Decarceration." Accessed May 8, 2023. Website: https://www.vera.org/care-first-la-tracking-jail-decarceration.

Wasserstein, Ronald L., and Nicole A. Lazar. 2016. "The ASA's Statement on *p*-Values: Context, Process, and Purpose." *The American Statistician* 70, 2: 129-133.

Exhibits

Table 1

Participation Outcomes by Enrollment Location: Jail Versus Community

Outcome	Jail Enrollment	Community Enrollment
Participated in RICMS (%)[a]	13.0	30.4
Mean Days Participated	174.3	225.6
Median Days Participated	151	190
Sample size	1,619	13,429

SOURCE: MDRC calculations from CHAMP.

NOTE: [a]Participants are those individuals who received RICMS services from a community health worker beyond initial enrollment for at least 30 days and had a care plan recorded in CHAMP.

Table 2

Characteristics of RICMS Participants and Nonparticipants, by Enrollment Location

Variable	Jail Enrollments[a]		Community Enrollments[b]		All	
	Participants	Non-Participants	Participants	Non-Participants	Participants	Non-Participants
Demographics						
Age (mean years)	39.8	39.9	41.1	40.3	41.0	40.3
Age (%)						
18-24 years	3.8	4.5	5.2	4.6	5.1	4.5
25-34 years	36.0	35.0	31.6	33.5	31.9	33.7
35-44 years	31.3	30.1	27.9	29.4	28.1	29.5
45 or more years	28.9	30.3	35.2	32.4	34.9	32.2
Gender (%)						
Woman	33.6	31.9	26.8	18.7	27.2	20.4
Man	63.5	67.5	71.7	80.2	71.3	78.6
Genderqueer	0.5	0.1	0.0	0.1	0.1	0.1
Trans woman	0.9	0.4	1.1	0.8	1.1	0.8
Trans man	0.9	0.1	0.3	0.1	0.3	0.1
Ethnicity (%)						
Hispanic	52.6	44.2	42.6	43.5	43.1	43.6
Race (%)						
White	36.5	41.9	23.5	43.5	24.1	43.3
Black	28.9	29.6	41.6	30.2	41.0	30.1
Hispanic	24.2	18.9	26.7	17.3	26.6	17.5
Asian	3.3	2.1	1.2	1.5	1.3	1.6
Pacific Islander	0.0	0.3	0.6	0.6	0.6	0.5
Native American	0.9	1.0	1.1	1.0	1.1	1.0
Multiracial	5.2	4.5	3.7	3.8	3.8	3.9
Service planning area (%)						
1. Antelope Valley	4.3	8.4	3.8	7.2	3.8	7.3
2. San Fernando Valley	10.9	15.3	13.8	16.8	13.7	16.6
3. San Gabriel Valley	18.0	11.5	12.3	10.2	12.6	10.4
4. Metro	19.4	22.0	13.4	24.4	13.7	24.1
5. West	2.8	4.3	2.3	4.6	2.4	4.5
6. South	19.9	15.2	39.5	15.0	38.5	15.0
7. East	13.3	8.9	6.4	9.0	6.7	9.0
8. South Bay	10.0	13.6	7.9	11.8	8.0	12.1
Contact with the criminal legal system						
Ever convicted of a misdemeanor (%)						
Within two years prior to enrollment	53.6	62.7	29.3	51.1	30.5	52.6
Between two and seven years priors to enrollment	50.7	60.4	34.8	50.5	35.6	51.8
Ever convicted of a felony (%)						
Within two years prior to enrollment	64.0	58.5	32.4	50.2	34.0	51.3
Between two and seven years priors to enrollment	39.3	49.6	30.6	42.5	31.0	43.4
Median time between most recent conviction and enrollment (days)[c]	68	78	315	84	286	84
Mean time incarcerated (days)						
Within two years prior to enrollment	174	198	62	162	67	166
Between two years and eight years prior to enrollment	150	218	106	194	108	197
Ever arrested (%)						
Within two years prior to enrollment	99.5	99.6	54.6	84.7	56.8	86.7
Between two years and eight years priors to enrollment	77.3	85.7	59.4	73.1	60.3	74.8
Medical care						
Physical health						
Number of primary care visits within two years prior to enrollment	0.6	0.6	0.7	0.6	0.7	0.6
Number of emergency services within two years prior to enrollment	0.7	1	0.5	1	0.5	1
Number of hospital admissions within two years prior to enrollment	0.1	0.1	0.1	0.2	0.1	0.2

(continued)

Table 2 (continued)

Mental health (%)						
Ever had inpatient mental health admission within prior three years	12.8	16.3	7.5	14.3	7.8	14.6
Ever had outpatient mental health service within prior three years	43.6	43.0	33.9	41.9	34.3	42.0
Ever had substance use disorder as recorded in mental health data within prior three years	35.1	27.4	19.9	27.5	20.6	27.5
Sample size	211	1,408	4,089	9,340	4,300	10,748

SOURCE: Calculations based on data from CHAMP management information system and InfoHub.

NOTES: Participants are RICMS clients who were enrolled in the program for at least 30 days and had a care plan recorded in CHAMP. Non-participants are similar individuals enrolled in but not participating in RICMS services. Five people are missing age data, eight people are missing gender data, 432 people are missing ethnicity data, 294 people are missing race data, and 118 people are missing service planning area data.

[a]Jail enrollment indicates people who enrolled in RICMS while in jail or while being released from jail.

[b]Community enrollment indicates people who enrolled in RICMS while living in the community. That is, they did not enroll while in jail or while being released from jail.

Table 3

One-Year Service Referrals Among RICMS Participants, by Enrollment Location

Outcome	Jail Enrollments			Community Enrollments			All		
	N	Percentage	Mean Number of Referrals	N	Percentage	Mean Number of Referrals	N	Percentage	Mean Number of Referrals
At least one referral to:									
Employment services	9	10.6	0.1	260	18.9	0.3	269	18.4	0.3
Housing services	24	28.2	0.4	476	34.5	0.6	500	34.2	0.5
Legal services	9	10.6	0.1	185	13.4	0.2	194	13.3	0.2
Mental health services	12	14.1	0.2	246	17.8	0.3	258	17.6	0.2
Physical health services	7	8.2	0.2	128	9.3	0.1	135	9.2	0.1
Substance use disorder services	14	16.5	0.3	106	7.7	0.1	120	8.2	0.1
At least one one-time:									
Assistance with food	8	9.4	0.1	312	22.6	0.6	320	21.9	0.6
Basic necessities (clothing, hygiene kit, phone charger, etc.)	15	17.6	0.2	248	18.0	0.3	263	18.0	0.3
Education	2	2.4	0.0	127	9.2	0.1	129	8.8	0.1
Employment (job applications, resume building, etc.)	5	5.9	0.1	222	16.1	0.3	227	15.5	0.2
Housing (SPDAT)	1	1.2	0.0	51	3.7	0.0	52	3.6	0.0
Legal services - other (ID cards)	9	10.6	0.2	165	12.0	0.2	174	11.9	0.2
Other supportive services	15	17.6	0.2	407	29.5	0.5	422	28.8	0.5
Social services (CalFresh, Medi-Cal, etc.)	19	22.4	0.3	210	15.2	0.2	229	15.6	0.2
Transportation services (gas cards, ride share rides, etc.)	9	10.6	0.1	214	15.5	0.3	223	15.2	0.3
Voter education or registration services	2	2.4	0.0	178	12.9	0.1	180	12.3	0.1
Referred to one or more distinct service categories	59	69.4	--	1,165	84.5	--	1,224	83.6	--
Referred to two or more distinct service categories	39	45.9	--	933	67.7	--	972	66.4	--
Referred to three or more distinct service categories	27	31.8	--	637	46.2	--	664	45.4	--
Referred to four or more distinct service categories	18	21.2	--	387	28.1	--	405	27.7	--
Sample size	85			1,379			1,464		

SOURCE: Calculations based on data from CHAMP management information system.

NOTES: Includes RICMS participants enrolled May 2020 through March 2021. Documented referrals in CHAMP may represent a floor or minimum rather than an exact accounting. In other words, at least the percentage of participants shown in this table were referred to the services shown, but possibly more received referrals to these services.

Participants are RICMS clients who were enrolled in the program for at least 30 days and had a care plan recorded in CHAMP.

Table 4

One- and Two-Year County Substance Use Disorder Service Use Outcomes for RICMS Clients, Community Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had SUD admission (%)	7.2	7.2	0.2	0.798
Number of SUD admissions	0.1	0.1	0.0	0.184
Ever had SUD outpatient treatment (%)	10.1	9.1	1.1	0.114
Number of SUD outpatient treatments	0.1	0.1	0.0	0.194
Sample size	3,469	3,469		
Two-year outcomes				
Ever had SUD admission (%)	9.3	10.0	-0.5	0.535
Number of SUD admissions	0.2	0.2	0.0	0.426
Ever had SUD outpatient treatment (%)	12.4	11.3	1.5	0.113
Number of SUD outpatient treatments	0.2	0.2	0.0	0.542
Sample size	2,168	2,115		

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Community enrollment indicates that people shown in this table enrolled in RICMS while living in the community. That is, they did not enroll while in jail or while being released from jail.

SUD = Substance use disorder.

Table 5

One- and Two-Year County Mental Health Care Service Use Outcomes for RICMS Clients, Community Enrollment

Outcome (%)	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had inpatient or outpatient mental health treatment	33.0	28.3	5.0 ***	<0.001
Ever had outpatient mental health treatment	32.9	28.1	5.1 ***	<0.001
Ever had inpatient mental health treatment	4.1	5.0	-0.6	0.181
Sample size	3,469	3,469		
Two-year outcomes				
Ever had inpatient or outpatient mental health treatment	37.8	35.5	3.2 ***	0.008
Ever had outpatient mental health treatment	37.6	35.3	3.2 ***	0.007
Ever had inpatient mental health treatment	6.0	7.5	-1.2 *	0.094
Sample size	2,168	2,115		

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Community enrollment indicates that people shown in this table enrolled in RICMS while living in the community. That is, they did not enroll while in jail or while being released from jail.

Table 6

One- and Two-Year County Physical Health Care Service Use Outcomes for RICMS Clients, Community Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Number of primary care visits	0.5	0.4	0.1 **	0.023
Ever had a primary care visit (%)	12.7	11.2	1.6 **	0.030
Number of ER visits	0.3	0.4	0.0	0.225
Ever had an ER visit (%)	11.7	15.1	-2.9 ***	<0.001
Number of inpatient hospital admissions	0.0	0.1	0.0 *	0.081
Ever had an inpatient hospital admission (%)	2.6	3.7	-1.0 **	0.016
Sample size	3,469	3,469		
Two-year outcomes				
Number of primary care visits	1.0	0.7	0.3 ***	0.001
Ever had a primary care visit (%)	17.0	15.3	1.9 *	0.083
Number of ER visits	0.5	0.6	-0.1	0.135
Ever had an ER visit (%)	18.4	22.6	-4.0 ***	<0.001
Number of inpatient hospital admissions	0.1	0.1	0.0	0.129
Ever had an inpatient hospital admission (%)	4.8	6.8	-1.8 **	0.011
Sample size	2,168	2,115		

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Community enrollment indicates that people shown in this table enrolled in RICMS while living in the community. That is, they did not enroll while in jail or while being released from jail.

Table 7

One- and Two-Year Criminal Legal System Contact Outcomes for RICMS Clients, Community Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Average number of days incarcerated in jail	12.4	20.8	-7.8 ***	<0.001
No jail incarceration (%)	72.4	66.7	5.6 ***	<0.001
No arrests (%)	71.8	65.8	5.7 ***	<0.001
Convictions (%)				
No new felony convictions	93.1	91.8	1.1 *	0.076
No new misdemeanor convictions	94.0	91.2	2.9 ***	<0.001
No new felony or misdemeanor convictions	88.2	85.3	2.8 ***	<0.001
On probation (%)	19.8	19.5	0.0	0.976
Among those on probation supervision:				
Probation revoked (%)	8.7	15.8	-7.1 ***	<0.001
Probation terminated (%)	1.1	1.3	-0.1	0.667
Probation extended (%)	0.5	0.6	-0.1	0.650
Sample size	3,469	3,469		
Two-year outcomes				
Average number of days incarcerated in jail	23.0	37.3	-12.5 ***	<0.001
No jail incarceration (%)	63.7	57.3	6.1 ***	<0.001
No arrests (%)	62.9	56.7	5.8 ***	<0.001
Convictions (%)				
No new felony convictions	90.1	88.1	1.5	0.103
No new misdemeanor convictions	90.6	86.3	3.9 ***	<0.001
No new felony or misdemeanor convictions	83.1	78.8	3.6 ***	0.001
On probation (%)	16.1	17.9	-1.5	0.116
Among those on probation supervision:				
Probation revoked (%)	11.2	19.3	-7.7 ***	<0.001
Probation terminated (%)	1.4	2.3	-0.8 **	0.042
Probation extended (%)	0.8	1.0	-0.2	0.573

(continued)

Table 7 (continued)

Sample size	2,168	2,115

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Community enrollment indicates that people shown in this table enrolled in RICMS while living in the community. That is, they did not enroll while in jail or while being released from jail.

Table A.1

Profiles of Programs in the RICMS Study

Organization Name	Other Services Provided	Service Provision Area	Participated in Staff Survey	Staff Participated in Interviews	Participants Interviewed	Additional Context
Ascent	Housing	8	✓▪	✓▪	✓▪	Focuses on young adults ages 18-24.
Amity Foundation	Housing, Substance Use Disorder Treatment, Family Reunification	4, 6	✓▪	✓▪	✓▪	Referrals come from jail, community, and CDCR.
Asian Youth Center	Food Distribution	3	✓▪			Also provides youth and family services for at risk youth on probation.
Catalyst Foundation	Countywide Benefits Entitlement Services	1	✓▪	✓▪	✓▪	Focuses on youth on probation and their families. Referrals come from jail, community, and CDCR.
Center for Employment Opportunities	Employment Services	4				Did not accept referrals from LA County Jail. RICMS contract expired June 30, 2022.
Center for Living and Learning	Employment Services	2	✓▪	✓▪	✓▪	Focus on job readiness for disadvantaged adults and youth.
ChapCare	Federally Qualified Health Center	3	✓▪			Assigns patients to a physician in ChapCare's network, where they work closely with a team to receive comprehensive care, regardless of ability to pay

(continued)

Table A.1 (continued)

Christ Centered Ministries	Housing	6	✓▪	✓▪		Provides transitional community based recovery housing for formerly incarcerated individuals and those experiencing homelessness. Contracted to provide interim housing for RICMS clients.
Communities in Schools	Tattoo Removal, Gang Intervention, Employment Services, Education	2	✓▪			
East Valley Community Health Center	Federally Qualified Health Center	3	✓▪	✓▪	✓▪	Has CalAim contract.
Exodus Recovery	Substance Use Disorder Treatment, Mental Health, Homeless Outreach, Housing	4, 8	✓▪	✓▪		One of the larger RICMS programs. Has CalAim contract.
Francisco Homes	Reentry Support, Housing					Provided reentry support and housing only for men on parole from long-term incarceration, mostly life sentences. Did not take jail referrals. RICMS contract expired June 30, 2022.
Flintridge Center	Employment Services	3	✓▪			Prepares formerly incarcerated and gang-impacted individuals for careers in union construction trades through apprenticeship preparation progam.
Heluna Health	Linkages Health Services	3	✓▪			Provides support for various health needs, such as chronic disease and aging, communicable diseases, and mental health and addiction.
Homeless Health Care Los Angeles	Housing, Substance Use Disorder Treatment, Mental Health	4	✓▪	✓▪	✓▪	One of RICMS' newer programs. Started in 2019.

(continued)

Table A.1 (continued)

Homeboy Industries	Gang Prevention and Intervention, Mental Health, Employment Services	4	✓▪			Provides training and support to formerly gang-involved and previously incarcerated people.
Paving the Way	Housing, Substance Use Treatment, Veterans Affairs, Housing, Domestic Violence	1	✓▪			Also provides low-income assistance, as well as housing for veterans and the AB 109 population.
Southern California Health & Rehabilitation Program	Mental Health, Rehabilitation	6, 7	✓▪	✓▪	✓▪	Referrals come from jail, community, and probation. There are also interdepartmental AB 109 referrals.
Shields for Families	Employment Services, Housing, Court Mandated Domestic Violence and Anger Management Classes	6	✓▪			Emphasizes culturally sensitive services models. Has staff with lived experience in substance use disorder, gang-involvement, and incarceration.
Homeless Outreach Program Integrated Care System	Housing, Mental Health, Employment Services, Legal	6	✓▪			Largest housing and homeless service angency in SPA 6.
St. John's Well Child	Transgender Services, Physical Health, Mental Health, Employment Services, Legal	4, 6	✓▪	✓▪	✓▪	Has CalAim contract.
St. Joseph's Center	Housing, Mental Health, Substance Use Disorder Treatment, Food Distribution	5	✓▪	✓▪	✓▪	Emphasizes street outreach to those experiencing homelessness.

(continued)

Table A.1 (continued)

Tarzana Treatment Center	Mental Health, Substance Use Disorder Treatment, Domestic Violence and Anger Management Classes, Parenting Classes, Court Services	2, 8	✓▪			Community based organization that operates a psychiatric hospital, residential and outpatient alcohol and drug treatment centers, and family medical clinics.
Turning Point Alcohol & Drug Education Program	Substance Use Disorder Classes	7	✓▪			Temorary and permanent housing support, mental health srvices, and drug and alcohol education.
Via Care	Federally Qualified Health Center	7				Emphasizes delivering health care services in a culturally and lingusitically competent manner.
Volunteers of America	Employment Services, Substance Use Disorder Treatment	3, 7	✓▪	✓▪		Has CalAim contract.
Watts Labor Community Action Committee	Domestic Violence and Anger Management Classes, Employment Services, Family Source Center, Food Distribution	6	✓▪	✓▪	✓▪	Has referral system with probation. Does not take jail referrals.

SOURCE: Reentry Division records, interviews with program staff, and study team records.

NOTES: CalAim (California Advancing and Innovating Medi-Cal) is California's effort to reform its Medicaid program.
Some RICMS programs were awarded Enhanced Care Management contracts to provide clinical and non-clinical supports to it's highest need enrollees.

Table A.2

Characteristics of RICMS Non-Participants and Participants, Jail Enrollment

Variable	Participants	Non-Participants
Demographics		
Age (mean)	39.8	40.1
Gender (%)		
Male	63.9	66.4
Female	34.1	32.7
Trans male	0.5	0.0
Trans female	1.0	1.0
Genderqueer	0.5	0.0
Ethnicity (%)		
Hispanic	52.4	50.5
Non-Hispanic	47.6	49.5
Race (%)		
Black	29.3	27.9
Multiracial	4.8	6.3
White	38.0	35.1
Hispanic	24.0	24.0
Asian	2.9	6.3
Native American	[a]	[a]
Pacific Islander	0.0	0.0
Enrolled during COVID-19 (%)	49.0	51.9
Contact with the criminal legal system		
Ever convicted of a misdemeanor (%)		
Within two years prior to enrollment	53.9	56.7
Between two and seven years priors to enrollment	51.0	52.4
Ever convicted of a felony (%)		
Within two years prior to enrollment	63.9	69.7
Between two and seven years priors to enrollment	38.9	36.1
Average days between most recent conviction and enrollment[b]	257	243
Average days incarcerated		
Within two years prior to enrollment	174	178
Between two years and eight years priors to enrollment	152	143

(continued)

Table A.2 (continued)

Ever arrested (%)		
Within two years prior to enrollment	99.5	99.5
Between two and eight years priors to enrollment	77.4	78.9
On probation at time of enrollment (%)	33.7	33.2
In jail at time of enrollment (%)	100.0	100.0
Medical care		
Physical health		
Number of primary care visits within two years prior to enrollment	0.6	0.5
Number of emergency services within two years prior to enrollment	0.7	0.7
Number of hospital admissions within two years prior to enrollment	0.1	0.1
Mental health (%)		
Ever had inpatient mental health admission within prior three years	12.5	10.1
Ever had outpatient mental health service within prior three years	43.8	41.8
Ever had substance use prior in mental health data within prior three years	34.6	32.7
Sample size	208	208

SOURCE: Calculations based on data from CHAMP management information system and InfoHub.

NOTES: Jail enrollment indicates that people shown in this table enrolled in RICMS while in jail or while being released from jail.

[a]Values not shown due to small cell size.

[b]Conviction data were available for the seven year period prior to client enrollment.

Table A.3

Characteristics of RICMS Non-Participants and Participants, Community Enrollment

Variable	Participants	Non-Participants
Demographics		
Age (mean)	40.8	40.9
Gender (%)		
Male	73.4	74.2
Female	25.2	24.5
Trans male	0.2	0.2
Trans female	1.1	1.0
Genderqueer	0.1	0.1
Ethnicity (%)		
Hispanic	43.2	56.9
Non-Hispanic	56.8	43.1
Race (%)		
Black	40.0	39.5
Multiracial	3.9	4.1
White	28.1	29.4
Hispanic	25.2	24.5
Asian	1.3	1.0
Native American	1.2	1.1
Pacific Islander	0.6	0.6
Enrolled during COVID-19 (%)	39.5	40.9
Contact with the criminal legal system		
Ever convicted of a misdemeanor (%)		
Within two years prior to enrollment	33.6	32.8
Between two and seven years priors to enrollment	36.8	36.9
Ever convicted of a felony (%)		
Within two years prior to enrollment	36.5	36.6
Between two and seven years priors to enrollment	31.3	31.2
Average days between most recent conviction and enrollment[a]	321	311
Average days incarcerated		
Within two years prior to enrollment	72	80
Between two years and eight years priors to enrollment	113	117

(continued)

Table A.3 (continued)

Ever arrested (%)		
Within two years prior to enrollment	62.8	63.1
Between two and eight years priors to enrollment	60.9	59.5
On probation at time of enrollment (%)	28.9	28.3
In jail at time of enrollment (%)	0.0	0.0
Medical care		
Physical health		
Number of primary care visits within two years prior to enrollment	0.6	0.6
Number of emergency services within two years prior to enrollment	0.5	0.7
Number of hospital admissions within two years prior to enrollment	0.1	0.1
Mental health (%)		
Ever had inpatient mental health admission within prior three years	8.5	8.9
Ever had outpatient mental health service within prior three years	35.8	36.0
Ever had substance use prior in mental health data within prior three years	21.2	21.9
Sample size	3,488	3,488

SOURCE: Calculations based on data from CHAMP management information system and InfoHub.

NOTES: Community enrollment indicates that people shown in this table enrolled in RICMS while living in the community. That is, they did not enroll while in jail or while being released from jail.

[a]Conviction data were available for the seven year period prior to client enrollment.

Table B.1

RICMS Staff Background and Lived Experiences

Category	Staff Type: Case Carrying	Staff Type: Non-Case Carrying	All
Demographics			
Ethnicity (%)			
Hispanic	54.7	68.2	58.1
Race (%)			
Black	47.7	28.6	41.5
Multiracial	4.5	9.5	6.2
White	31.8	28.6	30.8
Asian	4.5	0.0	3.1
Native American	0.0	0.0	0.0
Pacific Islander	0.0	0.0	0.0
Other	11.4	33.3	18.5
Gender (%)			
Male	36.2	18.2	31.9
Female	63.8	81.8	68.1
Age (mean)	39.6	44.7	41
Lived experiences (%)			
Family or someone close has experienced[a]			
Homelessness or housing instability	61.1	73.9	64.2
Incarceration	70.8	87.0	74.7
Other justice system involvement	62.5	78.3	66.3
Extended unemployment	59.7	73.9	63.2
Ongoing physical or mental health issue	61.1	65.2	62.1
Staff members who have personally experienced[a]			
Homelessness or housing instability	45.6	54.5	47.8
Incarceration	51.5	45.5	50.0
Other justice system involvement	44.1	36.4	42.2
Extended unemployment	41.2	40.9	41.1
Ongoing physical or mental health issue	30.9	22.7	28.9
Prior experience providing case management	65.7	73.9	67.8

(continued)

Table B.1 (continued)

Training/certificates received related to position[a]			
Certification[b]	32.3	26.1	30.7
Associate's degree (e.g., A.A., A.S., A.A.S.)	18.5	13.0	17.0
Bachelor's degree (e.g., BA, BS)	26.2	43.5	30.7
Graduate degree (e.g., MA, MFT, MSW, PsyD)	7.7	21.7	11.4
Sample size[c]	77	23	100

SOURCE: MDRC calculations from staff survey.

NOTES: [a]"None of the above" was not an option to this question. Therefore, in instances were no options were indicated for this question, it is not possible to determine whether the survey respondent intended to indicate that no options applied to them, or whether they skipped this question. Respondents who did not indicate any options are counted in the denomintar. Therefore, percentages shown for this quesiton should be seen as minimum or floor. Repsondents who indicated "Decline to answer" were not included in the denominator.

[b]For example, Alcohol/Drug Counseling Certificate, Clinical Mental Health Counseling, Recovery Support Specialists Certificate.

[c]The sample size shows the total number of respondents to the survey, though not every respondent answered each question shown on this table. The percentages reported are among the total number of respondents to the individual question.

Table B.2

RICMS Staff Roles

All Respondents	N	Percentage
Staff type		
Community health worker	70	70.0
Program manager	19	19.0
Other	11	11.0
When started working at organization		
Pre-March 2020	55	56.1
March 2020 or after	43	43.9
Caseload carrying?		
Yes	77	77
Sample size[a]	100	

SOURCE: MDRC calculations from staff survey.

Table B.3

Responsibilities of Caseload Carrying RICMS Staff

Responsibilities	Percentage	Median
Caseload types		
Staff has clients who are:		
Not yet released	50.6	--
Already released	98.7	--
Never been incarcerated	16.9	--
Responsibilities in a typical week		
Clients assigned to caseload[a]	--	30
In-person caseload	98.7	5
Virtual caseload	98.7	10
Text/email caseload	93.5	10
Hours worked in a typical week		
Total hours worked	--	40
Hours worked on RICMS	--	35
Recruiting potential clients from a local agency or in the community	--	3
Working with new RICMS clients to complete the intake and enrollment process	--	4
Providing case management support to RICMS clients[b]	--	10
Entering data into CHAMP	--	8
Managing or supervising other RICMS staff and/or overseeing performance of the program	--	0
Participation in RICMS-related training or professional development[c]	--	3
Working on other activities for RICMS that are not mentioned above	--	2
Sample size	77	

SOURCE: MDRC calculations from staff survey.

NOTES: [a]Some staff reported not being able to recall their caseload types. These responses of "do not recall" were included in the denominator of the percetange calculation. Therefore, percentages shown for this quesiton should be seen as minimum or floor.

[b]For example, helping clients individually, connecting to services and making referrals.

[c]Either receiving or delivering training.

Table B.4

Client Support Activities as Reported by Caseload Carrying Staff

Response	N	Percentage
Frequency of updating comprehensive screen assessment and/or other assessments of enrolled clients		
Frequently	25	35.2
Occasionally	37	52.1
Infrequently	7	9.9
Never	1	1.4
Don't recall	1	1.4
Frequency of development or updating the service plan of enrolled clients		
Frequently	55	76.4
Occasionally	16	22.2
Infrequently	0	0.0
Never	1	1.4
Frequency of assisting enrolled clients with obtaining and navigating housing		
Frequently	42	58.3
Occasionally	26	36.1
Infrequently	3	4.2
Never	1	1.4
Frequency of assisting enrolled clients with benefits enrollment		
Frequently	42	58.3
Occasionally	24	33.3
Infrequently	5	6.9
Never	1	1.4
Frequency of assisting enrolled clients with obtaining employment or educational opportunities		
Frequently	46	63.9
Occasionally	22	30.6
Infrequently	3	4.2
Never	1	1.4
Frequency of assisting enrolled clients with obtaining medical or behavioral health treatment		
Frequently	41	56.9
Occasionally	28	38.9
Infrequently	2	2.8
Never	1	1.4

(continued)

Table B.4 (continued)

Frequency of assisting enrolled clients with navigating court or supervision requirements		
Frequently	28	39.4
Occasionally	27	38.0
Infrequently	12	16.9
Never	4	5.6
Frequency of providing crisis intervention support to enrolled clients		
Frequently	25	34.7
Occasionally	30	41.7
Infrequently	17	23.6
Never	0	0.0
Sample size[a]	77	

SOURCE: MDRC calculations from staff survey.

NOTE: [a]The sample size shows the total number of case carrying staff, though not every respondent answered each question shown on this table. The percentages reported are among the total number of respondents to the individual questions.

Table B.5

Client Referrals to Services as Reported by Caseload Carrying Staff

Service Type	N	Percentage
Children's service agencies (including welfare agencies, schools, day care providers, pediatric health care providers)	31	43.1
Provided by staff member's organization	3	10.3
Provided by outside organization	26	89.7
Physical health services	62	86.1
Provided by staff member's organization	13	22.0
Provided by outside organization	46	78.0
Substance use disorder treatment	68	94.4
Provided by staff member's organization	18	28.1
Provided by outside organization	46	71.9
Mental health treatment	68	94.4
Provided by staff member's organization	25	39.1
Provided by outside organization	39	60.9
Employment services	70	97.2
Provided by staff member's organization	27	40.3
Provided by outside organization	40	59.7
Education support services	57	79.2
Provided by staff member's organization	17	31.5
Provided by outside organization	37	68.5
Housing services	69	95.8
Provided by staff member's organization	20	30.3
Provided by outside organization	46	69.7
Sample size[a]	72	

SOURCE: MDRC calculations from staff survey.

NOTES: This was presented as a multiple choice question in the staff survey.
[a]The sample size reported is caseload carrying staff who responded to the multiple choice question.

Table B.6

Agencies Coordinated with in the Past Month to Support RICMS Clients as Reported by Caseload Carrying Staff

Agency	N	Percentage
Department of Mental Health	56	78.9
Department of Public Social Services	61	85.9
Department of Public Health	32	45.1
Other offices in the Department of Health Services (Housing for Health, etc.)	42	59.2
Los Angeles Housing + Community Investment Department	24	33.8
Workforce Development Agency (WDACS or other)	30	42.3
Nonprofit service provider or other community-based organization	53	74.6
Sheriff's Department / Jail Staff	27	38.0
Community supervision (Probation or Parole)	52	73.2
Office of Diversion and Reentry	38	53.5
Other	3	4.2
Sample size[a]	71	

SOURCE: MDRC calculations from staff survey.

NOTES: This was presented as a multiple choice question in the staff survey.
[a]The sample size reported is caseload carrying staff who responded to the multiple choice question.

Table B.7

Benefits Enrollment Support for RICMS Clients as Reported by Caseload Carrying Staff

Benefit	N	Percentage
CalWORKS (California Work Opportunity and Responsibility to Kids)	50	70.4
Foster care	1	1.4
Medi-Cal	68	95.8
Supplemental Security Income (SSI)	56	78.9
Social Security Disability Income (SSDI)	53	74.6
CAPI (State Cash Assistance Program for Immigrants)	14	19.7
CalFresh (Food stamps)	68	95.8
In-Home Supportive Services (IHSS)	16	22.5
General relief	67	94.4
Other	1	1.4
Sample size[a]	71	

SOURCE: MDRC calculations from staff survey.

NOTES: This was presented as a multiple choice question in the staff survey.
[a]The sample size reported is caselaod carrying staff who responded to the multiple choice question.

Table C.1

One- and Two-Year County Substance Use Disorder Service Use Outcomes for RICMS Clients, Jail Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had SUD admission[a] (%)	12.0	10.6	1.1	0.728
Number of SUD admissions	0.2	0.1	0.1	0.174
Ever had SUD outpatient treatment (%)	8.7	6.3	1.9	0.465
Number of SUD outpatient treatments	0.1	0.1	0.0	0.344
Sample size	208	208		
Two-year outcomes				
Ever had SUD admission (%)	15.9	15.4	2.1	0.682
Number of SUD admissions	0.3	0.2	0.1	0.203
Ever had SUD outpatient treatment (%)	9.7	5.8	5.9	0.127
Number of SUD outpatient treatments	0.1	0.1	0.1	0.318
Sample size	113	104		

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Jail enrollment indicates that people shown in this table enrolled in RICMS while in jail or while being released from jail.

[a]SUD = Substance use disorder.

Table C.2

One- and Two-Year County Mental Health Care Service Use Outcomes for RICMS Clients, Jail Enrollment

Outcome (%)	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had inpatient or outpatient mental health treatment	40.9	28.9	9.6 **	0.014
Ever had outpatient mental health treatment	40.9	28.9	9.6 **	0.014
Ever had inpatient mental health treatment	8.7	6.7	0.7	0.777
Sample size	208	208		
Two-year outcomes				
Ever had inpatient or outpatient mental health treatment	42.5	39.4	4.9	0.414
Ever had outpatient mental health treatment	42.5	39.4	4.9	0.414
Ever had inpatient mental health treatment	8.9	11.5	-2.0	0.607
Sample size	113	104		

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Jail enrollment indicates that people shown in this table enrolled in RICMS while in jail or while being released from jail.

Table C.3

One- and Two-Year County Physical Health Care Service Use Outcomes for RICMS Clients, Jail Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Number of primary care visits	0.4	0.2	0.2	0.192
Ever had a primary care visit (%)	10.6	10.1	0.7	0.810
Number of ER visits	0.4	0.3	0.1	0.602
Ever had an ER visit (%)	17.3	18.8	-2.1	0.576
Number of inpatient hospital admissions	0.1	0.1	0.0	0.985
Ever had an inpatient hospital admission (%)	4.3	5.3	-0.9	0.675
Sample size	208	208		
Two-year outcomes				
Number of primary care visits	0.5	0.5	0.0	0.911
Ever had a primary care visit (%)	15.9	19.2	-1.5	0.773
Number of ER visits	0.3	0.6	-0.3	0.100
Ever had an ER visit (%)	19.5	29.8	-8.6	0.148
Number of inpatient hospital admissions	0.1	0.1	0.0	0.856
Ever had an inpatient hospital admission (%)	6.2	6.7	0.2	0.962
Sample size	113	104		

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Jail enrollment indicates that people shown in this table enrolled in RICMS while in jail or while being released from jail.

Table C.4

One- and Two-Year Criminal Legal System Contact Outcomes for RICMS Clients, Jail Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Average number of days incarcerated in jail	22.3	32.1	-9.2 *	0.0958
No jail incarceration (%)	55.3	42.3	14.4 ***	0.0027
No arrests (%)	54.8	41.8	14.5 ***	0.0026
Convictions (%)				
No felony convictions	89.9	85.1	4.7	0.1498
No misdemeanor convictions	91.8	80.8	11.0 ***	<0.001
No felony or misdemeanor convictions	81.7	72.1	9.8 **	0.0179
On probation (%)	28.4	26.4	2.5	0.4959
Among those on probation supervision:				
Probation revoked (%)	19.2	25.5	-6.5 *	0.083
Probation terminated (%)	1.4	1.9	-1.1	0.355
Probation extended (%)	1.4	0.0	1.6 *	0.071
Sample size	208	208		
Two-year outcomes				
Average number of days incarcerated in jail	36.0	68.3	-31.6 **	0.028
No jail incarceration (%)	47.8	29.8	17.4 ***	0.009
No arrests (%)	46.9	29.8	16.4 **	0.014
Convictions (%)				
No felony convictions	84.1	80.8	5.0	0.355
No misdemeanor convictions	91.2	67.3	20.2 ***	<0.001
No felony or misdemeanor convictions	76.1	58.7	15.8 **	0.012
On probation (%)	20.4	23.1	2.9	0.566
Among those on probation supervision:				
Probation revoked (%)	16.8	32.7	-11.3 **	0.034
Probation terminated (%)	3.5	0.0	1.9	0.246
Probation extended (%)	2.7	1.0	2.2	0.271

(continued)

Table C.4 (continued)

Sample size	113	104

SOURCE: MDRC calculations from InfoHub.

NOTES: Means are presented unadjusted for ease of comparison to outcomes for the full unrestricted sample (see Appendix C).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

Jail enrollment indicates that people shown in this table enrolled in RICMS while in jail or while being released from jail.

Table C.5

One- and Two-Year County Substance Use Disorder Treatment Service Use Outcomes for RICMS Clients

	Participants		Non-Participants	
Outcome	One Year	Two Year	One Year	Two Year
At least one outpatient service or inpatient admission (%)	13.7	16.5	15.2	19.3
Outpatient service use				
At least one outpatient service (%)	9.4	11.6	9.6	12.4
Average number of outpatient services	0.1	0.2	0.1	0.2
Inpatient service use				
At least one inpatient admission (%)	6.9	9.0	8.7	11.7
Average number of inpatient admissions	0.1	0.2	0.1	0.2
Among those admitted, more than one admission (%)	34.2	43.8	27.1	35.6
Among first admissions, discharges (%)	87.6	92.5	89.8	94.4
Positive treatment compliance	53.6	57.1	52.3	53.7
Negative treatment compliance	30.7	25.9	29.5	27.1
Sample size	4,300	2,675	10,748	6,461

SOURCE: MDRC calculations from CHAMP.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

Table C.6

One- and Two-Year County Mental Health Treatment Service Use Outcomes for RICMS Clients

	Participants		Non-Participants	
Outcome (%)	One Year	Two Year	One Year	Two Year
Ever had inpatient or outpatient mental health treatment	31.9	36.6	31.3	38.6
Ever had outpatient mental health treatment	31.8	36.3	30.9	38.3
Ever had inpatient mental health treatment	4.0	5.8	7.0	10.3
Sample size	4,300	2,675	10,748	6,461

SOURCE: MDRC calculations from CHAMP and InfoHub.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

Table C.7

One- and Two-Year County Physical Health Care Service Use Outcomes for RICMS Clients

	Participants		Non-Participants	
Outcome	One Year	Two Year	One Year	Two Year
Ever attended primary care visit (%)	12.7	17.0	11.3	15.9
Mean number of primary care visits	0.5	1.0	0.4	0.7
Ever admitted to ER (%)	11.7	18.1	17.7	26.0
Mean number of ER visits	0.3	0.5	0.4	0.8
Ever admitted to inpatient hospital (%)	2.5	4.7	4.5	8.2
Mean number of inpatient hospital admittances	0.0	0.1	0.1	0.1
Sample size	4,300	2,675	10,748	6,461

SOURCE: MDRC calculations from CHAMP and InfoHub.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

Table C.8

One- and Two-Year Criminal Legal System Contact Outcomes for RICMS Clients

	Participants		Non-Participants	
Outcome (%)	One Year	Two Year	One Year	Two Year
Convictions				
No felony convictions	93.7	90.7	87.5	81.9
No misdemeanor convictions	94.5	91.4	87.3	80.5
No felony or misdemeanor convitctions	89.0	84.1	78.1	69.3
No arrests	73.3	64.7	51.3	40.4
Among those on probation supervision:				
Probation revoked	8.1	10.1	21.9	25.5
Probation terminated	1.1	1.4	2.1	3.3
Probation extended	0.5	0.8	0.6	1.3
Sample size	4,300	2,675	10,748	6,461

SOURCE: MDRC calculations from CHAMP.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

Table E.1

Characteristics of RICMS Enrollees and Participants in the Interim Housing Program

Outcome	N	Percentage
Gender		
Male	56	100
Race		
Black	27	48.2
Hispanic	14	25.0
White	9	16.1
Asian	1	1.8
Pacific Islander	0	0.0
Native American	1	1.8
Multiracial	4	7.1
Ethnicity		
Hispanic	22	39.3
Age		
18-24 years	5	8.9
25-34 years	21	37.5
35-44 years	12	21.4
45 or more years	18	32.1
Service planning area		
1. Antelope Valley	0	0.0
2. San Fernando Valley	1	1.8
3. San Gabriel Valley	2	3.6
4. Metro	8	14.3
5. West	2	3.6
6. South	30	53.6
7. East	3	5.4
8. South Bay	8	14.3
Sample size	56	

SOURCE: MDRC calculations from CHAMP.

NOTES: One person is missing ethnicity data. Two people are missing service planning area data.

Table E.2

One- and Two-Year Criminal Legal System Contact Outcomes for RICMS Clients in the Interim Housing Program

Outcome (%)	One Year	Two Year
Convictions		
No new felony convictions	98.2	93.9
No new misdemeanor convictions	89.3	84.8
No new felony or misdemeanor convictions	87.5	78.8
Arrests		
No new felony arrests	71.4	60.6
No new misdemeanor arrests	73.2	57.6
No new felony or misdemeanor arrests	58.9	45.4
Among those on probation supervision:		
Probation revoked	5.4	6.1
Probation terminated	0.0	0.0
Probation extended	0.0	0.0
Sample size	56	33

SOURCE: MDRC calculations from CHAMP.

Figure 1

Reentry Intensive Case Management Services (RICMS) Logic Model

INPUTS

Coordinated agencies:
- Reentry Division
- Correctional Health Services
- Community-based providers
- Sheriff's Department
- Probation
- Parole

Program staff:
- Community Health Workers
- Correctional Health Services
- Medical case workers

Eligible participants:
- Adult felony probationers (SB 678)
- Individuals with mild to moderate substance use or mental health disorders who also have involvement in the criminal legal system (Proposition 47)

Evaluation enhanced resources
- Training to RICMS staff on using risk need-responsivity principles to drive service referrals and case management

ACTIVITIES IMPLEMENTED

System level coordination
- Reentry Division service agreements
- Reentry Division quality assurance
- Provider implementation based on standard operating procedures

Recruitment and screening
- Triage community referrals
- Triage in-jail referrals

Intake and assessment
- Use of validated assessment tool
- Case plan based on risks and needs
- Documentation in administrative management information system data

Client engagement
- Regular outreach by staff
- Warm hand offs and referrals to services
- Support to get to and during appointments
- Social support

Case management
- Case plans regularly updated
- Case conferencing with partner staff
- Coordinate pre- and post-release

OUTPUTS

System optimization
- Improved access to services for clients
- Number and types of trainings for providers
- Provider adherence to protocol

Enrollment
- Number of successful enrollments

Service receipt
- Number of referrals for services
- Social support provided
- Benefits enrollment

Service quality
- Alignment of service receipt with identified needs
- Client-staff relationship
- Client satisfaction

OUTCOMES

Outcomes at 12 months
- Improved health and wellbeing
- Reduced arrests
- Reduced convictions
- Reduced incarceration admissions
- Reduced incarceration days

Figure 2
Los Angeles County Reentry Services System Flow

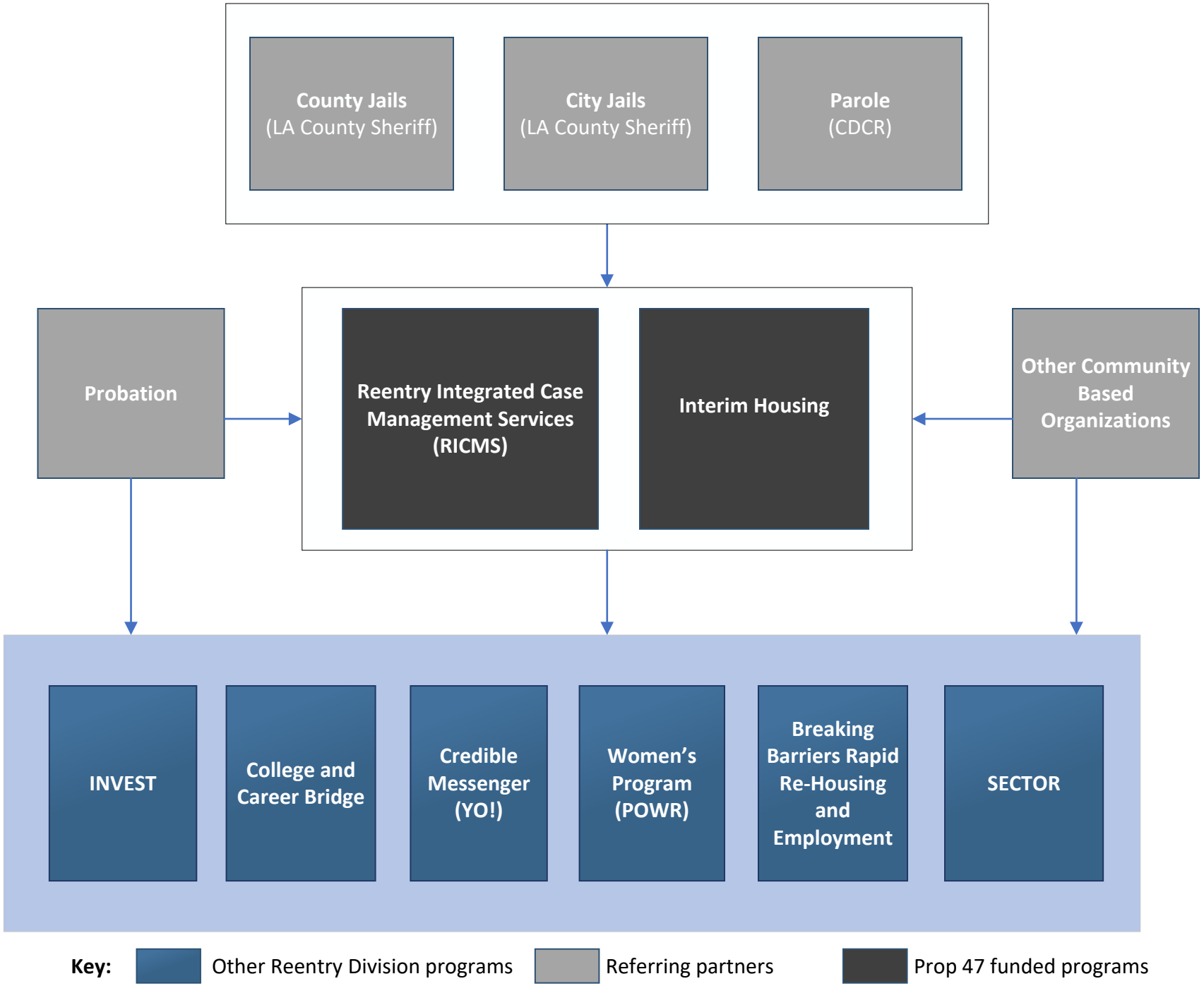
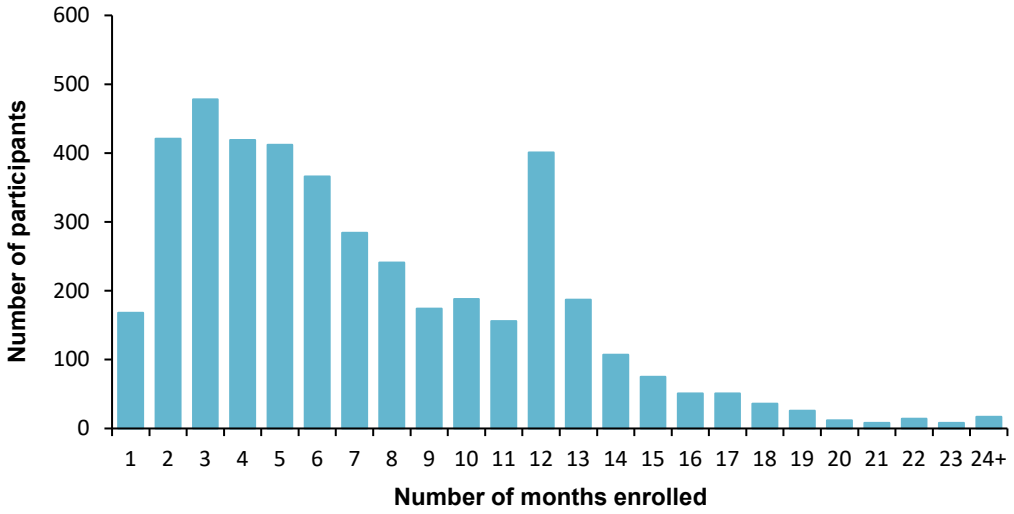


Figure 3

Number of Months Enrolled in RICMS Among Participants



SOURCE: MDRC calculations from CHAMP.

NOTE: Participants in RICMS had to be enrolled in the program for at least one month.

Figure A.1

Distribution of Propensity Scores,
Jail Enrollment Group

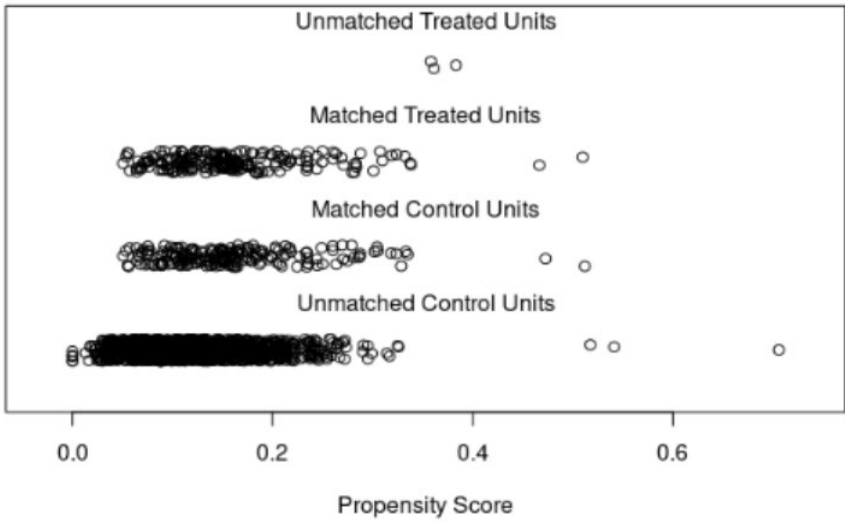


Figure A.2

Distribution of Propensity Scores, Community Enrollment Group

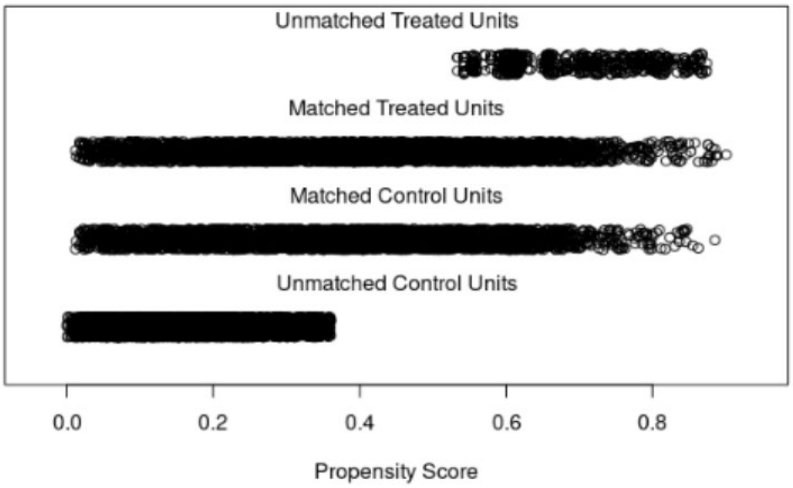
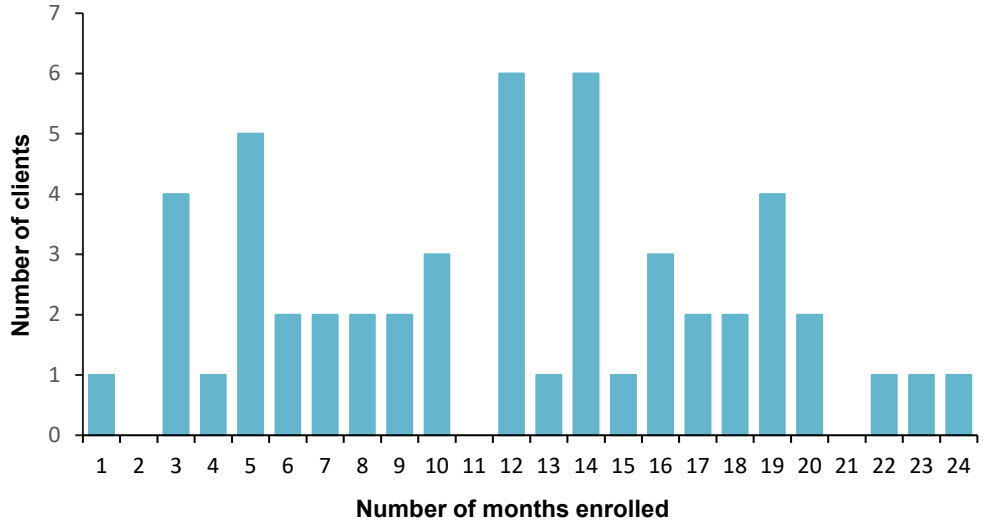


Figure E.1

Number of Months Enrolled in RICMS
Among Clients in the Interim Housing Program



SOURCE: MDRC calculations from CHAMP.

NOTE: Participants in RICMS had to be enrolled in the program for at least one month.

Box 1

In Their Own Voice: Three RICMS Clients Describe Their Life Experiences

In Recovery from Substance Use Treatment

Histories of substance use and treatment for substance use disorders (SUD) were a theme across interviews with RICMS participants. This client had a long history of addiction, relapse, and recovery, which at times, overlapped their experiences with incarceration and parole. Prior to being interview, this client had been living with a partner for 7 years and was addicted to crack cocaine, alcohol, methamphetamine, and heroin.

> "[After] many years of using alcohol and drugs, I was just tired of it. And this last time around, being addicted to crack cocaine was horrible…I was hallucinating a lot, and I was hearing voices. I was going crazy. I wasn't happy."

The client checked himself into rehab multiple times in the past after relapses happened. At the time of the interview, client was in recovery and on probation following their release.

Navigating Employment with Weak Social Ties

The ability to tap into personal social networks for help with accessing crucial resources like housing, employment, or emotional support can make all the difference when navigating reentry. For some RICMS clients, however, such networks or social ties were not available, or in some cases, never were. This client described never having a strong support system growing up:

> "I grew up without [a] family, you know what I'm saying? My dad is the same...I never had nobody care for me and I never asked for help from nobody."

Unlike other RICMS clients who were able leverage their social networks to find a place to stay or a job shortly after their release, another client had no such network to call upon, which is why he felt the help provided by his CHW was so crucial. For this client, the relationship that developed between him and his CHW represented a social bond that felt more familial than the ones he had with his family growing up:

> "Everybody in here, they're like… it's like a family I never had. [They've] done more than my family, you know? It's something I'm never going to forget."

Through working with a CHW, this client was able to access medical and employment services that ultimately lead him to getting a much-needed eyeglasses prescription and eventually to finding stable employment as a forklift operator.

Medical Needs Related to Physical Health

This RICMS client, like many, had been incarcerated for many years, in this case, 48 years. After their release, this client faced many challenges related to reentry, ranging from acclimating to new forms of technology and communication, to the mental and physical health needs associated with aging. After release, this client had trouble getting some of the medications he needed such as a monthly injection to help with the absorption of vitamins. Because he didn't have adequate income or access to insurance that would pay for this treatment, he ended up missing two doses over two months.

> "I went almost two months without any B12 injection. You know…at what point do I continue to become damaged, irreparable damage?"

Box 2

Client Persistence While Navigating Reentry

Through interviews with RICMS clients and CHWs, some key strengths and challenges, as well as the existence or lack of supports, were identified that appeared to either facilitate or hinder clients' ability to navigate reentry after incarceration.

Clients described their attitudes and dispositions toward the future and any goals or challenges they are facing or are anticipating facing as they work on their re-entry as positive and optimistic. One client said about navigating re-entry that "it's a battle. It's turmoil. I'm not gonna lie about it. It's very challenging. But you know, through it all, I know something great is in store for me." This sentiment, one of positive future orientation, reflected the perspectives of other clients that were interviewed. Another client acknowledged that the process required perseverance, explaining that "I have my days where I don't want to do anything... [but] I need to do it, nobody's gonna do it for me."

Additionally, many clients felt that a certain degree of persistence and grit was crucial to reaching their goals. For example, one client shared that he "stopped blaming people, you know. I stopped blaming the system… I stopped blaming people for the things that I do. I caused this for myself… I can't blame anybody for things that I did." In all cases where clients talked about their attitudes and dispositions towards their incarceration and reentry, relationships with CHWs appeared to be ones that reinforced their positive future orientations, and ultimately encouraged the grit that clients tapped into to deal with the many challenges they faced.

Box 3

Client Satisfaction with RICMS

Clients interviewed for the RICMS evaluation were asked to share their satisfaction with the CHW working with them and the services they accessed through the program. Nearly all interviewees described positive feelings about their experience with RICMS. Some interviewees described having a strong relationship with their CHWs, describing the emotional support they provide. A common refrain from clients when reflecting on their feelings towards their CHWs was that their CHWs were like family, and for some, family that they never had.

> "She's helped me all the way around, where it's just like, 'Damn, like, she did a lot more for me than my own family did for my child.'"

> "Everybody is kinda open and understanding. It feels like family. For somebody like me, this is one of the only connections I have without having family out here."

> "That's why I told her…you guys have done more than my family, you know….it's something I'm never going to forget."

Clients also described strong appreciation for the CHW's proactive outreach to them, their follow-through in securing services even when the process could feel slow and complicated to navigate, and for the effort they put in. One client described the communication and effort from their CHW:

> "I can be straight up and honest with her because that's the way she helps me, when I'm honest with her, you know? I think her way different. I don't see her like my social worker or my enemy or any way. She's really polite, and she really does help me and hear whenever I have [a problem]…and she checks up on me all the time. Like, if I don't call her for a week, she does call me. And she does check up on me to see like, 'What's going on? Are you okay? Do you need something?' You know? And I appreciate that, because not a lot of people do that, or agencies."

Sometimes clients expressed frustration with the constraints and limitations around services, such as the types of housing available or the hoops they felt they had to jump through to get support. However, they expressed trust that the CHW was working hard to reach the end result. One client described his perspective on the work his CHW was doing to help him meet healthcare needs that were taking time to sort out:

> "I believe everything is happening. It might not be happening as fast as I need it to happen, you know what I mean? But I see it happening. I have no problem with it."

NOTE: Clients that were interviewed for the RICMS implementation study were recruited through the local provider and tended to be actively served by the program at the time of interview. Researchers were not able to solicit feedback from people who had enrolled but were not engaged with RICMS.