MENTALLY ILL OFFENDER CRIME REDUCTION (MIOCR) GRANT

EL DORADO COUNTY GRANT LOCAL EVALUATION REPORT 2018

EL DORADO COUNTY EXECUTIVE SUMMARY

The project was designed to achieve a cost savings by reducing both the frequency and length of stay in custody (by law enforcement) for individuals with a severe mental health diagnosis (frequently having a co-occurring substance use diagnosis) and current criminal justice involvement, and to increase the long term stability of such individuals through early intervention assessments, case management, transitional supportive housing and referral and linkages to supportive services. *A third component - to reduce the number of individuals incarcerated with mental illness as a result of a substance overdose - was abandoned as this component was not evidenced as occurring with any frequency in our incarcerated population.

The project was successful. The 23* individuals who participated in the project (to date) had a collective 1,988 days incarcerated for the year prior to program engagement, 229 days incarcerated while engaged in treatment, and 611 days incarcerated in the year post-treatment, reducing the collective number of days incarcerated in the year post-treatment as compared to pre-program engagement by 69%. With the estimated cost of incarcerating an individual in California at $75,000 per year, or roughly $205 per day, there is an estimated cost savings of $282, 285 for the year post-treatment. *Two participants' incarceration records were unable to be verified and so numbers are based on 21 participants (the remaining two participants engaged in treatment less than one month).

Goals Accomplished

Achieve a Cost Savings by Reducing Both the Frequency and Length of Stay in Law Enforcement Custody

Roughly 22% of the participants (five) left treatment within the first month, and were deemed as having gained little to no benefit from the intervention.

Six individuals remained in treatment 1-3 months, three individuals 3-6 months, five individuals 6-12 months and four individuals for one year or more. If we were to remove the five individuals with one month or less of treatment (two of whose numbers were not included in the original findings due to inability to verify), and focus on the individuals who participated from more than a month to over a year, the collective days incarcerated were as follows:

- One year pre-treatment - 1,804 days (cost $369,820);
- During treatment - 189 days (cost $38,745); and
- One year post-treatment - 321 days (cost $65,805).

Reducing collective days of incarceration by 82% in the year post treatment for the 18 individuals who remained in the program for at least one month resulted in estimated cost savings of $304,015 for the year post-treatment.

Increase Long Term Stability of the Participants

Four of the twenty three (16%) participants left treatment due to incarceration. Of the remaining 19 participants, three remain currently engaged, three graduated and seven left the supportive living environment and remain engaged in and/or completed treatment (68%), demonstrating long term stability.

PROJECT OVERVIEW

1. **Did the project work as intended?**
   Yes, the first two targets (to increase cost savings by reducing the frequency and length of stay in custody for mentally ill offenders and to increase the long-term stability of these offenders through treatment engagement, which included supportive housing and linkage to community partners) were successful. Although nearly all of the participants were assessed as having a co-occurring substance use disorder, the third target, to reduce the number of individuals incarcerated with mental illness as a result of a substance overdose, was abandoned after it was not evidenced as occurring with any frequency in our incarcerated population.

2. **What were the project accomplishments?**
   Cost savings (based on the data of reduced days incarcerated during and following treatment engagement), reducing recidivism, and continued engagement in mental health treatment. Approximately one-half (12 of 23) of the participants who engaged in the project either remained in supportive housing until graduated or continued with treatment engagement after exiting the supportive housing.

3. **What goals were accomplished?**
   The project provided supportive residential housing to participants with mental health diagnosis (the majority of whom were assessed as having a co-occurring substance use disorder) and either current or frequent criminal justice involvement. Treatment was targeted at identifying and managing their criminogenic risk factors and symptoms of their mental health diagnosis. The supportive housing had staff on site or available by phone 24 hours a day, 7 days per week. Participants were assigned a clinician and were supported by the Intensive Case Management (ICM) team. Participants were offered individual, group and family therapy. Of the participants who engaged in treatment, more than half were successful in their ability to understand and manage their criminogenic risks and mental health symptoms, and reduce incidents of further incarceration. Several obtained further education and/or were able to obtain and maintain stable employment.

4. **What problems/barriers were faced and how where they addressed?**
   Training needs were identified early as mental health workers and clinicians are traditionally trained to recognize and assist with the management of mental health needs. Education on criminogenic risks and interventions are generally not taught in psychology-based programs or other mental health settings. Newly hired staff with histories of working in the corrections field (former probation or jail staff) would request to carrying weapons (pepper spray) or use physical interventions (restraints), neither of which were allowed in our setting. Instruction on Pro-ACT, which teaches verbal de-escalation techniques, training in traditional Dialectical Behavioral Therapy (DBT) and motivational interviewing skills were given to all staff. Additional training in Forensic DBT and the risk, needs and responsivity model were implemented as it was determined that the emphasis needed to be on criminogenic needs primarily and mental health symptoms secondarily. Substance use continues to be be one of the most difficult issues in treatment and we continue to explore best practices and emerging science in treating this behavior.

5. **Unintended outcomes (positive and/or negative)**
   One unintended outcome was heightened awareness of differing treatment/intervention philosophies and practices between community partners due to the differing opinions on best practice and treatment targets. For example, partners in the Behavioral Health Court (BHC) often believed offending was due to mental health symptoms despite presenting the science that most offending is due to criminogenic needs with little to no evidence indicating mental health as a contributing factor.

   There was inconsistency in the attending judges as well as to what consequences (sanctions) an individual should receive. Behavioral Health representatives would often request/suggest sanctions in BHC for failures with treatment adherence/engagement (missing appointments for reasons which are within their control) and behaviors identified as criminogenic (e.g., throwing objects at cars traveling on the road), and discourage them for issues we would expect in treatment (acknowledging substance use relapses) and request reinforcement for efforts to engage in pro-social behaviors (being honest and cooperating with law enforcement). More often than not, our suggestions were not adhered to and individuals were excused for behaviors they would have been held accountable for if they did not have a mental health disorder (which was often mistaken for the cause of the behavior).

   Another issue was in working with our community partners to adhere to best practices, for example developing a collaboration between intensive speciality Probation and Behavioral Health. We frequently saw and addressed in monthly multi-disciplinary team (MDT) and BHC meetings concerns regarding noncompliance with best practices. While

a specific Probation Officer was assigned to those cases, the Probation Officer often failed to keep scheduled appointments with his caseload. Some of the most high risk clients did not see their Probation Officer more than once per month. Additionally, suggested drug testing regimens were not adhered to, despite court orders. When Probation did drug test the clients, it was not random or intermittent, as is best practice. Efforts to address this at higher levels of Probation were met with promises to address and amend behaviors, which were/and are still not evidenced.

6. **Lessons learned**
   Substance use proved to be one of the most difficult behaviors to treat effectively. Most treatment "failures" were due to repeated substance use, which contributed to inability to remain in supportive housing, subsequent incidents of criminal behaviors and incarceration which interfered with treatment engagement and/or further involvement in treatment. We continue to explore emerging science on evidenced based and/or promising practices as they relate to substance use interventions. This has resulted in ongoing internal discussions on implementing changes we can make to overall substance use treatment provided by the County, as well as our policies for addressing substance use.

PROJECT DESCRIPTION

The project was designed to achieve a cost savings by reducing both the frequency and length of stay in custody for individuals with a severe mental diagnosis (frequently having a co-occurring substance use diagnosis) and current and/or frequent criminal justice involvement and to increase the long term stability of such individuals through early intervention assessments, case management, transitional supportive housing and referral and linkages to supportive services.

Project Goals

a. To achieve cost savings by reducing frequency and length of stay in custody for mentally ill and co-occurring diagnoses
b. To increase long-term stability of offenders through early intervention assessments, case management, transitional housing, and referrals/linkages to supportive services
c. To reduce the number of individuals incarcerated with a mental illness as a result of a substance use overdose (**discontinued due to lack of identified occurrences**).

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Project Objectives

a. To achieve cost savings by reducing the frequency and length of length of stay in custody of individuals with a severe mental health diagnosis by increasing linkages to mental health services including supportive housing and reducing barriers that offenders face in achieving their treatment goals

Project Population

South Lake Tahoe residents 18 years old and older with a serious mental health diagnosis that interferes substantially with the primary activities of daily living and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support and rehabilitation for a long or indefinite period of time (California Welfare and Institutions Code Sections 5600-5623.5) and who;

a. Qualify for Behavioral Health Court "BHC" **(modified** to include "or **current and/or frequent criminal justice involvement**, not necessary to be involved in BHC");
b. Offended due to a severe mental health crisis (**modified** to "having **severe mental health diagnosis and current and/or frequent involvement in criminal justice system**", as we were often unable to determine mental health diagnosis as the primary or even a contributing factor in most offending.)

An overview of participants receiving intervention.

A maximum of six clients could reside in the supportive housing at any time and rooms were designated by gender based on referrals and availability. Several individuals continued to be served after leaving the supportive housing. Length of stay in the supportive housing was expected to be 6-12 months. The average length of stay was 165.86 days with a wide standard deviation of 154.4 days. The longest stay was 475 days and the shortest stay was 1 day (this client engaged in threatening and violent behavior towards staff and other residents and was reincarcerated.). To date, twenty-three clients were served in the supportive housing; the original estimate was 18-24 participants. The project served sixteen men and seven women, 69% and 31% respectively, median age was 31 years old.

The process used to determine which interventions(s) a participant will receive.

Jail, Probation and criminal justice staff (lawyers/judges) identified individuals with mental health needs and referred to Behavioral Health. Interested individuals were assessed by a Mental Health Clinician to determine eligibility as well as linkages/referrals to services clients would most likely benefit from. At the onset of treatment engagement,

clients were assessed using the Adults Needs and Strengths Assessment ("ANSA") to assist with the determination of what services are needed. *It was the intention of the project to complete an ANSA at the end of treatment. Due to clients dropping out unexpectedly and the instrument inconsistently administered at the end of engagement for the participants, this measure was not included in outcome measures.

Treatment participants received during the program.

Participants worked with a designated ICM team made of Mental Health clinicians, Mental Health Workers and a Psychiatric Technician (nurse) who provided 24-7 support (either a physical presence or via our 24 crisis line). The ICM team provided education and support with both criminogenic needs and mental health symptom management. This support included education on activities of daily living, medication support and crisis management. Additionally individual could reside at the supportive transitional house, provided they complied with the rules, although treatment continued for most even after leaving the supportive transitional housing component, unless they were reincarcerated or discontinued treatment participation. Behavioral Health utilizes a DBT model, which was used throughout this process. Clients were expected to complete four DBT skills modules (Mindfulness, Distress Tolerance, Emotional Regulation, and Interpersonal Effectiveness); meet with their clinician for individual and/or family treatment at least one time weekly; and attend treatment groups specific to addressing criminogenic needs as well as other life skills or educational groups through Behavioral Health's outpatient clinic and Wellness program as identified in their individualized treatment plan. Additionally, clients were expected to attend Probation and court appointments as scheduled. As clients progressed through their treatment, they were encouraged to pursue education and participate in volunteer activities and/or employment, with the appropriate coaching and support to manage difficulties when and if they arose.

Treatment service(s)/practice(s) were monitored for quality and effectiveness.

Behavioral Health staff engaged in weekly team meetings where clients' progress and treatment goals were reviewed and we obtained monthly BHC progress reports that also helped to educate on treatment concerns and effectiveness. In addition, monthly staff performance reviews were utilized to ensure staff were adhering to treatment focus (criminogenic needs primarily and then mental health) and that staff had adequate training in DBT, forensic DBT, criminogenic targets based on the risk, need and responsivity model, motivational interviewing, and information on emerging science and best practices for addressing substance use. Monthly MDT team meeting were held to discuss and address concerns with community partners. Quarterly MIOCR reports were also generated.

Data Collection

Data was collected from incarceration records kept by the Sheriff's Office that allowed us to look at the history of incarceration one year prior to engagement in treatment, while in treatment, and one year post treatment, provided that amount of time had passed. This allowed us to evaluate if there was indeed a reduction in the number of days incarcerated during and following treatment.

The other source of data was documentation from Behavioral Health's electronic health records on treatment engagement during and following supportive housing (treatment plans and progress notes) and BHC monthly progress and graduation. On-going substance use was the primary reason for individuals leaving supportive housing. This did not disqualify them from continuing to engage in treatment, unless they were incarcerated for more than a month. Several participants did in fact leave supportive housing, voluntarily or otherwise, and still remained engaged in treatment.

The ANSA (Adult Needs and Strengths Assessment) was meant to be used as a pre- and post-treatment measure. While implemented routinely at the onset of treatment engagement, the post-treatment ANSA was often unable to be completed due to unplanned terminations. Due to the inconsistency of completion of the follow up ANSA, this measure was not used in the final analysis.

Similarly, we also implemented a formal assessment tool based on the risk, needs and responsivity model. This tool was also used inconsistently, primarily due to staff training issues on this instrument, as it required a license eligible clinician and several hours to interview and interpret data. We did not include this in the analysis, nor was it identified in the initial proposal.

LOGIC MODEL – SEE ATTACHED

RESULTS AND CONCLUSIONS

The participants were monitored for progress in the project: start /discharge dates, successful completions, etc., as well as tracked in terms of days of incarceration.

Data for the individuals that participated were gathered in an electronic health record (AVATAR) that EDC Behavioral Health uses. Additional information was gathered through jail records of dates/days of incarceration pre-, during- and post-treatment.

Project-oversight structure and overall decision-making process for the project.

Sabrina Owen, LMFT, who manages the EDC Behavioral Health clinic in South Lake Tahoe and has a forensic behavioral health background, is the project lead and oversees the project and staff at Behavioral Health. Additional project oversight was incorporated

into a once monthly MDT (multidisciplinary team) which includes law enforcement including CIT & Jail staff, Probation, and Public Defender who participates with the BHC, Behavioral Health and other involved community partners (i.e., NAMI)) to help identify potential candidates, discuss treatment concerns/interventions, and provide education on best practices.

How project components were monitored, assessed, and adjusted as necessary.

Weekly team meeting and monthly BHC reports provided an opportunity to review individual treatment engagement, effectiveness and difficulties, and adjust accordingly. Monthly staff performance reviews provided opportunities to monitor, assess, and train as needed. Rather than meeting every six months as originally proposed, monthly MDT meetings and BHC collaborative meetings provided additional information and oversight.

One significant change was implemented at the onset of year two, as it was identified that sufficient mental health interventions were occurring in the outpatient clinic and Wellness program, but the treatment in the supportive transitional house needed to focus specifically to address criminogenic needs. The house schedule was reordered to include two house groups per day (Monday- Friday) to specifically address the criminogenic needs of the clients, primarily focus being on the top three risk factors - anti-social thinking, behaviors, and associates with subsequent attention to problems with family relationships and support, problems with education/employment, substance use and developing pro-social leisure and recreational skills. Structured group activities that were scheduled for Saturday and Sunday were typically less structured and encouraged self care. Individual treatment plans for program participants, whether they were residing at the supportive transitional house or not, were all modified to include identifying and addressing criminogenic needs as part of their treatment goals. To support this, all staff, in addition to traditional DBT training, were enrolled and completed a course specific to Forensic DBT to increase understanding of modifying DBT to our clients with criminogenic needs.

PROCESS EVALUATION VARIABLES

Outcome variables that were tracked.

Number of days incarcerated one year pre-treatment, during treatment, and one year post-treatment. Treatment engagement start and end dates, whether the individual participated in supportive transitional housing, success in achieving treatment goals including, if applicable, completion of BHC and/or treatment engagement, and graduation to a lower level of care were gathered via electronic health records.

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Outcomes measures that were tracked.

1) Cost savings by reducing frequency and length of stay in custody for individuals with a severe mental health diagnosis (often a co-occurring diagnosis) and involvement in the criminal justice system
2) Long-term stability of individuals with severe mental health diagnoses (often co-occurring diagnoses) and involvement in the criminal justice system through early intervention assessments, case management/treatment, supportive transitional housing, and referrals/linkages to supportive service
3) To reduce the number of individuals incarcerated with a mental illness as a result of a substance use overdose (**discontinued due to lack of identified occurrences**)

Criteria for determining participant success for the intervention.

a. Decrease days incarcerated prior to participation in treatment compared to during and and following treatment.
b. Graduation/completion of BHC and/or treatment engagement that demonstrated stability of the participant as evidenced by a "step down" in treatment from FSP (Full Service Partnership) and engagement with the ICM team (Intensive Case Management) to a lower level of services (e.g., Wellness and Recovery Services) or to a community-based mild-to-moderate mental health service provider

Criteria for determining participant success/failure in the project.

Success:

a. A decrease in days incarcerated for participants comparing year prior to participation in treatment to during treatment and/or following treatment.
b. Long term stability of the participant demonstrated by graduation from either BHC, Probation and/or treatment by having improved functioning/lower service needs.

Failure:

a. Days incarcerated remained the same or increased.
b. An inability to demonstrate stability of participants with severe mental health diagnoses as evidenced by unplanned discontinuing from treatment and/or no improved functioning.

How the overall project was assessed for effectiveness including all individual project components.

Calculating and comparing the number of days incarcerated pre, during and post treatment via county jail records and estimating the costs savings based on the collective number of days of incarceration. Reviewing treatment engagement, disruption and/or completion, start/end dates and graduation and/or reducing level of care required which demonstrated stability.

Identify method(s) of determining if the project "worked" in terms of achieving the project set goals.

For goal 1) Calculated and compared the number of days incarcerated pre, during and post treatment via county jail records and estimated the costs savings based on the collective number of days of incarceration.

For goal 2) Reviewed treatment engagement, disruption and/or completion, start/end dates and graduation and/or reducing level of care required which demonstrated stability. Pre & Post ANSA comparison initially identified as a test measure of success was abandoned as the post ANSA was not routinely implemented.

Describe the research design used to complete the evaluation.

This project can be described as a field experiment to determine if the intervention would have a reduction in rates of incarceration and improvement in mental health stability by comparing these variables pre and post interventions.

Project cost of evaluation and cost per participant.

Cost of project evaluation is $1000

Average cost per participant $36,756.39 (actual costs per individual would be higher/lower depending on the length of time they engaged in services) based on Total State Funds expended: $599,641 and Total In-Kind Match expended: $245,756, with the Program Total of $845,397