Research Report

Local Evaluation Report for Los Angeles County's Mentally Ill Offender Crime Reduction (MIOCR) Program

Sarah B. Hunter, Maya Buenaventura, Matthew Cefalu

RAND Justice Policy

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Preface

In 2015, under California Penal Code Section 6045, titled the Mentally Ill Offender Crime Reduction (MIOCR) grant program, state funds were appropriated to support services and strategies aimed at reducing recidivism and criminal justice costs for individuals suffering from mental health disorders who are returning to the community after incarceration. Los Angeles County's Department of Health Services received a competitive award, administered by California's Board of State and Community Corrections (BSCC), to provide jail reentry services for up to 90 adults. These services could include supportive housing, mental health treatment services, and substance use disorder treatment services. As part of the grant objectives, each funded program was required to conduct a local evaluation that documented project results. In 2016, the Los Angeles County Department of Health Services selected RAND to perform the evaluation that was supported by BSCC grant funds. Information from this local evaluation report will be incorporated into a final MIOCR grant program report to the California Legislature. Interested stakeholders of this report also include other municipalities or entities that provide supportive services to criminal justice populations in and outside of Los Angeles County.

RAND Justice Policy

The research reported here was conducted in the RAND Justice Policy Program, which spans both criminal and civil justice system issues with such topics as public safety, effective policing, police–community relations, drug policy and enforcement, corrections policy, use of technology in law enforcement, tort reform, catastrophe and mass-injury compensation, court resourcing, and insurance regulation. Program research is supported by government agencies, foundations, and the private sector.

This program is part of RAND Justice, Infrastructure, and Environment (JIE), a division of the RAND Corporation dedicated to improving policymaking and decisionmaking in a wide range of policy domains, including civil and criminal justice, infrastructure protection and homeland security, transportation and energy policy, and environmental and natural resource policy.

Questions or comments about this report should be sent to the project leader, Sarah Hunter (Sarah_Hunter@rand.org). For more information about RAND Justice Policy, see www.rand.org/jie/justice-policy or contact the director at justice@rand.org.

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Recidivism is common among individuals who have been incarcerated in Los Angeles County, and the risks increase for those who suffer from mental health disorders and other health care conditions. To reduce the risk of recidivism and improve outcomes for individuals suffering from mental health disorders who are returning to the community after incarceration, California's Board of State and Community Corrections issued awards (called Mentally Ill Offender Crime Reduction [MIOCR] program grants) to communities to address the unique needs of these individuals. In 2015, Los Angeles County was awarded a three-year grant to provide jail in-reach and reentry services to individuals experiencing tri-morbid conditions (i.e., physical health, mental health, and substance use disorders) who were preparing for reentry into the community. A requirement for this award was the execution of a local evaluation that examined whether the program met its goals and achieved program outcomes. This report represents the evaluation of Los Angeles County's MIOCR grant program.

Program participants were enrolled into one of the three different community reentry service pathways: (1) assistance for individuals with mental illness that can live independently in the community with additional support, (2) supportive housing coupled with intensive case management, or (3) residential substance use treatment. Data were first collected from individuals referred to the program while incarcerated. Program staff conducted assessments of potential participants' health status and time before reentry to determine eligibility. Individuals who were eligible and interested in participating in the MIOCR program completed a health survey at program entry, and then at 6 and 12 months post-enrollment. At these time points, program staff also assessed the participants' progress on other program goals, such as benefit establishment, employment, and housing stability. Recidivism data were abstracted from the county's criminal justice data systems. All program enrollment and outcome data were entered into a program-specific Excel tracking sheet and shared with the evaluation team. The evaluation team also participated in program planning meetings and quarterly workgroup meetings and reviewed quarterly progress reports to help inform this evaluation.

Results from the evaluation demonstrate that Los Angeles County was successful in its recruitment goal of 90 participants. In fact, 98 participants were enrolled during the grant period, even with enrollment not starting until 2016. Data collected from participants at program entry demonstrated that participants had multiple health conditions and other characteristics that may increase their risk for recidivism, such as a history of homelessness and unemployment. Program retention rates for the one-year program were modest: 30 participants completed the program and 45 dropped out. Twenty-three participants had not reached the one-year program mark at the time of grant end date.

On average, participants who completed the one-year program maintained or improved their reported mental health and substance use status. Program graduates also demonstrated improvements in health care insurance status, benefit establishment, and housing stability. Data on criminal justice involvement show fewer convictions in the post-enrollment period than in the pre-enrollment period. Seventeen percent of program graduates spent time in jail in the post-reentry period.

The program met its goal of providing more than 90 individuals facing reentry who suffer from mental health and co-occurring physical health and substance use conditions with jail in-reach assessment and reentry planning services and linkages in the community with supportive services, including housing, mental health, and substance use services. However, 60 percent of program participants dropped out of the program before the one-year mark. Some dropouts required a higher level of care, but most were unlocatable by program staff. Twenty-four percent of the enrollees were still in the program at the end of the grant period, which precluded evaluation of their program outcomes. We were also limited to assessments of mainly program graduates, because follow-up surveys with program dropouts were not conducted. Because of these study design limitations, in addition to the lack of a comparison group of similar individuals who did not receive services, we are unable to draw causal conclusions from this study.

Acknowledgments

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This report was peer reviewed according to RAND's Standards for High-Quality Research and Analysis, available at www.rand.org/standards/standards_high.html. We appreciate the reviews by Suzanne Wenzel at the University of Southern California and Eunice Wong of the RAND Corporation.

Abbreviations

AUDIT-C	Alcohol Use Disorders Identification Test–Consumption
BSCC	California's Board of State and Community Corrections
CDC HQROL-4	Centers for Disease Control and Prevention Health-Related Quality of Life Survey
CI	confidence interval
COMPAS	Correctional Offender Management Profiling for Alternative Sanctions
DAST-10	Drug Abuse Screening Test
DHS	Los Angeles County Department of Health Services
DMH	Los Angeles County Department of Mental Health
FSP	Full Service Partnership
GR	General Relief
ICMS	intensive case management services
LAC	Los Angeles County
LASD	Los Angeles County Sheriff's Department
MHI-5	Mental Health Inventory–5
MIOCR	Mentally Ill Offender Crime Reduction
ODR	Los Angeles County Department of Health Services, Office of Diversion and Reentry
PCORI	Patient-Centered Outcomes Research Institute
SAPC	Los Angeles County Department of Public Health, Substance Abuse Prevention and Control
SD	standard deviation
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

1. Introduction

The Los Angeles County Jail System

Los Angeles County's (LAC's) jail system has the largest inmate population in the United States. In 2016, the average daily inmate population of the LAC jail system was 16,613. Twenty-five percent of this population is estimated to have a mental health disorder (Los Angeles County Sheriff's Department, 2016). Although the overall jail population has been decreasing, the number of inmates needing mental health treatment has steadily increased (Los Angeles County Sheriff's Department, 2016). In addition, almost one-half of the inmate population has at least one chronic disease, such as diabetes or HIV, and two-thirds of inmates experience a substance use disorder (California Healthline, 2018). The jail system, operated by the Los Angeles County Sheriff's Department (LASD), has become the default service provider to many individuals with mental health and substance use issues, due to the lack of affordable housing and social services in the community.

Substance Use, Mental Health, and Chronic Health Disorders and Recidivism

Several studies have found higher recidivism rates among individuals experiencing mental illness, relative to individuals without a mental illness. A 2014 evaluation by the California Department of Corrections and Rehabilitation examined three-year recidivism rates for three groups: (1) individuals with no mental health code, (2) individuals with an EOP (Enhanced Outpatient Program) designation (offenders who experience adjustment difficulties in a general population setting), and (3) individuals with a Correctional Clinical Case Management System designation (individuals whose symptoms are less severe and who receive treatment on an outpatient basis). Respective recidivism rates for these three groups were 52.4 percent, 69.6 percent, and 59.3 percent (California Department of Corrections and Rehabilitation, 2015). Silver, Cohen, and Spodak (1989) analyzed five-year re-arrest rates among a Maryland state prison cohort and found that 73.3 percent of individuals experiencing mental illness were re-arrested, while only 65.4 percent of individuals without a mental illness were re-arrested. Feder (1991) examined recidivism among a cohort of inmates released from New York state prisons and found that those with a mental illness had a 64 percent re-arrest rate, while those without a mental illness had a 60 percent re-arrest rate.

In addition, individuals experiencing co-occurring mental health and substance use disorders have even higher recidivism rates than individuals experiencing only mental health disorders (Baillargeon et al., 2009; Hartwell, 2004; Wilson et al., 2011). Wilson et al. (2011) analyzed four-year recidivism rates among a cohort of individuals admitted to a large U.S. urban jail

system in 2003 (Wilson et al., 2011). For purposes of analysis, the cohort was divided into four categories of individuals: without mental health or substance use disorders, with serious mental illness only, with substance use disorders only, and with co-occurring substance use and mental health disorders. The study found that individuals with co-occurring disorders had the higher number of jail readmissions, with 68 percent returning to jail at least once in the four-year follow-up period. Baillargeon et al. (2009) analyzed six-year recidivism rates among inmates in a Texas prison system and found that individuals with co-occurring psychiatric and substance use disorders had significantly higher rates of multiple incarcerations over the six-year follow-up period, compared with individuals experiencing only substance use disorders or only mental health disorders. Hartwell (2004) examined recidivism rates among individuals exiting prison in Massachusetts and found that individuals with co-occurring substance use and mental health disorders were significantly more likely to return to prison than individuals with only a mental health disorder. Although there is little or no evidence on recidivism rates among inmates experiencing mental health, physical health, and substance use issues, Mallik-Kane and Visher (2008) found that recidivism rates among individuals with chronic health conditions may be potentially higher than the general population's.

Reentry

An individual with a limited or low income, a criminal history, and a mental illness and/or a substance use disorder faces significant barriers in securing stable housing and necessary treatment upon release from incarceration (Baillargeon, Hoge, and Penn, 2010; Messina et al., 2004; Osher and Steadman, 2007; Peters and Bekman, 2007). Many return to their communities with no government benefits, no health insurance, and little or no family support (Baillargeon, Hoge, and Penn, 2010; Messina et al., 2004; Osher and Steadman, 2007; Peters and Bekman, 2007). Lack of access to treatment and other support results in higher rates of recidivism, homelessness, and poor health outcomes (Baillargeon, Hoge, and Penn, 2010; Messina et al., 2004; Osher and Steadman, 2007; Peters and Bekman, 2007).

Reentry—the process of transitioning from jail back to the community—has major implications for the life outcomes of these individuals, as well as for community safety and public spending (Re-Entry Policy Council, 2005). Although many individuals who are leaving hospitals have a discharge plan to coordinate community supports and treatment, this is not typically the case for incarcerated individuals who are released back into the community (Draine and Herman, 2007). A developing body of research indicates that provision of coordinated reentry services based on risk assessments can improve post-release outcomes across several domains, including housing, substance use, and employment (Jarrett et al., 2012; Lattimore and Visher, 2013; Re-Entry Policy Council, 2005; Visher, 2007). A multisite evaluation of prison reentry services found that increased in-prison service was associated with better employment, housing, and substance use outcomes three months after release (Lattimore and Visher, 2013). A

randomized control trial of a Critical Time Intervention (CTI)—a nine-month reentry intervention that uses advocacy with community agencies, motivational coaching, and individualized case management plans—resulted in individuals receiving CTI having a significantly higher likelihood of receiving medication and being registered with a general practitioner compared with those who had not received CTI (Jarrett et al., 2012). Successful reentry results in safer communities, better use of tax dollars, and improved individual outcomes (Re-Entry Policy Council, 2005).

In 2015, LAC received a three-year grant awarded and administered by California's Board of State and Community Corrections (BSCC). The Mentally Ill Offender Crime Reduction (MIOCR) grant program was designed to discover effective practices in reducing recidivism among individuals experiencing mental health issues. Los Angeles County's MIOCR grant program aimed to address the needs of individuals with co-occurring mental health, physical health, and substance use disorders. As further detailed later in the next chapter, by providing reentry services to inmates in LAC jails, LAC's MIOCR grant program was designed to assist individuals in obtaining treatment and other supports necessary to improve their life outcomes and prevent further justice system involvement.

Outline of This Report

The remainder of the report describes the program under study, our approach to examining program implementation and outcomes, the evaluation results, and conclusions and next steps from this work. Each of following chapters has been organized to include the topics specified in the local evaluation reporting requirements by the BSCC in its communication to local MIOCR grantees.

2. Project Description

Project Overview

As more fully described in the "Project Objectives" subsection below, LAC's MIOCR program objectives were to improve reentry outcomes, reduce recidivism, and attain long-term stability for "tri-morbid" inmates—i.e., those with co-occurring mental health, substance use, and physical health conditions. The program provided enhanced reentry services to tri-morbid inmates in LAC jails. The program targeted inmates with at least 30 days (and preferably 60–90 days) to their expected release date. Eligible participants included, but were not limited to, felony probationers in jail on a no-bail warrant and AB 109 (Assembly Bill 109) offenders serving their prison sentences locally. Participants at any stage of the court process were eligible. The program enrolled 98 inmates over the term of the grant, from July 1, 2015, through June 30, 2018. Program staff stopped enrollment in December 2017 so that participants received at least six months of services before the grant end date of June 30, 2018.

The program was designed so that participants received 30–90 days of jail-based reentry planning services with follow-up in the community by the program's community worker. Services included intensive case management; assistance in obtaining shelter/housing upon release; assistance in obtaining public benefits, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medi-Cal, General Relief (GR), and Cal-Fresh;[1] linkage to mental health and substance use disorder treatment; and identification of a medical home. These services were provided by a multidisciplinary project team consisting of an LAC Department of Health Services (DHS) Community Worker, Psychiatric Social Worker II, Registered Nurse I, and Custody Assistant (from LASD).

Referrals to the LAC MIOCR program came from multiple sources, including LAC Department of Mental Health (DMH) Jail Linkage program staff, DMH Court Linkage program staff, jail mental health clinicians, jail medical services staff, defense attorneys and prosecutors, and Community Collaborative Courts. Prior to the implementation of the LAC MIOCR program, reentry services were limited and did not focus specifically on the tri-morbid population.

Program Logic Model

A visual representation of the project, depicting the logical relationships between the input/resources, activities, outputs, outcomes, and impacts of the project, is provided in

[1] General Relief is an LAC-funded program that provides financial assistance to indigent adults who are ineligible for federal or state programs. An average GR case consists of one person, living alone, with no income or resources.

Table 2.1. This program logic model was initially drafted by the evaluation team. Program stakeholders, including staff from the Department of Health Services and Department of Mental Health Services, provided input before the model was finalized.

Table 2.1. Program Logic Model

Context: LAC operates the largest jail system in the United States. A large proportion of inmates have tri-morbid (physical, mental, and substance use) disorders and are at risk for homelessness and re-incarceration following reentry into the community. Currently, there is no integrated discharge planning available for these inmates due to lack of resources.

Collaborative Partners	Inputs	Outputs/Activities	Short-Term Outcomes	Medium-Term Outcomes	Long-Term Outcomes
LAC departments/ offices: • District Attorney • DMH • Sheriff's Department • Probation Department • DHS • SAPC • Department of Public Social Services • Public Defender • Alternate Public Defender	Funding from: • BSCC Staff dedicated to MIOCR: • registered nurse • psychiatric social worker • community worker • custody assistant In-kind community-based resources including: • 30 FSP slots • 30 permanent supportive housing slots with ICMS • 30 substance use disorder treatment slots Eligible participants—90 inmates with: • Severe mental illness • Chronic physical health condition • Substance use disorder • 30–90 days remaining custody time	Generate referrals to program from: • DMH Jail Linkage and DMH Court Linkage program staff • Jail mental health and medical services clinicians and staff • Prosecutors, defense attorneys, and courts Provide 30–90 days of jail-based reentry services, including: • Comprehensive assessment • Development of robust reentry plan • Assistance with benefits applications • In-reach by community-based service providers • Coordinated releases Provide linkage to and follow-up with community-based services upon release, including (as applicable to individual client): • DMH FSP • Transitional and permanent supportive housing, with ICMS • Substance use disorder treatment • Establishment of medical home • Community worker visits/follow-up	Prior to release: • Completion of comprehensive assessment • Development of reentry plan • Assessment of benefits status and assistance with application(s) • Linkage established to in-reach provider for FSP, permanent supportive housing/ICMS, substance use disorder treatment and/or other community service providers • Coordinated release (pick-up/warm-handoff) accomplished	Post-release: • Connection to medical home and needed specialty care • Receipt of relevant benefits • Receipt of FSP, permanent supportive housing/ICMS, substance use disorder treatment, and/or other community services (as applicable to individual client)	• Improved health, mental health and substance use status • Decreased hospitalizations and emergency department visits • Increased housing stability/ retention in housing • Decreased recidivism (re-arrests, convictions)

NOTES: FSP = Full Service Partnership; ICMS = intensive case management services.

Project Goals

The LAC MIOCR project goals were as follows:

1. Provide enhanced, integrated reentry planning to LAC jail inmates with co-occurring mental health, substance use, and medical conditions, including a comprehensive assessment, initiation of benefits applications, and jail in-reach services.
2. Conduct a coordinated release with linkages to community based services, including health and mental health services, interim and permanent supportive housing, substance use disorder treatment, and other services, based on individual needs
3. Improve participants' health, mental health, and substance use status; decrease hospitalizations and emergency department visits; increase housing stability and retention in housing; and decrease recidivism (re-arrests, convictions).

Project Objectives

The LAC MIOCR project objectives were as follows:

1. Complete comprehensive assessments and developing reentry plans for 90 tri-morbid inmates.
2. Provide jail-based case management services by multidisciplinary project team and in-reach by community-based service providers.
3. Initiate applications for Medi-Cal, SSI/SSDI, and other benefits where appropriate.
4. Provide linkage to and follow-up with one of three community-based service pathways upon release, including (as applicable to individual client): DMH Full Service Partnership (FSP) program, interim and permanent supportive housing with intensive case management services (ICMS), and/or residential substance use disorder treatment
5. Ensure linkages to medical home and specialty treatment upon release.

Project Population

The target population was LAC jail inmates who had a severe mental illness, chronic physical health condition, substance use disorder, and 30–90 days of remaining custody time. Participants were to be referred from multiple sources, including DMH Jail Linkage program staff, DMH Court Linkage program staff, jail mental health and medical services clinicians and staff, prosecutors, defense attorneys, and courts.

Services and Interventions

The project team, consisting of a psychiatric social worker, registered nurse, community worker, and custody assistant, performed comprehensive assessments to determine the service needs of participants and worked with participants to develop individualized reentry plans. All participants were screened for benefits status and eligibility (e.g., SSI/SSDI, Medi-Cal, GR), and applications were prepared while in custody. Jail-in reach services were provided, and

individuals received a coordinated release to a community-based service provider to ensure linkages to community services upon reentry. In sum, the MIOCR team services included

1. assessment of health, mental health, substance use disorder, housing, employment, and other needs
2. development of a comprehensive reentry plan to address needs
3. assessment for SSI/SSDI, Medi-Cal, and other benefits
4. identification and linkage to a medical home; linking to and facilitating in-reach by DMH FSP providers, DHS housing, ICMS providers, residential substance use disorder treatment, and other community-based service providers.

Dedicated community-based resources/programs available upon release included one of three service pathways:

1. 30 FSP slots to be provided by DMH and DMH-contracted providers, for individuals with mental illness that can live independently in the community with additional support
2. 30 DHS permanent supportive housing slots, provided through the DHS Office of Diversion and Reentry (ODR), and assignment to an ICMS provider (DHS-contracted agency)
3. Four to five at a time (30 total) substance use disorder residential treatment slots at Department of Public Health, Substance Abuse Prevention and Control (SAPC)–contracted providers that also provide mental health services.

In addition, community workers provided community-based visits and follow-up as inmates enrolled in the program were released to the community.

How Services and Practices Were Monitored for Quality and Effectiveness

Staff documentation was included in the project and service tracking activities—that is, the personnel conducting the referral, assessment, service planning, and service delivery were noted in the tracking forms. Project staff met regularly (i.e., twice per month and then once or twice per week once reaching capacity in mid-2017) to discuss referrals, assessments, and participant progress, including linkages post-release. This ensured that staff were fully informed about potential caseloads and appropriate linkages and that appropriate referrals were made. The psychiatric social worker served as the project team lead and reviewed and monitored the work and case notes of the community worker and registered nurse for quality and effectiveness. Anonymized summaries from the project staff meetings were shared with the MIOCR Project Workgroup and evaluation team to help troubleshoot any issues and convey progress. The workgroup, evaluation team, and project staff met quarterly to discuss grant progress. In addition, as further detailed in Chapter Three, a number of process variables and measures were collected and monitored throughout the project.

Project-Oversight Structure and Overall Decisionmaking Process for the Project

Project oversight was led by LAC's DHS. DHS established a MIOCR Project Workgroup, composed of members from the District Attorney's office, Sheriff's Department, DMH, Department of Public Health (which includes the SAPC unit), Probation Department, Public Defender, and Alternate Public Defender. This team met on a regular basis to review project implementation, including the number and type of referrals, number of completed assessments, participation rates, completed reentry plans, benefits establishment, and engagement in reentry services (FSP, permanent supportive housing/ICMS, substance use disorder treatment, and other relevant community services). This team worked closely with the RAND evaluation team to ensure that all project components were monitored and documented and kept the evaluation team apprised of any project adjustments. The evaluation team worked with the project team on quarterly and final report requirements and provided feedback to the project team on evaluation findings.

How Project Components Were Monitored, Assessed, and Adjusted as Necessary

As noted above, the MIOCR Project Workgroup met on a regular basis to review project implementation, including the number and type of referrals, number of completed assessments, participation rates, completed reentry plans, benefits establishment, and engagement in reentry services. The team worked closely with the RAND evaluation team to ensure that all project components were being monitored and documented. In addition, as noted above, project staff used Excel worksheets to document assessment completion, reentry plan establishment, benefit application activities, and linkage to FSP, permanent supportive housing/ICMS, and/or substance use disorder treatment. Staff also tracked dates of referral, assessment, service referrals, release dates, community-based activities and program status, and criminal justice involvement. Narrative descriptions of program progress were developed each quarter and submitted to BSCC as part of the grant requirements and shared with the evaluation team.

3. Evaluation Methods

Process Evaluation Methods

As noted in the program logic model, the primary project components were

1. Generate referrals to program from the following sources: DMH Jail Linkage and DMH Court Linkage program staff, jail mental health and medical services clinicians and staff, and prosecutors, defense attorneys, and courts.
2. Provide jail-based reentry services, including: a comprehensive assessment, the development of reentry plan, benefits assessment, in-reach services by community-based providers, and coordinated releases
3. Provide linkage to and follow-up with community-based services upon release, including (as applicable to individual client) one of three main service pathways: DMH FSP, transitional and permanent supportive housing, with ICMS provided by ODR or substance use disorder treatment through referral by the SAPC. The program also included follow-up by a community worker.

These project components were tracked in an Excel-based project tracking worksheet, as further detailed below. We also collected information on implementation challenges and successes from workgroup members at quarterly meetings and through the review of the quarterly progress reports submitted to the BSCC. The BSCC also requested that we report program costs per participant and the evaluation costs. Program staff provided us with an estimate of overall program costs to help address this requirement. We present in Table 3.1 the major project components and associated measures and methods by which the measures were tracked.

Table 3.1. Process Evaluation Methods and Measures by Project Component

Project Components	Methods	Measures
Generate referrals	Excel-based project tracking sheet	# referred from each source
Provide jail-based reentry services	Excel-based project tracking sheet	# assessed: • COMPAS (criminal justice risk) • Psychiatric evaluation • Benefits status • Employment/Income status • Housing status # with reentry plan # received in-reach services by FSP, ODR, or SAPC
Provide linkage and follow-up with community-based services upon release	Excel-based project tracking sheet	# of coordinated releases # receiving FSP, ODR, or SAPC services # receiving community worker follow-up services through 6 and 12 months, including dropouts and reasons for dropout
Implementation challenges and successes	Workgroup quarterly meetings Quarterly progress reports	Field notes from discussions at meetings; narratives describing program in reports
Program cost	Quarterly progress reports; lead agency estimates	Program spending as reported by lead agency (DHS)

NOTE: COMPAS = Correctional Offender Management Profiling for Alternative Sanctions.

How Participants Were Tracked

Service Documentation

The project team documented service delivery using a range of tools. All those who were referred to the program were entered into an Excel-based project tracking worksheet by the psychiatric social worker into a worksheet that program staff used to document whether those referred were assessed, the date of assessment, the outcomes of the assessment, and the recommended reentry service plan activities, such as benefit application status and assignment to a relevant housing support and/or relevant community service program. Jail-in-reach service staff tracked contact time and service activities, including reentry planning. All client encounters and case management work/contacts were documented in paper case files. For services in jails, a note was also documented in the jail's electronic medical system.

Participant Tracking Plan

Project staff used Excel worksheets to document assessment completion, reentry plan establishment, benefit application activities, and linkage to FSP, permanent supportive housing/ICMS, and/or substance use disorder treatment. Staff also tracked dates of referral, assessment, service referrals, and release dates. Key demographic information (age, gender,

race/ethnicity, tri-morbid status and diagnoses) and past historical information (e.g., prior criminal justice involvement, homelessness, and receipt of benefits six months prior to enrollment) were also recorded.

Impact Evaluation Methods

The outcomes that we measured were as follows:

1. physical health, mental health, and substance use status
2. recidivism (i.e., convictions and days in jail)
3. benefits status
4. employment and income status
5. housing stability.

Although there were other outcomes originally specified (e.g., hospitalizations and emergency room visits, linkages to a medical home), we did not receive valid information on those outcomes to use in this evaluation. In the next sections of this chapter, we described how these outcomes were measured and the analytic approaches used. Table 3.2 provides an outline of the outcomes and methods and measures used.

Table 3.2. Impact Evaluation Methods and Measures by Outcome

Outcome	Methods	Time Points	Measure
Physical health	Self-report assessment	Program entry (baseline); 6- and 12-month follow-ups	CDC HRQOL-4
Mental health	Self-report assessment	Program entry (baseline); 6- and 12-month follow-ups	MHI-5
Substance use problems	Self-report assessment	Program entry (baseline); 6- and 12-month follow-ups	AUDIT-C DAST-10
Recidivism	County criminal justice databases	12 months prior to program enrollment and 12 months post-enrollment	# of felony convictions # of misdemeanor convictions # of jail days
Benefits establishment	Self-report assessment	12 months prior to program enrollment; 6- and 12-month follow-ups	SSI/SSDI GR Medi-Cal/other health insurance
Income	Self-report assessment	12 months prior to program enrollment; 12-month follow-ups	Employed/receiving stipend
Housing stability	MIOCR staff assessment	12 months prior to program enrollment; 12-month follow-ups	Domiciled, jail, homeless, or unknown

NOTE: AUDIT-C = Alcohol Use Disorders Identification Test–Consumption; CDC HRQOL-4 = Centers for Disease Control and Prevention Health-Related Quality of Life Survey; DAST-10 = Drug Abuse Screening Test; MHI-5 = Mental Health Inventory-5.

Measures

Physical Health, Mental Health, and Substance Use Status

Part of the BSCC grant requirements was to select and execute assessments of participants' health status at program entry and at 6 and 12 months post-enrollment. We assessed self-reported physical health, mental health, and substance use status at program entry and at 6 and 12 months post-enrollment using validated tools. As further detailed below, the Centers for Disease Control and Prevention's standard four-item set of "Healthy Days" core questions was used to collect data on self-perceived physical and mental health; the Mental Health Inventory–5 (MHI-5) was used to screen for overall psychological well-being and symptoms of anxiety and depression; and the three-item Alcohol Use Disorders Identification Test–Consumption and ten-item Drug Abuse Screening Test were used to assess alcohol and drug use. These assessment tools (along with other candidate measures) were first identified by the evaluation team and brought to the program planning group, which consisted of members of the Department of Health Services and LASD for selection for use in this project. Next, we describe each of these measures.

Centers for Disease Control and Prevention Health-Related Quality of Life Survey (HRQOL-4)

The Centers for Disease Control and Prevention's standard four-item set of "Healthy Days" core questions (CDC HRQOL-4) was used to collect data on an individual's perceived physical and mental health (Centers for Disease Control and Prevention, 2017b). The questions on the CDC HRQOL-4 are as follows:

1. Would you say that in general your health is: excellent, very good, good, fair, or poor?
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

The four measures from the CDC HRQOL-4 have been part of the full sample Behavioral Risk Factor Surveillance System (BRFSS) since 1993. The BRFSS is a continuous, state-based, random telephone survey of community-dwelling U.S. adults age 18 and older (Centers for Disease Control and Prevention, undated). Summary statistics for the four items on the CDC HRQOL-4 from recent surveys of the general U.S. population are summarized in Chapter Four.

The CDC HRQOL-4 has also been administered to criminal justice system involved populations. Brent and Maschi (2015) reported CDC HRQOL-4 results from a study with a sampling frame that consisted of approximately 1,700 male and 50 female older adults incarcerated in the New Jersey Department of Corrections. Gjelsvik et al. (2014) analyzed CDC HRQOL-4 data from individuals with childhood exposure to the incarceration of a household

member. Summary statistics for CDC HRQOL-4 data from these studies are also summarized in Chapter Four.

Mental Health Inventory–5

The MHI-5 contains the first five items from the 36-Item Short-Form Health Survey (SF-36), which measures mental distress and mental well-being. The MHI-5 is a tool used to screen for overall psychological well-being and symptoms of anxiety and depression. The five questions on the MHI-5 ask for how much of the time during the past month the respondent has

1. been a very nervous person
2. felt downhearted and blue
3. felt calm and peaceful
4. felt so down in the dumps that nothing could cheer them up
5. been a happy person.

Participants choose one of six responses (all of the time, most of the time, a good bit of the time, some of the time, a little bit of the time, or none of the time) to each of the five questions.

The MHI-5 has been used in studies of a number of criminal justice system involved populations (Baćak and Wildeman, 2015; Karus et al., 2007; Sugie and Turney, 2017; Wilkinson et al., 2015). For example, Karus (2007) administered the survey to a population consisting of male inmates seriously ill with HIV/AIDS at two large jails in Los Angeles and New Orleans. Wilkinson et al. (2015) used MHI-5 data from the 2008 panel of the National Longitudinal Survey of Youth 97 to compare young adults with incarceration experience with those without incarceration experience. Summary statistics for MHI-5 data from these studies are summarized in Chapter Four.

Three-Item Alcohol Use Disorders Identification Test–Consumption

The three-item Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) is a short, validated tool to identify risky drinking and alcohol abuse and dependence (Frank et al., 2008). The questions on the AUDIT-C are as follows:

1. How often did you have a drink containing alcohol in the past year? (Response options: never, monthly or less, two to four times a month, two to three times per week, and four or more times a week.)
2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? (Response options: 1 or 2 drinks, 3 or 4, 5 or 6, 7 to 9, and 10 or more.)
3. How often did you have six or more drinks on one occasion in the past year? (Response options: never, less than monthly, monthly, weekly, and daily or almost daily.)

For this study, the baseline version (i.e., used at program enrollment) asked participants to report on the six months prior to incarceration (rather than the past year). At the follow-up survey time points, participants were asked about the past six months.

The AUDIT-C has been used in studies of a number of criminal justice system involved populations (Bolano et al., 2016; Caviness et al., 2009; Humphreys et al., 2017; Kinner et al., 2015; Kinner et al., 2014; Myers et al., 2018; Thibodeau et al., 2009). For example, Myers et al. (2018) administered the AUDIT-C to 270 HIV-infected adults incarcerated in the San Francisco County Jail who were not held in a high level of security during the time of initial recruitment. Thibodeau et al. (2009) administered the AUDIT-C to a convenience sample of 49 men incarcerated in a minimum-security Wisconsin state prison. The AUDIT-C was administered at one-month pre-release in prison and one-month post-release via telephone. Bolano et al. (2016) administered the AUDIT-C to 125 older jail inmates in an urban county jail. Humphreys et al. (2017) administered the AUDIT-C to 101 adults over the age of 55 in an urban county jail. Caviness et al. (2009) administered the AUDIT-C to 2,079 women at the Adult Correctional Institute in Rhode Island.

The AUDIT-C is also administered to non-incarcerated populations. For example, Frank et al. (2008) administered the AUDIT-C to 1,292 outpatients from an academic family practice clinic in Texas. The study sought to evaluate the validity of the AUDIT-C among primary care patients from the predominant racial/ethnic subgroups within the United States: white, black, and Hispanic. Ninety percent of the randomly sampled outpatients who were eligible to participate in the study based on their membership in one of the three racial ethnic/subgroups of interest agreed to participate in the study.

Drug Abuse Screening Test (DAST-10)

The DAST-10 is a ten-item tool that assesses drug use (not including alcohol and tobacco use) in the past 12 months, which has been validated for use with incarcerated individuals (Bolano et al., 2016). The ten questions on the DAST-10 are as follows:

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")
4. Have you had "blackouts" or "flashbacks" as a result of drug use?
5. Do you ever feel bad or guilty about your drug use? (If never use drugs, choose "No.")
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?

Survey respondents fall into one of five categories based on their scored responses: no problems reported, low level, moderate level, substantial level, and severe level. For this study, the baseline version (i.e., used at program enrollment) asked participants to report on the six

months prior to incarceration (rather than the past year). At the follow-up survey time points, participants were asked about the past six months.

The DAST-10 has been used in a number of studies of criminal justice system involved populations (Alpert et al., 2013; Bolano et al., 2016; Evren et al., 2014; Humphreys et al., 2017; Izenberg et al., 2014; Mukherjee et al., 2016; Myers et al., 2018; Owens, Rogers, and Whitesell, 2011; Shiu-Yee et al., 2018; Thibodeau et al., 2009; Walker, 2011). For example, Owens, Rogers, and Whitesell (2011) administered the DAST-10 to 100 individuals who were on probation or parole in two counties in a southeastern state. Myers et al. (2018) administered the DAST-10 to 270 HIV-infected adults incarcerated in the San Francisco County Jail who were not held in a high level of security during the time of initial recruitment. Bolano et al. (2016) administered the DAST-10 to 125 older jail inmates in an urban county jail. Humphreys et al. (2017) administered the DAST-10 to 101 adults over the age of 55 in an urban county jail. Thibodeau et al. (2009) administered the DAST-10 to a convenience sample of 49 men incarcerated in a minimum-security Wisconsin state prison. Walker (2011) administered the DAST-10 to 91 mothers with a history of incarceration and who may or may not have been on parole.

Recidivism

To assess recidivism, program staff employed by the LASD abstracted information from the county criminal justice databases on the number of felony and misdemeanor convictions and the number of days spent in county jail. Data for the period 12 months prior to enrollment into the program and for the 12 months after reentry were abstracted for each program participant. More specifically, we looked at the number of previous felony and misdemeanor convictions (not counting the one in which participants were currently incarcerated for) and days in jail for a prior offense in the 12-month period before program enrollment and compared that to the number of felony and misdemeanor convictions and days in jail for the 12-month period post-reentry.

Benefits Establishment

Program staff assessed whether participants were eligible and/or receiving the following benefits during the 12 months prior to enrollment and at the 6- and 12-month follow-up time points: SSI or SSDI, GR, and Medi-Cal or other health insurance.

Income

Program staff assessed whether participants were employed or receiving a stipend during the 12 months prior to enrollment and at program completion for the individuals who graduated from the program (12 months post-enrollment).

Housing Stability

Program staff assessed the living status of participants for the 12 months prior to enrollment and at program completion (12 months for the individuals who graduated from the program). Living status was classified as either domiciled, homeless, jail, or unknown.

Analytic Methods

Physical Health, Mental Health, and Substance Use Status

We used linear mixed-effects regression models to estimate the effect of one year of participation in the LAC MIOCR program on each measure included in the survey. Standard linear regression models assume that observations are independent. However, the surveys were administered to the same individuals at baseline, 6 months, and 12 months. Thus, observations are not independent. Because multiple observations were collected from the same individuals, data are clustered, with multiple observations grouped at the individuals level. Typically, observations from the same cluster are more similar to each other than observations from different clusters. In other words, one individual's responses at baseline, 6 months, and 12 months are likely to be more similar to each other than they are to other individuals' responses at baseline, 6 months, and 12 months. If we assumed independence and used standard linear regression models, estimates of variance and resulting p-values would have been incorrect. Linear mixed-effects regression models allowed us to account for correlations among survey responses for each individual. Linear mixed-effects regression models accounted for clustering by allowing for random variation across time periods and survey respondents. We ran the linear mixed-effects regression models using all available baseline, 6-month, and 12-month survey data. We also ran the linear mixed-effects regression models using only the survey responses from the 20 individuals who completed the baseline, 6-month, and 12-month surveys. We used the mixed command in STATA to implement the linear mixed-effects regression models.

Other Outcomes

For recidivism metrics, we performed paired t-tests comparing 12-month pre-period raw means with 12-month post-period raw means for the 24 graduates and 28 dropouts for whom we have pre- and post-period recidivism data. For benefits establishment, income, and housing stability, we performed proportion tests to determine whether there are statistically significant differences between 12-month pre-period proportions and 6-month post-enrollment proportions and whether there are statistically significant differences between 12-month pre-period proportions and proportions at program completion. These quantitative analyses were completed in STATA.

We also present descriptive information (i.e., mean values and/or percentages of individuals, standard deviations, and ranges) on measures of recidivism, benefits establishment, income, and housing status by the available time period (i.e., the 12 months prior to program enrollment, at

6 months post-enrollment, and/or at 12 months post-reentry/program completion) by participant status (i.e., graduated, in program, dropout) as of June 30, 2018.

4. Results and Conclusions

Overview

In this chapter, we first provide an overview of the results from the recruitment and enrollment efforts. We then describe program participation results, implementation challenges, and solutions. We then present information about program outcomes and program costs. Finally, we provide conclusions and next steps regarding our study findings.

Results

Recruitment and Enrollment

During the grant period, 152 individuals were referred to the MIOCR program. Of those, 64 percent were enrolled in the program. In Table 4.1, we describe the documented reasons for why some participants were not enrolled in the program. First, about 25 percent of participants were not enrolled because their projected release date was less than 30 days from the date of assessment. Next, some referred individuals did not meet the program criteria of demonstrating a mental health, physical health, and substance use disorder. About 13 percent of participants declined to participate; others needed higher level of care or were on parole or sent to a state hospital (Patton State Hospital) or state prison before enrollment could occur.

Table 4.1. Reason for Not Enrolling (Individuals Who Were Referred but Did Not Enroll)

Reason Not Enrolled (N=54)	
Insufficient time before release	25.9%
Substance use disorder criteria not met	14.8%
Physical health criteria not met	13.0%
Client declined	13.0%
Mental health criteria not met	11.1%
Need higher level care	7.4%
Parole	9.3%
Patton/prison	5.6%

Next, we examined the characteristics of the referred population by enrollment status (see Table 4.2). We did not find large differences between those who were referred but not enrolled in the program from those who were enrolled. The average age of program participants was 42 years, with participants ranging in ages from 20 to 74. Approximately 90 percent of program participants were male, as the program was initiated and operated out of Twin Towers

Correctional Facility. Over 50 percent of the participants were black, almost 30 percent were Hispanic, and under 20 percent were white. Only 3 percent were reported as veterans. There was variation in the referral source, demonstrating that awareness of the program was well known among the different entities serving the target population. About a third of the participants were referred from the DMH Jail Linkage program and the Mental Health Evaluation team; both of these groups provide services in the county jails.

Table 4.2. Descriptive Statistics of the Referred Population by Enrollment Status

	Not Enrolled (N=54)	Enrolled (N=98)
Age*		
Mean	42.6	42.3
Range	19 to 67	20 to 74
Gender		
Male	90.7%	90.8%
Female	9.3%	9.2%
Race		
Black	42.6%	52.0%
Hispanic	24.1%	28.6%
White	27.8%	18.4%
Other	3.7%	1.0%
Not reported	1.9%	0.0%
Veteran status		
No/unknown	98.1%	96.9%
Yes	1.9%	3.1%
Referring entity		
Jail Linkage	31.5%	33.7%
Jail Mental Health Evaluation Team	27.8%	37.8%
Court Linkage	11.1%	12.2%
Public Defender	9.3%	7.1%
Men's Forensic Outpatient Program	5.6%	2.0%
Inmate Reception Center	5.6%	0.0%
Homeless Initiative D2	1.9%	1.0%
Century Regional Detention Facility	1.9%	0.0%
Whole Person Care	1.9%	0.0%
Client request	1.9%	0.0%
Forensic Inpatient Unit	1.9%	0.0%
Office of Diversion and Reentry	0.0%	3.1%
Education Based Incarceration (reentry coordinator)	0.0%	2.0%
Department of Mental Health	0.0%	1.0%

* A total of 152 individuals were referred, including 98 enrollees and 54 individuals who did not enroll. No age was reported for two of the individuals who did not enroll (N=52).

In Table 4.3, we describe program participants' risk level as assessed at program entry on a number of dimensions, including a criminal justice risk assessment tool, health insurance status,

self-reported emergency room visits, and whether the participant reported being employed or homeless in the past 12 months.

Table 4.3. Participant Assessment Risk Level, Insurance, Emergency Room Visits, Admissions to Inpatient Facility, Employment, and Housing at or During 12 Months Prior to Enrollment (N=98)

	N	%
Criminal Justice risk level		
High	43	43.9%
Medium	21	21.4%
Medium with override consideration	14	14.3%
Low	16	16.3%
None	2	2.0%
Not reported	2	2.0%
Medi-Cal or other insurance at enrollment		
No	64	65.3%
Yes	34	34.7%
Number of emergency room visits in 12 months prior to enrollment		
0	83	84.7%
1	5	5.1%
2	2	2.0%
3	1	1.0%
8	1	1.0%
11	1	1.0%
13	1	1.0%
Not reported	4	4.1%
Unemployed during the 12 months prior to enrollment		
Yes	72	73.5%
No	26	26.5%
Homeless during the 12 months prior to enrollment		
No	69	70.4%
Yes	28	28.6%
Not reported	1	1.0%

NOTES: Project staff also recorded admissions to acute inpatient facilities in the 12 months prior to enrollment. For each individual, the number of admissions to acute inpatient facilities is identical to the number of emergency room visits. In other words, aside from admissions in conjunction with emergency room visits, there were no additional admissions to acute inpatient facilities.

Program staff utilized Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) for assessing criminal justice risk. This tool is a research-based risk and needs instrument that has been selected for use by the California Department of Corrections and Rehabilitation (California Department of Corrections and Rehabilitation, 2017) and classifies individuals into one of four risk categories—high, medium, medium with override consideration,

and low—based on an individual's history of substance use, education, family background, criminal activity, and social functioning. Staff from the LASD trained in implementing the COMPAS provided all assessments.

At enrollment, a little over one-third of participants reported having Medi-Cal or some other form of health insurance. Few participants (7 percent) reported visiting the emergency room in the 12 months prior to enrollment in the MIOCR program. Most participants (74 percent) reported not being employed in the 12 months prior to enrollment in the MIOCR program. A little less than one-third of participants reported being homeless in the 12 months prior to program enrollment.

In Table 4.4, we present the most common physical health, mental health, and substance use issues that were reported by participants. Almost one-third reported being HIV-positive or having AIDS. Hypertension was reported by about one-quarter of the population. Over one-third of the population reported more than one physical health condition. Major depression was the most common mental health diagnosis among participants. Over half of the population reportedly had amphetamine/methamphetamine problems and over one-third had alcohol use issues. Marijuana use was also frequently reported. Thirty-six percent of participants had more than one reported substance use problem. In sum, these findings demonstrate that this tri-morbid population often suffers from several physical, mental and substance use related conditions.

Table 4.4. Most Common Physical Health, Mental Health, and Substance Use Issues Reported by Enrollees (N=98)

	N	%
Physical health conditions		
HIV/AIDS	30	30.6%
Hypertension	25	25.5%
Asthma	9	9.2%
Back pain	8	8.2%
Hepatitis C	8	8.2%
Diabetes	7	7.1%
Cirrhosis or gastrointestinal	5	5.1%
Glaucoma	5	5.1%
Cancer	4	4.1%
Arthritis	4	4.1%
Physical health conditions in more than one category	37	37.8%
Mental health conditions		
Depressive disorder	38	38.8%
Schizophrenia	18	18.4%
Bipolar	15	15.3%
Schizoaffective disorder	14	14.3%
Anxiety	7	7.1%
Psychosis	7	7.1%
Not otherwise specified	5	5.1%
Other mood disorder	3	3.1%
Post-traumatic stress disorder	2	2.0%
Gender identity disorder	1	1.0%
Mental health conditions in more than one category	11	11.2%
Reported substance use problems		
Amphetamine/methamphetamine	57	58.2%
Alcohol	34	34.7%
Marijuana	27	27.6%
Cocaine/Crack	17	17.3%
Heroin	4	4.1%
Mushrooms	2	2.0%
Unspecified substance use	2	2.0%
Ecstasy	1	1.0%
Opioid	1	1.0%
Other stimulant	1	1.0%
Substance use in more than one category	36	36.7%

NOTE: The percentages under physical health conditions, mental health conditions, and substance use do not add up to 100 because some individuals reported that more than one category of physical health condition, mental health condition, or substance use applied to them. The number of individuals who reported physical health conditions that fall under more than one category was 37 (37.8%); 11 individuals (11.2%) reported mental health conditions that fall under more than one category; and 36 individuals (36.7%) reported substance use that falls under more than one category.

Process Evaluation Results

As noted previously, the primary project components were (1) generate referrals to the program, (2) provide jail-based reentry services, and (3) provide linkage to and follow-up with community-based services upon release. These project components were tracked using an Excel-based project tracking worksheet, as detailed in Chapter Three. We provide descriptions of these services as reported by the DHS service providers. The sections below detail the number of individuals who received services under each project component. We also present findings regarding program participation, including graduation and dropout rates and reasons for dropout. Finally, we summarize what we learned about implementation challenges and how they were resolved from participation in quarterly program planning and workgroup meetings and review of the quarterly reports submitted to the BSCC.

Generate Referrals to Program

As presented in Table 4.2, the program was successful in generating referrals from a variety of entities that resulted in meeting their enrollment goals.

Provide Jail-Based Reentry Services

All 98 participants were assessed prior to program enrollment to determine whether they met program criteria by a licensed clinical social worker. All participants were also assessed for criminal justice risk by LASD staff trained in employing the COMPAS tool. In addition, 64 percent (i.e., 63 participants) had a documented psychiatric evaluation. Benefit status (provision/eligibility for SSI/SSDI, GR, Medi-Cal or other health insurance) was also assessed for all 98 participants while in custody, and this is reported as part of the impact evaluation findings. Participants' past work status and homelessness were also recorded and are reported as part of the impact evaluation findings. Ninety-seven participants had a comprehensive reentry plan completed; one participant dropped out of the program before a reentry plan was developed. In terms of release services, 81 participants had a documented coordinated release, which is a release at a predetermined time to an identified community-based service provider who picks up or accepts the client into services directly from jail.

The coordinated release process included the following steps. First, the psychiatric social worker submitted a referral request to one of the three service pathway providers that was deemed most appropriate based on her clinical assessment of the individual (i.e., ODR Permanent Supportive Housing program, SAPC substance use treatment program, or the DMH FSP). Next, county staff from the referred agency reviewed and assigned the case to one of their contracted programs, who then sent a staff person to conduct a jail in-reach visit to further determine whether the individual was appropriate for the program and build rapport with the potential participant. If the individual was accepted to the program, then a coordinated release was set up so that the contracted program staff would be present at the time of the participant's release for transport and/or acceptance into their program. For example, the ODR housing

program would place an individual into a transitional living facility until a permanent housing unit was available, the SAPC-funded providers would provide transport to residential substance use treatment setting, and FSP would assign individuals to receive intensive case management services at their place of residence.

Provide Linkage to and Follow-Up with Community-Based Services upon Release

Of the 98 individuals enrolled in the LAC MIOCR program during the grant period, 29 were linked to the ODR Permanent Supportive Housing program, 29 were linked to a SAPC-contracted substance use treatment program, and 27 were linked to a DMH-funded FSP program. Five participants were not successfully linked to any program, and eight were linked to a different program (e.g., shelter). Eighty-seven participants had more than one contact while in custody; contacts ranged from one to 28 times. Once a participant was in the community, it was the community worker's responsibility to provide in-person hand-offs with key service providers. For example, the community worker may have accompanied a participant to his or her first appointment with a new primary care physician. There was not consistent information provided on contacts out of custody. Of the 45 participants with complete information, the number of out-of-custody contacts ranged from 0 to 17 by phone and 0 to 13 in person. Data on linkages to medical homes were only available for program graduates, 23 percent (7 out of 30) of whom had a documented linkage to a medical home or specialty medical care.

Program Participation

As noted earlier, 98 individuals were enrolled in the LAC MIOCR program during the grant period. Of those, 30 graduated from the program during the grant period, 23 were still enrolled in the program at the grant end date, and 45 had dropped out of the program (see the appendix for the distribution of participants across the different service pathways). Table 4.5 presents information about the reasons why individuals dropped out of the program and retention time among program dropouts. About half of the program participants were dropped from the program because program staff were unable to locate them in the community. Just over 20 percent declined program services at some time after enrollment. Another 18 percent were transferred to a state hospital (i.e., Patton) or prison after enrollment. Many program dropouts still received several months of program services; the average number of days that participants who dropped out of the program were in the program was 211.6, with a range from 37 to 359 days.

Table 4.5. Reasons for Program Termination and Days in the Program for All Program Dropouts (N=45)

	All Dropouts	
	N	%
Termination reason		
Client declined	10	22.2%
Moved out of LAC	2	4.4%
Needed higher level of care	2	4.4%
Patton/prison	8	17.8%
Unable to locate	22	48.9%
Unknown	1	2.2%
Total	45	
Days in program		
Mean	211.6	
Standard deviation	93.6	
Range	37 to 359	

Implementation Challenges and Solutions

The narrative quarterly reports to the BSCC shed light on some of the implementation challenges faced during the grant period. First, between the writing of the grant and the award, LAC reorganized care delivered in the Los Angeles County jail. DHS became the provider of correctional health care rather than the LASD Medical Services Bureau. As a result of these organizational changes, the oversight of the grant and the hiring of staff positions was shifted and caused some delay in project start-up. Grant expenditures began in the sixth quarter of the grant (i.e., 1.5 years after award). The project was not operational until the seventh quarter of the grant period, as there were also some challenges in hiring staff due to the temporary nature of the project. Program enrollment started in December 2016. An additional staff member (forensic registered nurse) joined the team in the ninth quarter. Despite these changes and delays in project start-up, program staff were successful in exceeding their recruitment goals during the grant period.

After the program had launched, it experienced some growing pains around the eighth quarter due to the high number of participants who had transitioned to the community (i.e., nearly 50). Initially, only one community case worker had been hired, and the geographical dispersion of and high needs among participants made it challenging for one case worker to address. As a result, a second case worker was hired in this quarter. During this period, there were also some challenges with the substance use treatment pathway—that is, having contracted residential substance use treatment service providers accept program participants. These challenges evolved for a few different reasons. First, finding a bed available at time of reentry was challenging. That is, timing the release with an open treatment slot was difficult. Second, most programs were not equipped to handle MIOCR participants who had co-occurring physical

health needs. Third, delays in the reinstatement of Medi-Cal for the formerly incarcerated had yet to be addressed, which prevented substance use treatment programs from accepting participants. The MIOCR program helped to identify these barriers by facilitating coordination between the different stakeholders, more specifically DHS and SAPC partners, to help resolve these issues during the grant period. This coordination will likely result in smoother transitions from jail to receipt of publicly funded substance use treatment in the future.

Other program barriers experienced relate to the provision of in-jail services and characteristics of program participants. More specifically, there were some delays in the provision of in-jail visits by FSP and SAPC staff to assess and enroll the referred participant into their programs due to the LASD clearance process. In at least one case, a participant who had been referred to FSP was released before linkage with an FSP provider was secured, and the participant was unable to be located after release. Also, program staff found that participants with past histories of arson and sexual offenses were hard to place. Despite treatment slots being committed by DMH and SAPC for program participants, these departments were unable to require their contracted agencies to accept individuals with these backgrounds. Also, in the last year of operation, ODR changed the eligibility criteria for its supportive housing program, requiring participants to be in pre-trial rather than in post-conviction status. This change prevented some participants from being linked to the ODR pathway.

Impact Evaluation Results

In this section, we first report on individual-level changes over time among program participants, then we provide descriptive statistics on the group-level survey scores related to general health, mental health, and substance use in comparison to other relevant populations. Finally, we report group-level results on the other outcomes.

Individual-Level Physical Health, Mental Health, and Substance Use Status

We present the results from our analyses of individual-level physical health, mental health, and substance use status in Table 4.6. As noted above, we ran the linear mixed-effects regression models using all available baseline, 6-month, and 12-month survey data. We also ran the linear mixed-effects regression models using only the survey responses from the 20 individuals who completed the baseline, 6-month, and 12-month surveys.

Table 4.6. Regression Results for Physical Health, Mental Health, and Substance Use Changes Among Program Graduates

	All Available Survey Data		20 Participants with Baseline, 6-Month, and 12-Month Survey Data	
	Coefficient on Time Variable	p-Value of Coefficient on Time Variable	Coefficient on Time Variable	p-Value of Coefficient on Time Variable
CDC HRQOL-4				
CDCHRQOL 1: Would you say that in general your health is: 1="Excellent" 2="Very good" 3="Good" 4="Fair" 5="Poor"	–0.28	0.217	–0.3	0.444
CDCHRQOL 2: Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?	–1.71	0.524	–2.8	0.458
CDCHRQOL 3: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?	–6.69	0.008	–9.1	0.017
CDCHRQOL 4: During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	–1.93	0.326	–4.7	0.186
MHI-5				
Higher scores indicate better mental health status; scale of 0 to 100	1.99	0.103	3.2	0.055
AUDIT-C				
Positive, optimal for identifying hazardous drinking or active alcohol use disorders: score of 4+ for men or 3+ for women; scale of 0 to 12	–2.31	0.001	–2.1	0.011
DAST-10				
No problems reported (score of 0), Low level (score of 1–2), Moderate level (score of 3–5), Substantial level (score of 6–8), Severe level (score of 9–10)	–2.98	0.000	–1.9	0.012

NOTE: Baseline survey: N=97; 6-month follow-up survey: N=43; 12-month follow-up survey: N=22.

The coefficient on the time variable for each measure, listed in Table 4.6, indicates the estimated effect of a year in the LAC MIOCR program on each measure. For example, in the model using all available baseline, 6-month, and 12-month survey data, the coefficient of –6.69 on the time variable in the CDC HRQOL-4 ("Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?") equation means that one year of participation in the LAC MIOCR program results in an estimated 6.69 fewer days in the past 30 days during which participants' mental health was not good. The coefficient of –2.31 on the time variable in the AUDIT-C equation means that one year of participation in the LAC MIOCR program results in an estimated 2.31-point reduction in participants' AUDIT-C score. The coefficient of –2.98 on the time variable in the DAST-10 equation means that one year of participation in the LAC

MIOCR program results in an estimated 2.98-point reduction in participants' DAST-10 score. Coefficients on all measures indicate that participation in the LAC MIOCR program moves the measure in the desired direction. When a lower score indicates better physical or mental health, the time coefficient is negative. When a higher score indicates better physical or mental health, the time coefficient is positive. However, only the p-values for the time coefficients in the CDC HRQOL-4, AUDIT-C, and DAST-10 equations were less than 0.05, indicating that the desirable effects of one year of program participation on these measures are the only statistically significant results.

As shown in Table 4.6, when we ran the linear mixed-effects regression models using only the survey responses from the 20 individuals who completed the baseline, 6-month, and 12-month surveys, the estimated effects were always in the same direction and were typically larger in magnitude. This provides evidence that if bias exists in the full analysis, it appears to be attenuating the estimated effect toward zero. This means that the full analysis may be conservative in its estimation (not biasing the results to favor larger impacts—if anything, biasing toward no impact). This provides evidence that lack of survey responses at 6 months and 12 months due to program dropout and survey nonresponse is not leading us to make false conclusions. In addition, as with the full analysis, only the p-values for the time coefficients in the CDC HRQOL-4, AUDIT-C, and DAST-10 equations were less than 0.05, indicating that the desirable effects of one year of program participation on these measures are the only statistically significant results.

Because of program dropout and survey nonresponse, many individuals who completed the baseline survey did not complete the 6-month and 12-month surveys. We attempted to weight individual survey responses at 6 and 12 months based on how well the respondent represented the entire population of enrollees in terms of gender, race, veteran status, age, risk level, insurance status in the 12-month pre-period program, homelessness in the 12-month pre-period, employment in the 12-month pre-period, number of emergency room visits in the 12-month pre-period, program, and referring entity. The weight units were inversely proportional to the probability of response, and individuals who were more representative of the population of enrollees received larger weights. We were unable to generate weights that would ensure the respondents at 12 months were representative of the enrollee population. However, as noted above, the linear mixed-effects regression models using only the survey responses from the 20 individuals who completed the baseline, 6-month, and 12-month surveys provide evidence that lack of survey responses at 6 months and 12 months due to program dropout and survey nonresponse is not leading us to make false conclusions.

Group-Level Physical, Mental, and Substance Use Status at Program Entry, 6 Months Post-Release, and 12 Months Post-Release

In this section, we provide group-level descriptive statistics from our survey findings in relation to results from other studies to help put these results into context.

CDC Health-Related Quality of Life Survey (HRQOL-4)

We provide a summary of our findings on the CDC HRQOL-4 at the different program time points in relation to other study populations and the general U.S. population in Table 4.7. Examining results from the MIOCR population that completed the survey at each of the three different time points, we found that general health reporting stayed relatively stable, with over half reporting "fair" or "good" health at each time point.

Table 4.7. CDC Health-Related Quality of Life Survey (CDC HRQOL-4) Results for Los Angeles County MIOCR Enrollees and Other Populations

	General U.S. Population (BRFSS)	Brent and Maschi (2015)	Gjelsvik et al. (2014)	LAC MIOCR Baseline (N=97)	LAC MIOCR 6 Months (N=43)	LAC MIOCR 12 Months (N=22)
General health is (Centers for Disease Control and Prevention, 2017a):						
Excellent (1 point)	18.4%			11.3%	11.6%	9.1%
Very good (2 points)	33.5%			9.3%	16.3%	18.2%
Good (3 points)	31.5%			29.9%	32.6%	40.9%
Fair (4 points)	12.5%			34.0%	27.9%	18.2%
Poor (5 points)	4.4%			14.4%	11.6%	13.6%
Mean		2.9678		3.28	3.11	3.09
Days during the past 30 days when physical health was not good	3.8 days (United Health Foundation, 2018b)			11.5 days	12.9 days	8.8 days
Days during the past 30 days when mental health was not good	3.8 days (United Health Foundation, 2018a)			15.2 days	12.4 days	8.0 days
% reporting 14 or more days during which poor physical or mental health prevented usual activities*	8.4% (Dwyer-Lindgren et al., 2017)		33%	32.99%	37.21%	13.64%

* To obtain an estimate of a person's overall unhealthy days, responses to questions two and three are added together, with a maximum of 30 unhealthy days. For example, if an individual reports two physically unhealthy days and five mentally unhealthy days, the individual is assigned a value of seven unhealthy days. If an individual reports 20 physically unhealthy days and 25 mentally unhealthy days, he or she is assigned the maximum of 30 unhealthy days. Eleven percent of respondents said that their mental health was not good more than seven days a month.

For comparison, summary statistics from the CDC HRQOL-4 data from Brent and Maschi (2015) (approximately 1,700 male and 50 female older adult incarcerated people in the New Jersey Department of Corrections) and Gjelsvik et al. (2014) (individuals with childhood exposure to the incarceration of a household member) are also summarized in Table 4.7. Not surprisingly, MIOCR participants reported substantially lower levels of health-related quality of life than the general U.S. population. Their health-related quality of life ratings were also similar

(to the Gjelsvik et al. study) or worse (compared with the Brent and Maschi study) than those reported in studies of other criminal justice–involved populations.

Mental Health Inventory-5 (MHI-5)

These summary statistics are included in Table 4.8. The MHI-5 mean for the general U.S. population is approximately 75, with a standard deviation of approximately 20, according to the Patient-Centered Outcomes Research Institute (PCORI) (Patient-Centered Outcomes Research Institute, 2016). Higher scores on the MHI-5 translate to better mental health. Previous research has used a score of 52 as the cutoff point for psychological distress, such that scores equal to or lower than 52 on the MHI-5 signal psychological distress (Wilkinson et al., 2015). These statistics are included in Table 4.8. For comparison, summary statistics from the MHI-5 data from Karus et al. (2007) (male inmates seriously ill with HIV/AIDS at two large jails in New Orleans and Los Angeles) and Wilkinson et al. (2015) (comparison of young adults with and without incarceration experience) are also summarized in Table 4.8. The MIOCR participants' scores were, on average, in a range similar to other incarcerated populations at baseline. The MIOCR participants' scores were significantly worse than those of the general U.S. population. About half the participants who completed follow-up surveys reported continued psychological distress. Four individuals (18.2 percent of the 22 individuals who completed the baseline and 12-month surveys) had a score of 52 or less at baseline but not at 12 months. Eight individuals (36.4 percent) had a score of 52 or less at baseline and at 12 months. Three individuals (13.6 percent) had a score above 52 at baseline but had a score of 52 or less at 12 months. Seven individuals (31.8 percent) had a score above 52 at baseline and at 12 months.

Table 4.8. Mental Health Inventory–5 (MHI-5) Results for Los Angeles County MIOCR Participants and Other Populations

	General U.S. Pop. (PCORI, 2016)	Karus et al. (2007) (Los Angeles)	Karus et al. (2007) (New Orleans)	Wilkinson et al. (2015) Incarcer-ation	Wilkinson et al. (2015) No Incarcer-ation	LAC MIOCR Baseline (N=97)	LAC MIOCR 6 months (N=43)	LAC MIOCR 12 months (N=22)
Mean (SD)	75 (20)	44.2 (22.6)	57.6 (23.2)			52.1 (23.9)	54.6 (24.3)	59.8 (24.2)
% with psychological distress (≤52)				20.73%	10.72%	51.55%	51.16%	50.00%

NOTE: SD = standard deviation.

Three-Item Alcohol Use Disorders Identification Test–Consumption (AUDIT-C)

Summary statistics for the AUDIT-C data are included in Table 4.9. For comparison, AUDIT-C summary statistics from the incarcerated populations in Myers et al. (2018) (270 HIV-infected

adults incarcerated in San Francisco County Jail), Thibodeau et al. (2009) (49 men incarcerated in a minimum security Wisconsin state prison, administered 1-month pre- and post-release), Bolano et al. (2016) (125 older inmates in urban county jail), Humphreys et al. (2017) (101 adults over the age of 55 in an urban county jail), and Caviness et al. (2009) (2,079 women at the Adult Correctional Institute in Rhode Island) are also included in Table 4.9. In addition, summary statistics from a study of the non-incarcerated population in Frank et al. (2008) (1,292 white, black, and Hispanic outpatients from family practice clinic in Texas) are included. Higher scores on the AUDIT-C are indicative that the respondent's drinking is affecting his or her safety. The MIOCR program participants' scores were in a similar range to other incarcerated populations at baseline, with about one-third scoring in the positive range for a probable alcohol use disorder. As noted earlier, scores substantially declined at the follow-up time points, with about 21 percent in the positive range for a probable disorder at the 6-month time point and less than 10 percent of program graduates reporting values in the positive range for a probable disorder at the 12-month time point.

Table 4.9. Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) Results for Los Angeles County MIOCR Enrollees and Other Populations

	Frank et al. (2008) *Non-incarcerated*	Myers et al. (2018)	Thibodeau et al. (2009) Pre-Release	Thibodeau (2009) Post-Release	Bolano et al. (2016)	Humphreys et al. (2017)	Caviness et al. (2009)	LAC MIOCR Baseline (N=97)	LAC MIOCR 6 Months (N=43)	LAC MIOCR 12 Months (N=22)
Mean			6.52	<2				3.48	1.98	1.42
% positive optimal	17% (men); 9% (women)	33.33%			38%	40%	54.5%	36.1%	20.9%	9.1%

NOTES: The AUDIT-C is scored on a scale from 0 to 12. For men, a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. In women, a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.

Drug Abuse Screening Test (DAST-10)

Summary statistics for the DAST-10 data are included in Table 4.10. For comparison, summary statistics from the DAST-10 data from the incarcerated populations in Owens, Rogers, and Whitesell (2011) (100 individuals on probation or parole in two counties in a southeastern state), Myers et al. (2018) (270 HIV-infected adults incarcerated in San Francisco County Jail), Thibodeau et al. (2009) (49 men incarcerated in a minimum security Wisconsin state prison, administered 1-month pre- and post-release), Bolano et al. (2016) (125 older inmates in urban county jail), Humphreys et al. (2017) (101 adults over the age of 55 in an urban county jail), and Walker (2011) (91 mothers with a history of incarceration) are also included in Table 4.10. The reports from the MIOCR sample were similar to those from other incarcerated populations at program entry, with scores in the moderate to severe range, suggesting the degree of problems

related to their use and need for intensive assessment. LAC MIOCR participants had substantially lower scores at the 6- and 12-month follow-up periods, suggesting lower levels of problems related to drug use, with no participants reporting use in the "severe" range at the 12-month follow-up time point.

Table 4.10. Drug Abuse Screening Test (DAST-10) Results for Los Angeles County MIOCR Enrollees and Other Populations

	Owens, Rogers, and Whitesell (2011)	Myers et al. (2018)	Thibo-deau et al. (2009) Pre-Release*	Bolano et al. (2016)	Hum-phreys et al. (2017)	Walker (2011)	LAC MIOCR Baseline (N=97)	LAC MIOCR 6 Months (N=43)	LAC MIOCR 12 Months (N=22)
Mean (SD) [range]	5.99 (3.37) [0–10]		4.57			5.47 [0–10]	5.84 (2.71) [0–10]	3.30 (2.76) [0–9]	3.03 (2.50) [0–7]
% moderate, substantial, or severe drug use		84.81%		66%	69%		82.47%	48.84%	50.00%
% severe drug use		8.15%					15.46%	2.33%	0.00%

* Post-release DAST-10 results not reported.
NOTE: Individuals fall into one of five categories based on their scored DAST-10 responses: no problems reported (0), low level (1–2), moderate level (3–5), substantial level (6–8), and severe level (9–10).

Other Outcomes

In this section, we present the findings regarding the other program outcomes, including recidivism, benefits establishment, employment, and housing stability. We present these findings by outcome, organized by time period (i.e., the 12-month pre-enrollment period and 6 and/or 12 months post-enrollment) and program status (graduated, still enrolled, dropped out). These findings are also broken down by the three different service pathways (i.e., ODR housing, FSP, and SAPC) and presented in the appendix.

Recidivism

Data were available on 96 participants in the 12-month period before program enrollment and for 52 participants who had a full 12 months post-enrollment. On average, program graduates had 1.4 prior convictions (in addition to the one that they were currently serving time for) in the past 12 months prior to enrollment and 0.3 convictions in the 12-month post-enrollment period (see Table 4.11). These results were not different from those experienced by program dropouts. Program graduates were in jail on average for six days for a previous offense in the prior year, compared with eight days for participants who were still enrolled and 21 days by program dropouts. The number of days in jail in the 12-month post-enrollment period was on average 27

for program graduates and 16 for dropouts. Not shown here, but important to the interpretation of these results, is that four of the 24 program graduates (17 percent) had any jail days in the 12-month post period and 11 out of the 28 program dropouts (39 percent).

Table 4.11. Recidivism Results for Los Angeles County MIOCR Participants by Program Status

	Total	Graduated	Still Enrolled	Dropouts
	All Enrolled	All Graduates	All Still Enrolled	All Dropouts
N	**96**	**30**	**21**	**45**
12-month pre-period (includes the 96 individuals for whom we have pre-period conviction and jail days data)				
All convictions				
Mean	1.2	1.4	0.6	1.5
Standard deviation	1.9	2.0	1.1	2.0
Range	0–10	0–8	0–4	0–10
Felony convictions				
Mean	0.5	0.3	0.2	0.8
Standard deviation	0.8	0.6	0.4	1.0
Range	0–4	0–2	0–1	0–4
Misdemeanor convictions				
Mean	0.7	1.1	0.3	0.7
Standard deviation	1.6	2.0	1.0	1.5
Range	0–9	0–8	0–4	0–9
Jail days				
Mean	13.3	6.1	8.1	20.5
Standard deviation	31.7	16.5	22.7	40.6
Range	0–153	0–74	0–99	0–153
12-month post-period (only includes the 52 individuals who have 12 full months of post-enrollment data)				
	All at 12 Months	All Graduates	All Still Enrolled	All Dropouts
N	**52**	**24**		**28**
All convictions				
Mean	0.6	0.3		0.6
Standard deviation	1.1	0.8		1.0
Range	0–6	0–3		0–4
Felony convictions				
Mean	0.3	0.2		0.4
Standard deviation	0.6	0.4		0.7
Range	0–2	0–1		0–2
Misdemeanor convictions				
Mean	0.3	0.2		0.4
Standard deviation	1.0	0.6		1.2
Range	0–6	0–3		0–6
Jail days				
Mean	20.9	26.5		16.1
Standard deviation	54.6	68.3		39.9
Range	0–233	0–233		0–203

We performed t-tests to compare the pre- and post-enrollment recidivism metrics. For the 24 graduates for whom we have 12-month post-period recidivism data:

- There was a statistically significant ($p < 0.05$) decrease in the mean number of overall convictions (pre-period mean = 1.6; SD = 2.2; 95-percent confidence interval [CI] = 0.7–2.6; post-period mean = 0.3; SD = 0.8; 95-percent CI = 0.01–0.7; t = 2.8; df = 23; p-value = 0.0095).
- There was a decrease in the mean number of felonies, but the decrease was not statistically significant (pre-period mean = 0.4; SD = 0.7; 95-percent CI = 0.1–0.6; post-period mean = 0.2; SD = 0.4; 95-percent CI = 0.006–0.3; t =1.2; df = 23; p-value = 0.2329).
- There was a statistically significant ($p < 0.05$) decrease in the mean number of misdemeanors (pre-period mean = 1.3; SD = 2.2; 95-percent CI = 0.3–2.2; post-period mean = 0.2; SD = 0.6; 95-percent CI = –0.1–0.4; t = 2.4; df = 23; p-value = 0.0245).
- There was an increase in the mean number of jail days, but this increase was not statistically significant ($p < 0.05$) (pre-period mean = 7.3; SD = 18.3; 95-percent CI = –0.5–15.0; post-period mean = 26.5; SD = 68.3; 95-percent CI = –2.3–55.4; t = –1.3; df = 23; p-value = 0.2115). (Also, as noted above, only four of the 24 program graduates for whom we have 12-month post-period recidivism data experienced any jail days in the post-period.)

For the 28 dropouts for whom we have 12-month post-period recidivism data:

- There was a decrease in the mean number of overall convictions, but this decrease was not statistically significant ($p < 0.05$) (pre-period mean = 1.9; SD = 2.4; 95-percent CI = 0.9–2.8; post-period mean = 0.8; SD = 1.3; 95-percent CI = 0.3–1.3; t = 2.0; df = 27; p-value = 0.0614).
- There was a statistically significant ($p < 0.05$) decrease in the mean number of felonies (pre-period mean = 0.9; SD = 1.1; 95-percent CI = 0.5–1.3; post-period mean = 0.4; SD = 0.7; 95-percent CI = 0.1–0.7; t = 2.2; df = 27; p-value = 0.0368).
- There was a decrease in the mean number of misdemeanors, but this decrease was not statistically significant ($p < 0.05$) (pre-period mean = 0.9; SD = 1.8; 95-percent CI = 0.2–1.6; post-period mean = 0.4; SD = 1.2; 95-percent CI = –0.07–0.9; t = 1.2; df = 27; p-value = 0.2286).
- There was a decrease in the mean number of jail days, but this decrease was not statistically significant ($p < 0.05$) (pre-period mean = 24.6; SD = 46.2; 95-percent CI = 6.7–42.6; post-period mean = 16.1; SD = 39.9; 95-percent CI = 0.6–31.6; t = 1.0; df = 27; p-value = 0.3211).

Benefits Establishment

Data were available on all 98 participants in the 12-month period before program enrollment and 6 months post-enrollment, and for the 30 individuals who graduated from the program at 12 months post-enrollment. As shown in Table 4.12, 34 individuals were receiving SSI or SSDI in the 12 months prior to program enrollment, 10 of whom were program completers. This was maintained at the 6-month post-enrollment period. At program completion, 40 percent of program completers (n = 12) were receiving SSI or SSDI and the same number of individuals

(40 percent or n = 12) were receiving GR, showing an improvement in benefit receipt among graduates. However, the difference between the proportion of the 30 graduates who were receiving SSI or SSDI in the 12 months prior to enrollment and the proportion of the 30 graduates who were receiving SSI or SSDI at program completion is not statistically significant ($p < 0.05$) (pre-period proportion = 33.3 percent; 95-percent CI = 0.2–0.5; post-period proportion = 40.0 percent; 95-percent CI = 0.2–0.6; z = –0.5; p-value = 0.5921). Dropouts had lower benefit receipt in the time prior to program enrollment and at the 6-month time point (18 percent).

Table 4.12. Benefit Establishment Among Los Angeles County MIOCR Participants by Program Status

	Total	Graduated	Still Enrolled	Dropouts
	All Enrolled	All Graduates	All Still Enrolled	All Dropouts
N	**98**	**30**	**23**	**45**
12-month pre-period (includes all 98 enrollees)				
N with SSI/SSDI	34	10	16	8
% with SSI/SSDI	34.7%	33.3%	69.6%	17.8%
6-month post-period (includes all 98 enrollees)				
N with SSI/SSDI	34	10	16	8
% with SSI/SSDI	34.7%	33.3%	69.6%	17.8%
Program completion (includes 30 individuals who graduated)				
N with SSI/SSDI		12		
% with SSI/SSDI		40.0%		
N with GR		12		
% with GR		40.0%		

With regard to receipt of Medi-Cal or other health insurance, about two-thirds of participants (n = 64) reported having some form of health care insurance in the 12-month period prior to program enrollment (see Table 4.13). At the 6-month period post-enrollment, only 50 percent had some form of health care insurance; the decrease was found among participants who dropped out of the program. Among individuals who completed the program, 93 percent (28 out of 30) had some form of health care insurance at the 12-month post-enrollment time point, showing an improvement of 27 percent.

Table 4.13. Receipt of Medi-Cal or Other Health Care Insurance Among Los Angeles County MIOCR Participants by Program Status

	Total All Enrolled	Graduated All Graduates	Still Enrolled All Still Enrolled	Dropouts All Dropouts
N	**98**	**30**	**23**	**45**
12-month pre-period (includes all 98 enrollees)				
N with Medi-Cal/other insurance	64	20	15	29
% with Medi-Cal/other insurance	65.3%	66.7%	65.2%	64.4%
6-month post-period (includes all 98 enrollees)				
N with Medi-Cal/other insurance	49	21	20	8
% with Medi-Cal/other insurance	50.0%	70.0%	87.0%	17.8%
Program completion (includes 30 individuals who graduated)				
N with Medi-Cal/other insurance		28		
% with Medi-Cal/other insurance		93.3%		

The increase in the proportion of graduates who had some form of health care insurance from 12 months pre-enrollment to 6 months post-enrollment is not statistically significant ($p < 0.05$) (pre-period proportion = 66.7 percent; 95-percent CI = 0.5–0.8; post-period proportion = 70 percent; 95-percent CI = 0.5–0.9; $z = –0.3$; p-value = 0.7814). The increase in the proportion of graduates who had some form of health care insurance from 12 months pre-enrollment to 12 months post-enrollment is statistically significant ($p < 0.05$) (pre-period proportion = 66.7 percent; 95-percent CI = 0.5–0.8; post-period proportion = 93.3 percent; 95-percent CI = 0.8–1.0; $z = –2.6$; p-value = 0.0098).

The decrease in the proportion of dropouts who had some form of health care insurance from 12 months pre-enrollment to 6 months post-enrollment is not statistically significant ($p < 0.05$) (pre-period proportion = 64.4 percent; 95-percent CI = 0.5–0.8; post-period proportion = 17.8 percent; 95-percent CI = 0.06–0.3; $z = 4.5$; p-value = 0.0000).

Employment

Information about whether participants were employed or receiving some other type of stipend was available for all 98 participants for the 12-month period before program enrollment and for the 12-month post-enrollment period for the 30 participants who graduated from the program (see Table 4.14). About one-quarter (n = 26) of program participants reported being employed or receiving a stipend in the 12 months prior to program enrollment. For participants who completed the program, only 13 percent (4 out of 30) had employment or a stipend at the program completion. The decrease in the proportion of graduates who were receiving income from a stipend or employment from 12 months pre-enrollment to 12 months post-enrollment is not statistically significant ($p < 0.05$) (pre-period proportion = 20.0 percent; 95-percent CI =

0.06–0.3; post-period proportion = 13.3 percent; 95-percent CI = 0.01–0.3; z = 0.7; p-value = 0.4884).

Table 4.14. Income from Employment or Stipend Among Los Angeles County MIOCR Participants by Program Status

	Total	Graduated	Still Enrolled	Dropouts
	All Enrolled	All Graduates	All Still Enrolled	All Dropouts
N	**98**	**30**	**23**	**45**
12-month pre-period (includes all 98 enrollees)				
Employed/stipend (N)	26	6	9	11
Employed/stipend (%)	26.53%	20.0%	39.1%	24.4%
Program completion (includes 30 individuals who graduated)				
Employed/stipend (N)		4		
Employed/stipend (%)		13.3%		

Housing Stability

Data about participants' living situation were available for all 98 participants for the 12-month period before program enrollment and for the 12-month post-enrollment period for the 30 participants who graduated from the program (see Table 4.15). Participants' housing stability was categorized as whether the participant was "domiciled," "homeless," in "jail," or unknown during the time periods. Twenty-eight participants reported being homeless sometime in the 12 months prior to enrollment. The rate was higher among program dropouts compared with those who graduated from the program (38 percent as compared to 20 percent). Twenty-five out of the 30 program graduates (83 percent) were housed at program completion time-point, with two reported as homeless and three in jail. The decrease in the proportion of graduates who were homeless from 12 months pre-enrollment to 12 months post-enrollment is not statistically significant ($p < 0.05$) (pre-period proportion = 20.0 percent; 95-percent CI = 0.06–0.3; post-period proportion = 6.7 percent; 95-percent CI = –0.02–0.2; z = 1.5; p-value = 0.1287).

Table 4.15. Living Situation for Los Angeles County MIOCR Participants by Program Status

	Total	Graduated	Still Enrolled	Dropouts
	All Enrolled	All Graduates	All Still Enrolled	All Dropouts
N	**98**	**30**	**23**	**45**
12-month pre-period (includes all 98 enrollees)				
Homeless (N)	28	6	5	17
Homeless (%)	28.6%	20.0%	21.7%	37.8%
Domiciled (N)	69	24	18	27
Domiciled (%)	70.4%	80.0%	78.3%	60.0%
Unknown (N)	1	0	0	1
Unknown (%)	1.0%	0.0%	0.0%	2.2%
Program completion (includes 30 individuals who graduated)				
Homeless (N)		2		
Homeless (%)		6.7%		
Domiciled (N)		25		
Domiciled (%)		83.3%		
Jail (N)		3		
Jail (%)		10.0%		

Project Cost of Evaluation and Cost per Participant

At the time of writing of this report, program expenditures, which included actuals through March 2018 plus estimated expenditures for the final quarter of April–June 2018, were as follows:

Grant funds:	$596,011
In-kind costs:	$885,730
Total:	$1,481,741.

We did not receive information about each participant's utilization of program services and costs of those services to calculate an exact program cost per participant. The program service cost could vary depending on how long the participant was in the program, what service pathway the participant was assigned to (ODR housing, SAPC treatment, or DMH FSP), and the intensity of services received, which could vary even within a service pathway. For example, a participant may receive 3, 30, 60, or 90 days of residential substance use treatment or receive one to three visits a week from an FSP provider. Taking into account the enrollment of 98 individuals, and subtracting out the evaluation costs ($150,000), the program cost per participant was $13,589.19. These costs are similar to those observed for other permanent supportive housing programs that LAC operates, e.g., the DHS Housing for Health annual permanent supportive housing costs were reported as $15,288 on average per individual (see Hunter et al., 2017).

Conclusions and Next Steps

Summary

Ninety-eight participants were enrolled in the LAC MIOCR program. Based on assessments taken at program enrollment, participants were experiencing multiple health care conditions, including a mental health, physical health, and substance use disorder, and 78 percent scored in the medium to high risk category on the criminal justice risk assessment tool. Eighty-five participants were successfully linked to one of three service pathways: ODR supportive housing, DMH FSP (intensive mental health care management services), or SAPC residential substance abuse treatment services.

In terms of results, the LAC MIOCR participants demonstrated ratings that were worse than the general U.S. population on physical, mental, and substance use–related health status measures. Their scores were also similar to or sometimes worse than other incarcerated populations, demonstrating the high acuity and needs of this participant population, which was selected based on its members' tri-morbid health status. As of June 30, 2018, 30 participants had graduated from the program, 23 were still enrolled (yet to reach the 12-month post-enrollment mark), and 45 individuals had dropped out of the program. Among program graduates, individuals maintained or improved their reported mental health and substance use status. More specifically, at program entry, about one-third of participants scored positive for a probable alcohol use disorder, and, at the 12-month follow-up, less than 10 percent of program graduates reported symptoms associated with a probable alcohol use disorder. Decreases in drug use reporting were also observed, with 15 percent reporting a severe drug use at program entry and none of the program graduates reporting this at the 12-month time point. Program graduates also demonstrated improvements in health care insurance status, benefit establishment, and housing stability. Program participants had lower conviction rates in the 12-months post-enrollment period than in the pre-12-month period. Only 10 percent of program graduates had spent time in jail at the 12-month post-enrollment period. Although these data suggest improvements in outcomes among program participants, the study design does not allow for us to attribute any changes in the measures to program participation, and therefore these results should be interpreted with caution in terms of the causal link between program participation and outcomes. In addition, the current program attrition rate of 60 percent suggests there may be some room for improving the connection and engagement in services for this population.

Study Limitations

We experienced several challenges in conducting a robust evaluation of the MIOCR program. The program did not start recruitment until the second year, and although its administrators successfully enrolled more than 90 participants, many participants (23) had not reached the 12-month program completion time frame by the end of the grant period, so 12-month outcome data

were not available to us. Even among the 30 program completers, we had survey data from only 73 percent (22 completers) of the sample at 12 months. We do not know whether the eight people who did not complete the surveys would have scored better or worse on these measures and whether they would have influenced the overall reported group scores. We were also limited to assessments of mainly program graduates, because follow-ups with program dropouts were not conducted. The changes over time on the self-reported measures (e.g., health status) may be subject to social desirability effects. Because of these study design limitations, along with the lack of a comparison group of similar individuals who did not receive the MIOCR services, we are unable to draw causal conclusions from this study.

Next Steps

As noted in the grant stipulations and quarterly progress reports, DHS will continue the program under implementation of a Whole Person Care Pilot supported by the California 1115 Waiver renewal program supported by the federal Medicaid program (California Department of Health Care Services, 2015). The LAC pilot includes a focus on high-risk individuals in the jail reentry population with medical, mental health, and/or substance use conditions. This funding will allow LAC to build and expand on the model developed in the MIOCR grant and sustain services beyond the project period.

Appendix. Further Results

Table A.1. Program Dropout Status and Reasons for Dropout by Program Status

	All Enrollees (N=98)		ODR SHP (N=29)		SAPC (N=29)		FSP (N=27)		Other (N=8)		None (N=5)	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Graduated	30	30.6	14	48.3	4	13.8	11	40.7	1	12.5	0	0.0
Still enrolled	23	23.5	3	10.3	11	37.9	5	18.5	4	50.0	0	0.0
Dropped out	45	45.9	12	41.4	14	48.3	11	40.7	3	37.5	5	100.0

	All Dropouts		ODR SHP		SAPC		FSP		Other		None	
	N	**%**	N	%	N	%	N	%	N	%	N	%
Termination reason												
Client declined	10	22.2	3	25.0	3	21.4	2	18.2	0	0.0	2	40.0
Moved out of LAC	2	4.4	0	0.0	0	0.0	1	9.1	1	33.3	0	0.0
Needed higher level of care	2	4.4	0	0.0	1	7.1	1	9.1	0	0.0	0	0.0
Patton/prison	8	17.8	1	8.3	2	14.3	2	18.2	1	33.3	2	40.0
Unable to locate	22	48.9	8	66.7	7	50.0	5	45.5	1	33.3	1	20.0
Unknown	1	2.2	0	0.0	1	7.1	0	0.0	0	0.0	0	0.0
Total	45		12		14		11		3		5	
Days in program*												
Mean	211.6		257.9		196.4		191.5		237.7		161.5	
SD	93.6		92.0		88.5		93.7		31.8		124.5	
Range	37–359		57–355		64–329		38–359		201–258		37–323	

* N=44. One of the dropouts, whose entry date was listed as five days after the exit date, was not included.
NOTES: ODR SHP = Office of Diversion and Reentry Supportive Housing Program; SAPC = Substance Abuse Prevention and Control residential substance abuse treatment program.

Table A.2. Participant Health Survey Results Organized by Data Collection Time Period and Service Pathway

CDC HRQOL-4 1: Would you say that in general your health is:

	All (N=97)		FSP (N=27)		ODR SHP (N=29)		SAPC (N=29)		Other (N=8)		None (N=4)	
Baseline	N	%	N	%	N	%	N	%	N	%	N	%
Excellent	11	11.3	4	14.8	3	10.3	2	6.9	1	12.5	1	25.0
Very good	9	9.3	1	3.7	2	6.9	4	13.8	2	25.0	0	0.0
Good	29	29.9	9	33.3	11	37.9	7	24.1	2	25.0	0	0.0
Fair	33	34.0	7	25.9	11	37.9	11	37.9	2	25.0	2	50.0
Poor	14	14.4	6	22.2	2	6.9	4	13.8	1	12.5	1	25.0
No response	1	1.0	0	0.0	0	0.0	1	3.4	0	0.0	0	0.0
	All (N=43)		**FSP (N=14)**		**ODR SHP (N=17)**		**SAPC (N=10)**		**Other (N=2)**			
6-month follow-up	N	%	N	%	N	%	N	%	N	%		
Excellent	5	11.6	0	0.0	3	17.6	1	10.0	1	50.0		
Very good	7	16.3	3	21.4	3	17.6	1	10.0	0	0.0		
Good	14	32.6	7	50.0	5	29.4	2	20.0	0	0.0		
Fair	12	27.9	1	7.1	5	29.4	5	50.0	1	50.0		
Poor	5	11.6	3	21.4	1	5.9	1	10.0	0	0.0		
	All (N=22)		**FSP (N=8)**		**ODR SHP (N=12)**		**SAPC (N=2)**					
12-month follow-up	N	%	N	%	N	%	N	%				
Excellent	2	9.1	1	12.5	1	8.3	0	0.0				
Very good	4	18.2	3	37.5	1	8.3	0	0.0				
Good	9	40.9	1	12.5	8	66.7	0	0.0				
Fair	4	18.2	1	12.5	1	8.3	2	100.0				
Poor	3	13.6	2	25.0	1	8.3	0	0.0				

NOTES: FSP = Department of Mental Health Full Service Partnership program; ODR SHP = Office of Diversion and Reentry Supportive Housing Program; SAPC = Substance Abuse Prevention and Control residential substance abuse treatment program. Darker cell shading indicates higher percentage.

Table A.3. Recidivism by Data Collection Time Period and Service Pathway

	Graduated					Still Enrolled					Dropouts					
	All Graduates	ODR SHP	SAPC	FSP	Other	All Still Enrolled	ODR SHP	SAPC	FSP	Other	All Drop-outs	ODR SHP	SAPC	FSP	Other	None
N	**30**	**14**	**4**	**11**	**1**	**21**	**3**	**11**	**4**	**3**	**45**	**12**	**14**	**11**	**3**	**5**
12-month pre-period (includes the 96 individuals for whom we have pre-period conviction and jail days data)																
All convictions																
Mean	1.4	0.8	0.5	2.5	0.0	0.6	0.0	0.8	0.3	0.7	1.5	1.3	1.3	2.5	0.3	1.0
SD	2.0	1.0	0.6	2.9		1.1		1.4	0.5	0.6	2.0	1.9	1.4	3.0	0.6	0.7
Range	0–8	0–2	0–1	0–8	0–0	0–4	0–0	0–4	0–1	0–1	0–10	0–7	0–4	0–10	0–1	0–2
Felony convictions																
Mean	0.3	0.4	0.25	0.3	0.0	0.2	0.0	0.3	0.3	0.3	0.8	0.8	0.6	1.1	0.0	0.8
SD	0.6	0.7	0.5	0.5		0.4	0.0	0.5	0.5	0.6	1.0	1.1	0.8	1.1		0.8
Range	0–2	0–2	0–1	0–1	0–0	0–1	0–0	0–1	0–1	0–1	0–4	0–4	0–2	0–3	0–0	0–2
Misdemeanor convictions																
Mean	1.1	0.4	0.3	2.3	0.0	0.3	0.0	0.5	0.0	0.3	0.7	0.5	0.6	1.4	0.3	0.2
SD	2.0	0.8	0.5	2.9		1.0	0.0	1.3		0.6	1.5	0.9	0.9	2.6	0.6	0.4
Range	0–8	0–2	0–1	0–8	0–0	0–4	0–0	0–4	0–0	0–1	0–9	0–3	0–2	0–9	0–1	0–1
Jail days																
Mean	6.1	9.5	1.0	4.2	0.0	8.1	0.0	13.2	0.3	8.0	20.5	10.6	33.3	27.9	0.7	4.4
SD	16.5	23.3	1.4	7.0		22.7		30.4	0.5	12.2	40.6	22.3	55.4	45.5	1.2	4.5
Range	0–4	0–74	0–3	0–21	0–0	0–99	0–0	0–99	0–1	0–22	0–153	0–62	0–153	0–117	0–2	0–11

	Graduated					Still Enrolled					Dropouts					
	All Graduates	ODR SHP	SAPC	FSP	Other	All Still Enrolled	ODR SHP	SAPC	FSP	Other	All Drop-outs	ODR SHP	SAPC	FSP	Other	None
12-month post-period (only includes the 52 individuals who have 12 full months of post-enrollment data)																
N	**24**	**13**	**2**	**8**	**1**						**28**	**10**	**8**	**7**	**1**	**2**
All convictions																
Mean	0.3	0.2	0	0.8	0.0						0.8	0.5	0.6	1.1	3.0	0.5
SD	0.8	0.4		1.2							1.3	0.8	0.7	2.3		0.7
Range	0–3	0–1	0–0	0–3	0–0						0–6	0–2	0–2	0–6	3–3	0–1
Felony convictions																
Mean	0.2	0.2	0	0.3	0.0						0.4	0.2	0.5	0.3	2.0	0.5
SD	0.4	0.4		0.5							0.7	0.4	0.8	0.8		0.7
Range	0–1	0–1	0–0	0–1	0–0						0–2	0–1	0–2	0–2	2–2	0–1
Misdemeanor convictions																
Mean	0.2	0.0	0	0.5	0.0						0.4	0.3	0.1	0.9	1.0	0.0
SD	0.6			1.1							1.2	0.7	0.4	2.3		0.0
Range	0–3	0–0	0–0	0–3	0–0						0–6	0–2	0–1	0–6	1–1	0–0
Jail days																
Mean	26.5	21.5	0	44.6	0.0						16.1	4.7	40.3	4.0	29.0	12.0
SD	68.3	63.7		87.6							39.9	9.5	70.1	7.7		17.0
Range	0–233	0–228	0–0	0–233	0–0						0–203	0–26	0–203	0–20	29–29	0–24

NOTE: ODR SHP = Office of Diversion and Reentry Supportive Housing Program; SAPC = Substance Abuse Prevention and Control residential substance abuse treatment program; FSP = Department of Mental Health Full Service Partnership program.

Table A.4. Benefit Establishment by Data Collection Time Period and Service Pathway

	Graduated					Still Enrolled					Dropouts					
	All Grad-uates	ODR SHP	SAPC	FSP	Other	All Still Enrolled	ODR SHP	SAPC	FSP	Other	All Drop-outs	ODR SHP	SAPC	FSP	Other	None
N	**30**	**14**	**4**	**11**	**1**	**23**	**3**	**11**	**5**	**4**	**45**	**12**	**14**	**11**	**3**	**5**
12-month pre-period (includes all 98 enrollees)																
N with SSI/SSDI	10	3	3	4	0	16	2	9	3	2	8	1	3	2	1	1
% with SSI/SSDI	33.3	21.4	75.0	36.4	0.0	69.6	66.7	81.8	60.0	50.0	17.8	8.3	21.4	18.2	33.3	20.0%
6-month post-period (includes all 98 enrollees)																
N with SSI/SSDI	10	1	3	6	0	16	2	5	5	4	8	2	2	2	1	1
% with SSI/SSDI	33.3	7.1	75.0	54.5	0.0	69.6	66.7	45.5	100.0	100.0	17.8	16.7	14.3	18.2	33.3	20.0
Program completion (includes 30 individuals who graduated)																
N with SSI/SSDI	12	8	2	2	0											
% with SSI/SSDI	40.0	57.1	50.0	18.2	0.0											
N with GR	12	4	2	5	1											
% with GR	40.0	28.6	50.0	45.5	100.0											

NOTE: ODR SHP = Office of Diversion and Reentry Supportive Housing Program; SAPC = Substance Abuse Prevention and Control residential substance abuse treatment program;

Table A.5. Receipt of Medi-Cal or Other Health Care Insurance by Data Collection Time Period and Service Pathway

	Graduated					Still Enrolled					Dropouts					
	All Grad-uates	ODR SHP	SAPC	FSP	Other	All Still Enrolled	ODR SHP	SAPC	FSP	Other	All Drop-outs	ODR SHP	SAPC	FSP	Other	None
N	**30**	**14**	**4**	**11**	**1**	**23**	**3**	**11**	**5**	**4**	**45**	**12**	**14**	**11**	**3**	**5**
12-month pre-period (includes all 98 enrollees)																
N with Medi-Cal/other insurance	20	11	3	6	0	15	1	8	4	2	29	10	8	7	2	2
% with Medi-Cal/other insurance	66.7	78.6	75.0	54.5	0.0	65.2	33.3	72.7	80.0	50.0	64.4	83.3	57.1	63.6	66.7	40.0
6-month post-period (includes all 98 enrollees)																
N with Medi-Cal/other insurance	21	10	3	8	0	20	3	9	5	3	8	2	3	2	1	0
% with Medi-Cal/other insurance	70.0	71.4	75.0	72.7	0.0	87.0	100.0	81.8	100.0	75.0	17.8	16.7	21.4	18.2	33.3	0.0
Program completion (includes 30 individuals who graduated)																
N with Medi-Cal/other insurance	**28**	13	4	10	1											
% with Medi-Cal/other insurance	**93.3**	92.9	100.0	90.9	100.0											

NOTE: ODR SHP = Office of Diversion and Reentry Supportive Housing Program; SAPC = Substance Abuse Prevention and Control residential substance abuse treatment program.

Table A.6. Income by Employment or Stipend by Data Collection Time Period and Service Pathway

	Graduated					Still Enrolled					Dropouts					
	All Grad-uates	ODR SHP	SAPC	FSP	Other	All Still Enrolled	ODR SHP	SAPC	FSP	Other	All Drop-outs	ODR SHP	SAPC	FSP	Other	None
N	**30**	**14**	**4**	**11**	**1**	**23**	**3**	**11**	**5**	**4**	**45**	**12**	**14**	**11**	**3**	**5**
12-month pre-period (includes all 98 enrollees)																
Employed/stipend (N)	6	2	1	3	0	9	0	5	1	3	11	5	1	3	2	0
Employed/stipend (%)	20.0	14.3	25.0	27.3	0.0	39.1	0.0	45.5	20.0	75.0	24.4	41.7	7.1	27.3	66.7	0.0
Program completion (includes 30 individuals who graduated)																
Employed/stipend (N)	4	2	0	2	0											
Employed/stipend (%)	13.3	14.3	0.0	18.2	0.0											

NOTE: ODR SHP = Office of Diversion and Reentry Supportive Housing Program; SAPC = Substance Abuse Prevention and Control residential substance abuse treatment program.

Table A.7. Living Situation by Data Collection Time Period and Service Pathway

	Graduated					Still Enrolled					Dropouts					
	All Grad-uates	ODR SHP	SAPC	FSP	Other	All Still Enrolled	ODR SHP	SAPC	FSP	Other	All Drop-outs	ODR SHP	SAPC	FSP	Other	None
N	**30**	**14**	**4**	**11**	**1**	**23**	**3**	**11**	**5**	**4**	**45**	**12**	**14**	**11**	**3**	**5**
12-month pre-period (includes all 98 enrollees)																
Homeless (N)	6	5	0	1	0	5	2	2	0	1	17	4	4	4	2	3
Homeless (%)	20.0	35.7	0.0	9.1	0.0	21.7	66.7	18.2	0.0	25.0	37.8	33.3	28.6	36.4	66.7	60.0
Domiciled (N)	24	9	4	10	1	18	1	9	5	3	27	8	9	7	1	2
Domiciled (%)	80.0	64.3	100.0	90.9	100.0	78.3	33.3	81.8	100.0	75.0	60.0	66.7	64.3	63.6	33.3	40.0
Unknown (N)	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0
Unknown (%)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.2	0.0	7.1	0.0	0.0	0.0
Program completion (includes 30 individuals who graduated)																
Homeless (N)	2	1	0	1	0											
Homeless (%)	6.7	7.1	0.0	9.1	0.0											
Domiciled (N)	25	11	4	9	1											
Domiciled (%)	83.3	78.6	100.0	81.8	100.0											
Jail (N)	3	2	0	1	0											
Jail (%)	10.0	14.3	0.0	9.1	0.0											

NOTE: ODR SHP = Office of Diversion and Reentry Supportive Housing Program; SAPC = Substance Abuse Prevention and Control residential substance abuse treatment program.

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