

**Alameda County Sheriff's Office**  
**Mentally Ill Offender**  
**Crime Reduction Grant**

***Final Evaluation Report***  
***FY2016-18***

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### **About Hatchuel Tabernik & Associates**

Hatchuel Tabernik & Associates (HTA) is a consulting firm whose mission is to support and empower organizations to create a more healthy, educated, equitable and just society. From our experiences as social service practitioners and as researchers, planners, and evaluators, we understand that complex social issues require collaborative and comprehensive solutions in order to truly move the needle and create lasting social change. HTA has been designing and conducting program evaluations since 1996.

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## Introduction

Since 2009, partnering agencies –Alameda County Probation, Health Care Services Agency, Social Services Agency, District Attorney, Public Defender, Community Development Agency, and many community-based organizations such as Building Opportunities for Self Sufficiency (BOSS), La Familia Counseling, Building Futures, Options Recovery Services, the Bread Project, etc., have been working directly with the Alameda County Sheriff's Office Operation My Home Town (OMHT) case managers and program staff to create a wraparound, pre- and post-release clinical case management model aimed at assisting ex-offenders to lead productive lives in the community, decreasing recidivism, and improving public safety. In July 2015, the Alameda County Sheriff's Office (ACSO) was awarded a three-year Mentally Ill Offender Crime Reduction (MIOCR) funds from the Board of State and Community Corrections (BSCC) to expand OMHT to better serve seriously mentally ill (SMI) inmates being released from Santa Rita jail. The Youth and Family Services Bureau (YFSB) Manager, a Licensed Clinical Social Worker, manages the OMHT clinical case management model, the MIOCR expansion of OMHT, and other YFSB Behavioral Health programs. The YFSB Captain is responsible for the YFSB, Crime Prevention Unit, Behavioral Health Unit, Deputy Sheriff's Activity League, and School Resource Officer Unit. Clients served as part of this expanded program are referred to as MIOCR clients in this report; and the clinical case manager dedicated to MIOCR clients is referred to as the MIOCR case manager.

## Systems-Level Outcomes

### Cultivating & Leveraging Partnerships

In the past three years, the OMHT program leaders focused on relationship-building with critical program partners, such as the Alameda County multi-disciplinary forensic team led by BART Police Department and Behavioral Health Care Services (BHCS) – which oversees the Adult Forensic Behavioral Health (formerly named Criminal Justice Mental Health) division at Santa Rita Jail, and other significant behavioral health services provided by the county and contracted providers such as Building Opportunities for Self-Sufficiency (BOSS). Primarily through dedicated participation in multidisciplinary team meetings, OMHT staff maintained an active presence in the county and forged or built upon strategic relationships, framed within the context of improving services for the SMI population in Santa Rita Jail and as they transition into the community.

While OMHT has been committed to the development and cultivation of partnerships long before the MIOCR grant was awarded, grant funding helped to bring some partnerships to a new level through the piloting of new activities. BOSS, the Bread Project, and the Deputy Sheriffs' Activities League (DSAL) entered into subcontracts to bolster workforce development supports for the SMI population.

- 1) BOSS' contract included provisions for them to pilot evidence-based Individual Placement and Support (IPS) Employment<sup>1</sup> for 20 MIOCR clients during the grant-funded period via supervised wraparound employment services.
- 2) The Bread Project was originally envisioned to serve a similar role by providing skills instruction, on-the-job training, and an entrée into a career as a pastry chef.
- 3) DSAL created a curriculum and implementation plan to increase their capacity and ability to implement a paid internship program with worksite supervision with reentry clients and to

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<sup>1</sup> Go to <https://ipsworks.org/index.php/what-is-ips/> for more information on IPS Employment.

provide barrier reduction supports (e.g., emergency shelter, clothing, hygiene products, etc.) on behalf of SMI clients via the MIOCR clinical case managers.

According to program leaders, the contract with BOSS was very successfully executed. As promised, a total of 20 MIOCR clients were served, and will continue to be served beyond the grant period. When the grant came to an end, YFSB and BOSS program management met with Alameda County Behavioral Health Care Services (BHCS) to advocate for an increase in the IPS Employment contract to continue to serve the reentry population, thus making the work with MIOCR clients sustainable. BHCS made a commitment to make continuation of the work possible.

The contract with Bread Project was reportedly not quite as successfully executed. Although their contractual work was implemented in good faith, it was found that MIOCR clients were not a good fit for their program. It was discovered that for clients to succeed in the Bread Project's training an individual needs to be self-motivated and generally at a higher functioning mental health level. Some MIOCR clients started the program, but did not show up for all of the training. Although this program did not work well for all SMI clients, the program leaders agreed that the partnership was strengthened and both groups learned much on how they could work successfully with higher functioning clients moving forward.

It is too soon to make a judgement regarding the success of the contract with DSAL as they were just launching their reentry internship program as the MIOCR grant came to an end. However, the initial work has been positively received by program leaders. In the last four months of the grant period, DSAL worked closely with Earthseed Consulting to design and plan for a Dig Deep Farms (DDF) Reentry Internship implementation, which included an outreach strategy, onboarding toolkit for all DDF managers, training curriculum for the reentry population including SMI clients, and 2-day "train the trainer" intensive training for DDF managers. According to the DSAL Executive Director, DDF managers had struggled in the past to oversee justice-involved interns, many of whom struggled with serious mental health issues, in a successful way. Therefore working with the experienced Earthseed Consulting group<sup>2</sup> allowed the DDF team to think in a long-term and sustainable way in working with justice-involved interns. The training curriculum includes how to effectively provide barrier reduction supports via OMHT clinical case managers and arrange meaningful and well-earned stipends to interns.

Key informant interviews were held with the Adult Forensic Behavioral Health Program Discharge Planner and a Workforce Development Specialist from Alameda County Training & Education Center to characterize the level of collaboration between agencies and define the ways in which they work together to best serve clients. Collaboration with MIOCR was described at two levels: 1) top level and 2) ground level. Top level collaboration was described as having MOUs established between all of the different agencies and participating in regular Steering Committee meetings. On the ground level, collaboration involved partners working with clinical case managers to establish re-entry plans for individual clients.

The Steering Committee meetings were especially valued as they provided a regular time and place to touch base with clinical case managers for case review and collaboration. However, partners

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<sup>2</sup> Using regenerative strategies and new media approaches, Earthseed Consulting engages multiple stakeholders in the design and implementation of innovative projects aimed at diverse communities.

acknowledged that they did not attend every meeting, due to heavy workloads and other logistical conflicts. According to partners, the biggest challenges in working with MIOCR included:

- Silo Effect – despite all partners being dedicated to collaboration, there is a lack of communication between agencies at the clinician level. There is currently no “liaison” between agencies to help triage referrals.
- Although standing meetings are scheduled (both through MIOCR and through other agencies), partners cannot consistently attend with the dedication that would make the collaborative aspect of meetings most fruitful.
- There is no central place for tracking MIOCR enrollment, so other agencies are not always aware of who is a MIOCR client and who is not.
- The MIOCR program did not start with processes in place – it evolved over time into its strengths as the grant funding came to an end.
- Some clients fell into gaps, due in part to the lack of central tracking, so that there is sometimes dual enrollment with other programs and then services were not as coordinated or as all-encompassing as they could be if communication and systems were stronger.

The most promising elements of MIOCR according to the program partners included:

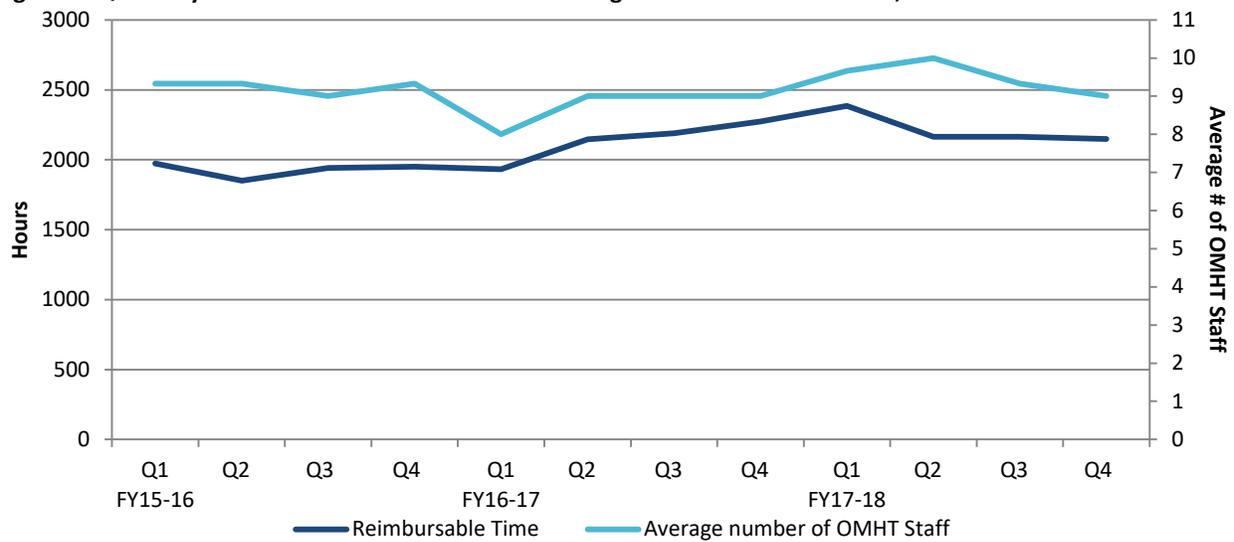
- The multidisciplinary team approach
- Recognizing each client as an individual with distinct characteristics and complexities
- Clinical Case Management that included addressing the need for making overall behavioral changes to lead to more promising outcomes
- Strong communication with clinical case managers including report outs as standing agenda items at meetings, and regular client case reviews
- High levels of outreach to clients while in custody
- Pre-release engagement, which does not happen with other agencies due to an inability to bill Medi-Cal for clients in custody
- A willingness to follow clients for the long term (longer than most other programs)

## Growing Sustainability

The YFSB administration continues to focus on building a sustainable plan through an ongoing revenue stream by leveraging the Affordable Care Act in billing clinical care provided to OMHT and MIOCR clients with Medi-Cal. Due to the medical necessity requirements for Medi-Cal covered services, not all of the OMHT-MIOCR clients will qualify for Medi-Cal reimbursable services depending on the severity of their mental health symptoms. Therefore, YFSB also draws down federal reimbursement via the Medi-Cal Administrative Activities (MAA) program through a Time Survey process of accounting for health-related administrative activities.

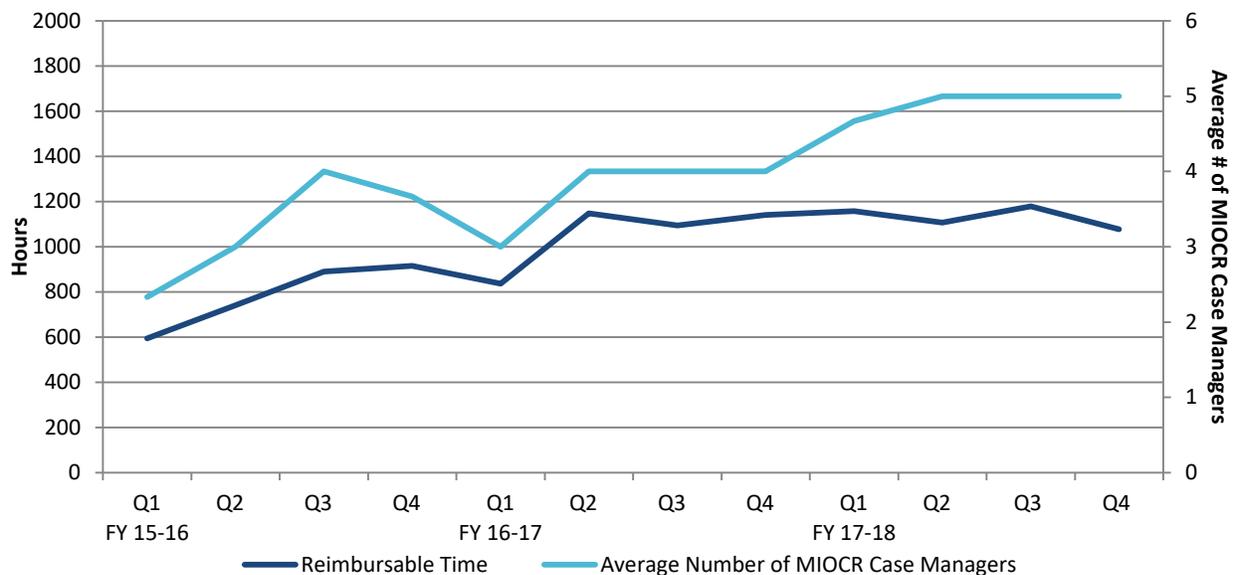
Figures 1 and 2 presents the quarterly MAA reimbursable time and staffing for OMHT and MIOCR case managers from July 2015- June 2018. The changes in the number of reimbursable hours and average number of OMHT staff mirror each other. Throughout the three years, as the number of OMHT staff increases or decreases, so does the total number of reimbursable hours. The same holds when considering the change in capacity of MIOCR case managers alone. As MIOCR case manager staffing increased, so did the number of reimbursable hours, though in the final year of the program there is a slight divergence. The average number of MIOCR case managers increased, while the total reimbursable hours remained constant.

**Figure 1. Quarterly MAA Reimbursable Time<sup>3</sup> and Average Number of OMHT Staff, FY 2015-2018**



Source: Medi-Cal Administrative Activities (MAA) data, July 2015-June 2018

**Figure 2. Quarterly MAA Reimbursable Time and Average Number of MIOCR Case Managers, FY 2015-2018**



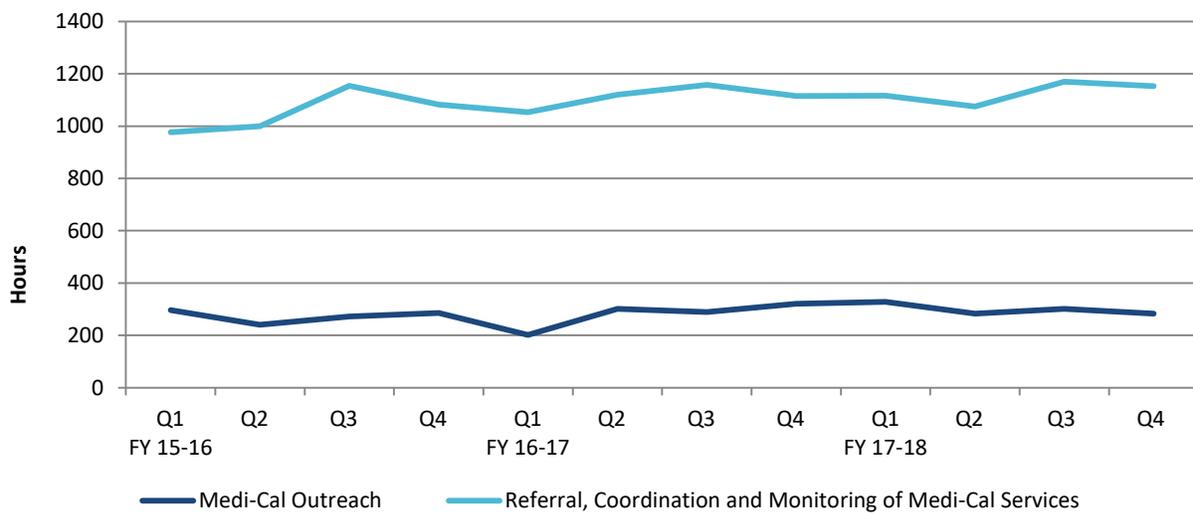
Source: Medi-Cal Administrative Activities (MAA) data, July 2015-June 2018

The majority of OMHT staff’s reimbursable time in all three fiscal years was spent conducting “Medi-Cal Outreach” (YFBS Code 4) and “Referral, Coordination, and Monitoring of MediCal Services” (YFBS Code 6). Figure 3 presents the top three reimbursable time categories for OMHT

<sup>3</sup> Reimbursable time includes the following YFBS codes: 4-MediCal outreach, 6-Referral, coordination, and monitoring of MediCal services; 8-Facilitation MediCal applications; 10-Arranging and/or providing non-emergency, non-medical transportation to a MediCal covered service; 12-Contract administration (A) for MediCal services for MediCal populations; 13-Contract Administration (B) for MediCal services for MediCal and non-MediCal populations; 15-Program planning & policy development (A) (non-enhanced) - MediCal services/MediCal clients; 16-Program planning & policy development (A) (enhanced) - MediCal services/MediCal clients; 17-Program planning & policy development (B) (non-enhanced) - MediCal services/MediCal & non-MediCal clients; 18-Program planning & policy development (B) (enhanced-SPMP) - MediCal service/MediCal & non-MediCal clients; 19-MAA/TCM coordination and claims administration; and 20-MAA/TCM implementation training

case managers from July 2015-June 2019. Over the three fiscal years, the number of hours spent on “Referral, Coordination, and Monitoring of MediCal Services” increased slightly, while the number of reported hours for “Medi-Cal Outreach” remained stable. When considering only MIOCR case managers, the two categories of reimbursable time with the most recorded hours (excluding PTO) were the same as for all OMHT staff, but there was a clearer upward trend in the number of hours for each category was observed over the program’s three years (data not shown).

**Figure 3. Top Two MAA Reimbursable Time Categories (excluding PTO) of OMHT Case Managers, FY 2015-2018**



Source: Medi-Cal Administrative Activities (MAA) data, July 2015-June 2018

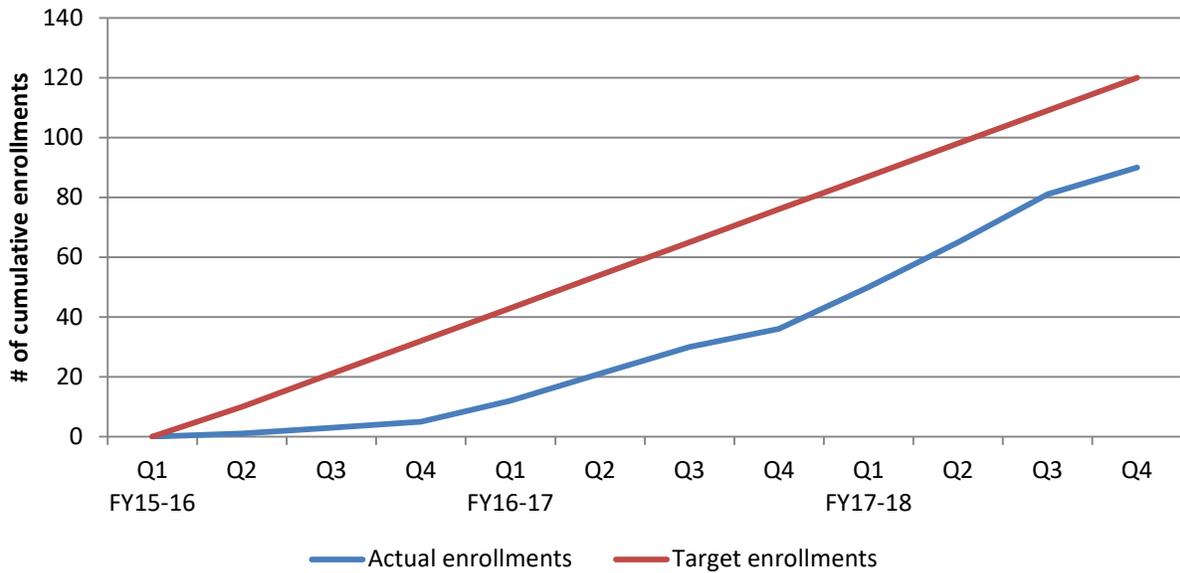
## Building Capacity & Professional Development

### Capacity to Serve SMI Clients

Figure 4 presents the cumulative enrollments over the three years of implementation. In the first fiscal year of the program, only five clients had been enrolled in the MIOCR program. However by the end of the second and third years, enrollment increased to 36 and 90, respectively. The goal was to serve 120 clients by the end of the grant period.

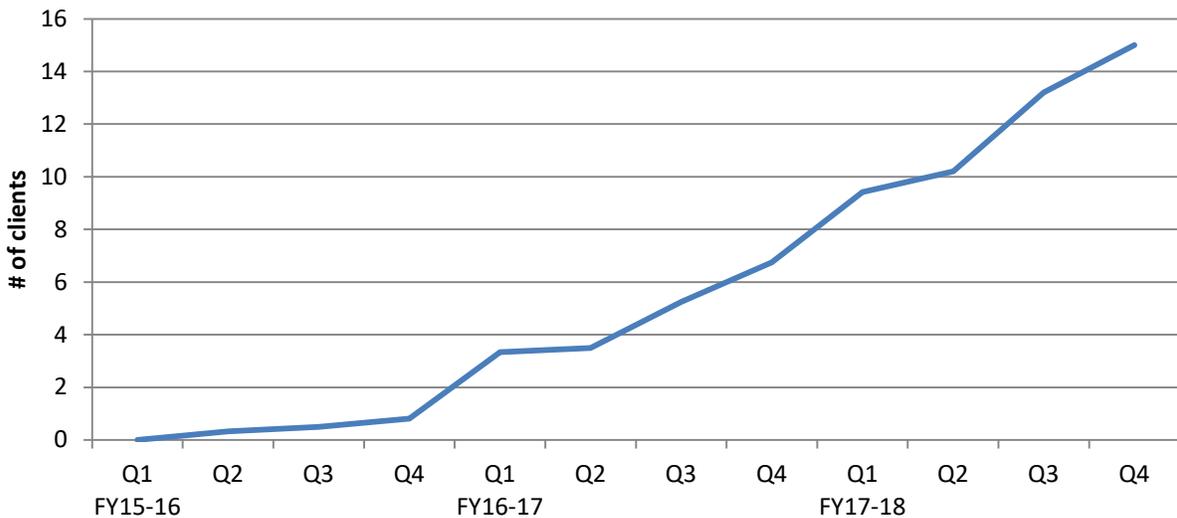
It quickly became clear in the first year that the initial estimate of MIOCR clients for this project was going to be difficult to obtain with only one MIOCR-client-dedicated clinical case manager. Therefore by the end of Q1 of FY2016-17, YFSB developed a contingency plan by hiring an additional MIOCR clinical case manager and to utilize a portion of the caseloads for three additional OMHT clinical case managers to serve MIOCR clients.

**Figure 4. Cumulative MIOCR Enrollments, FY2015-2018**



Source: OMHT Enrollment Data, July 2015-2018

**Figure 5. Ratio of MIOCR Clients to Case Managers, FY2015-2018**



Source: Medi-Cal Administrative Activities (MAA) data, July 2015-June 2018; OMHT Enrollment Data, July 2015-2018

Figure 5 graphs the MIOCR client to case manager ratio over the three years of the implementation<sup>4</sup>. It is clear that the ratio of clients to case managers steadily increased over time as additional clinical case managers were trained to work with MIOCR clients and enrollment numbers increased, with an average of 15 clients to 1 case manager by the end of the last quarter.<sup>5</sup>

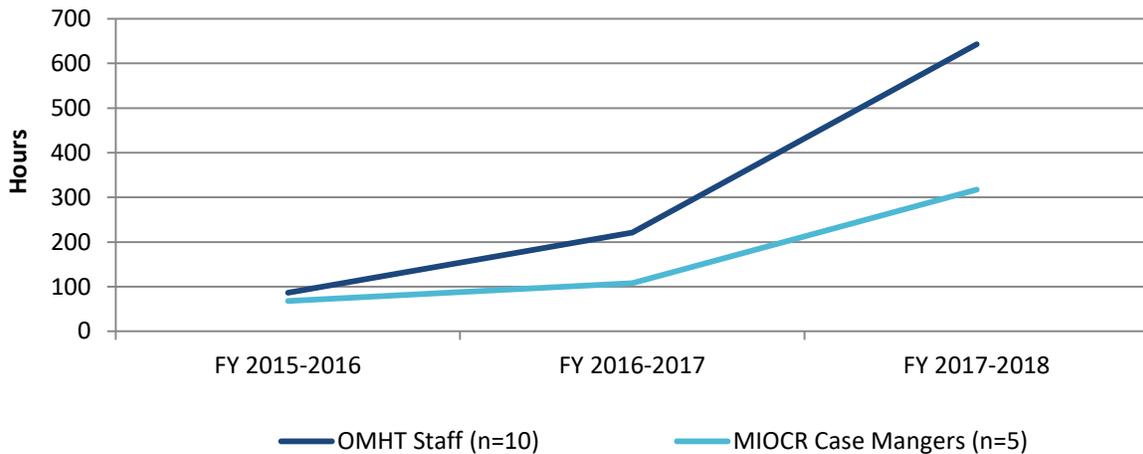
<sup>4</sup> Calculated as the number of active clients in each quarter divided by the number of FTE MIOCR case managers in each quarter.

<sup>5</sup> Over the three years, a total of six unique CCMs worked with MIOCR clients (two FTE; two 0.25FTE; and two with 2-3 cases each; one of the FTE left in the first program year and was replaced by the second FTE)

## Professional Development of Case Managers

Throughout the three years of the program, the number of hours of professional development for OMHT clinical case managers increased. Figure 6 shows the professional development hours of OMHT and MIOCR-client dedicated clinical case managers from FY 2016-2018. As seen, the number of professional development hours increased threefold.

**Figure 6. Professional Development Hours Completed, OMHT Staff<sup>6</sup> & MIOCR Case Managers, FY2015-18**



Source: OMHT-MIOCR Training Log, 2015-2018

Out of all time spent on professional development, 62% was spent on learning and practicing therapeutic and trauma-informed evidence-based practices, including: family therapy; cognitive behavioral therapy; motivational interviewing; psychotherapy; Seeking Safety therapy; mindfulness, energy psychology (EP), and Screening, Brief Intervention and Referral to Treatment (SBIRT).

Other learning opportunities included the following professional development topics:

- Adult suicide assessment and intervention
- Treatment outcomes with formerly incarcerated clients
- Psychiatric medications
- Electronic health records/clinical documentation
- Forensic Mental Health Association of California (FMHAC) Annual Conference
- Milton H. Erickson Foundation's Evolution of Psychotherapy conference

## Cost Per Participant

One way to determine the effectiveness of a program is to analyze the cost of the program per participant. Theoretically, the lower the cost per participant, the more valuable a program is. If the cost seems exorbitant, it is one indicator that a program might not have been as efficient or effective as it could have been.

To determine the cost per participant we developed the following formulas:

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<sup>6</sup> OMHT staff consists of 8 Case managers and 2 supervisors

**Figure 7. Formula for determining the cost of evaluation per participant**

$$\text{Evaluation cost per participant} = \frac{\text{Evaluation expenditures}}{\text{MIOCR Clients Served}} = \frac{\text{Evaluation Costs expended for the MIOCR grant project each year}}{\text{Number of new MIOCR clients + Number of active MIOCR clients}}$$

**Figure 8. Formula for determining the cost of the program per participant**

$$\text{Program cost per participant} = \frac{\text{Expenditures}}{\text{MIOCR Clients Served}} = \frac{(\text{MIOCR Grant Funds + Cash Match + In-Kind Match expended each year}) - \text{Evaluation Costs expended for the MIOCR grant project each year}}{\text{Number of new MIOCR clients + Number of active MIOCR clients}}$$

**Evaluation Costs**

The MIOCR evaluation included ongoing meetings and project check-ins with the client; the development of a comprehensive evaluation plan, including a logic model and performance measures; conducting a literature review and working with the client to select appropriate instruments for the population (namely the Brief Symptom Inventory); data collection monitoring and quality checks; data entry; interviews with all MIOCR clinical case managers at two points in time (February and May 2018) some spanning three days to collect outcome data on all clients; a case manager focus group; key informant interviews; participation in BSCC site visits; and annual evaluation reports. This cost a total of \$142,500 over three years, or \$1,583 per client.

$$\text{Evaluation cost per participant} = \frac{\$142,500 \text{ expended}}{90 \text{ clients served}} = \$1,583$$

**Program Costs**

The MIOCR program itself (minus the evaluation) expended \$2,683,062 over three years<sup>7</sup> (the majority of which came from in-kind contributions), or \$29,812 per client. In light of the systems-level outcomes mentioned previously and the client-level outcomes outlined on the pages to come, and considering the high needs of the SMI re-entry population, this amount seems reasonable and justified.

$$\text{Program cost per participant} = \frac{\$2,683,062 \text{ expended}}{90 \text{ clients served}} = \$29,812$$

<sup>7</sup> State funds (not including the evaluation) = \$1,109,640; In-kind match = \$1,573,422.

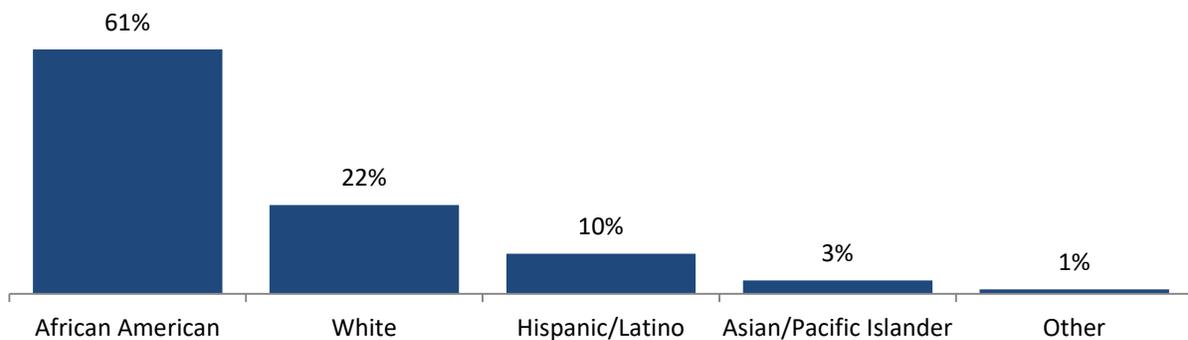
# Client-Level Outcomes

## Baseline Characteristics

### Demographics

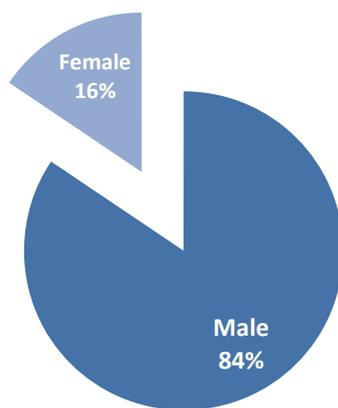
Figures 9-11 and Table 1 show the demographics of enrolled MIOCR clients. Of the 90 clients enrolled in MIOCR, the majority of clients were African-American/Black (61%), male (84%), and with an average age of 36 years. While 18% were transitional age youth (18-25 years), and 19% were over the age of 45 years, the majority were between 26-44 years of age.

**Figure 9. Race/Ethnicity of MIOCR Clients, FY2015-18 (n=90)<sup>8</sup>**



Source: OMHT Enrollment Data, July 2015-2018

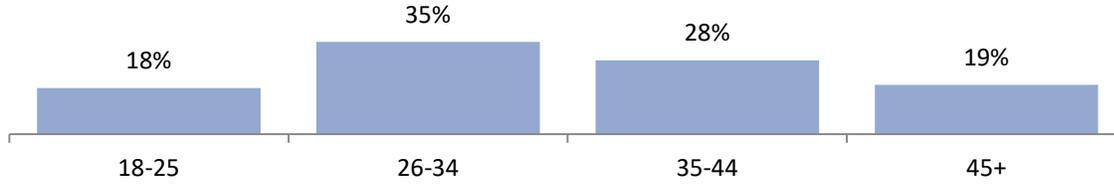
**Figure 10. Gender of MIOCR Clients, FY2015-18 (n=90)**



Source: OMHT Enrollment Data, July 2015-2018

<sup>8</sup> The total percent is less than 100%, as 2 clients refused to provide race/ethnicity.

**Figure 11. Age Distribution of MIOCR Clients, FY2015-18 (n=85)**



Source: OMHT Enrollment Data, July 2015-2018

**Table 1. Age Statistics of MIOCR Clients, FY2015-18 (n=85)**

Minimum	Maximum	Mean	Std. Deviation
19	65	35.81	11.3

Source: OMHT Enrollment Data, July 2015-2018

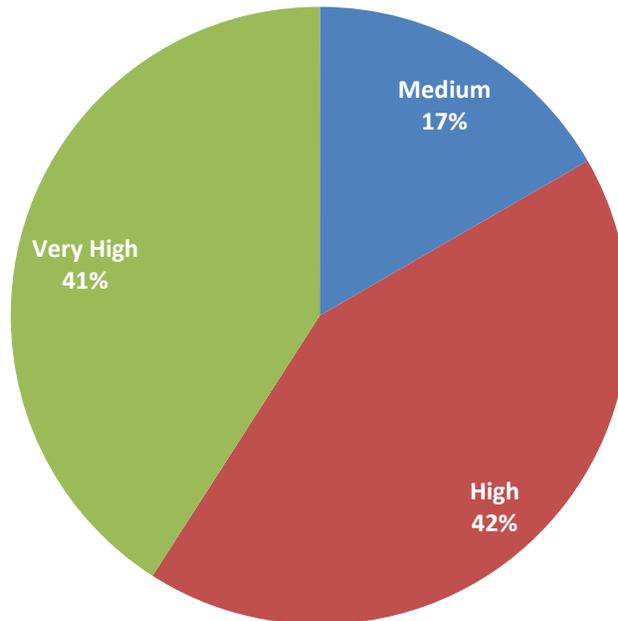
### **Criminogenic Risk Factors/Needs**

Evidence-based practices recommend that offenders be screened or triaged with an actuarial risk/needs assessment and that treatment resources be reserved for those at highest risk to re-offend<sup>9</sup>. OMHT uses the *Level of Service/Case Management Inventory (LS/CMI)* instrument which is a well validated assessment that measures the risk and need factors, as well as strengths, of late adolescents and adult offenders, both male and female. It is a fully functioning case management tool, that the clinical case managers use to match level of service to level of risk/need (i.e., clients assessed as high risk receive intensive services, medium risk receive monthly services, and so on).<sup>10</sup> Of the 90 clients enrolled in MIOCR, 73% (66 of 90) had a complete and valid LS/CMI assessment in the case manager file. Of these, 83% were deemed to be at high or very high risk/need. See Figure 12.

<sup>9</sup> Crime and Justice Institute at Community Resources for Justice (2009). *Implementing evidence-based policy and practice in community corrections*, 2<sup>nd</sup> edition. Washington, D.C.: National Institute of Corrections.

<sup>10</sup> Andrews, D.A., Bonta, J.L., Wormith, J.S. 2004. *Level of Service/Case Management Inventory (LS/CMI™): An Offender Assessment System. User's Manual*. Multi-Health Systems, Inc.: North Tonawanda, NY

Figure 12. LS/CMI Total Risk/Need Levels for MIOCR Clients, n=66



Source: OMHT LS/CMI Data, July 2015-2018

Not surprisingly, the majority (55-67%) of clients scored as **high** or **very high risk/need** in six of the eight LS/CMI domains or sub-categories<sup>11</sup>:

- 67%-- **Anti-Social Patterns** domain, indicating many symptoms consistent with Antisocial Personality Disorder, e.g., extreme egocentrism, patterns of violations of trust and responsibility, overt hostility and anger, and disregard for rules and feelings of others;
- 65%-- **Companions** domain, indicating a high number of friends and acquaintances involved in crime who serve as models for behavior and interpersonal sources of rewards and costs;
- 64%-- **Family/Marital** domain, indicating negative or destructive relationships with spouse or equivalent, parent/guardians, or other close relatives, and these close relatives may serve as models or supports for unlawful behavior;
- 62%-- **Leisure/Recreation** domain, indicating significant free and idle time outside of education/employment, family/marital and pro-social activities combined with personality characteristics conducive to filling up this free time in “exciting ways”;
- 59%-- **Alcohol/Drug Problems** domain, indicating high history and/or current levels of alcohol or drug abuse, and large impact of alcohol or drug use on school, work, family, marriage, legal status, and physical health; and
- 55%-- **Criminal History** domain, indicating a high past history of criminal behavior in terms of frequency, variety of settings, early onset and seriousness.

<sup>11</sup> Based on: Andrews, D.A., Bonta, J.L., Wormith, J.S. 2004. Level of Service/Case Management Inventory (LS/CMI™): An Offender Assessment System. User’s Manual. Multi-Health Systems, Inc.: North Tonawanda, NY

On other hand, the majority (53-55%) of clients were **very low, low, or medium risk/need** on the two LS/CMI domains:

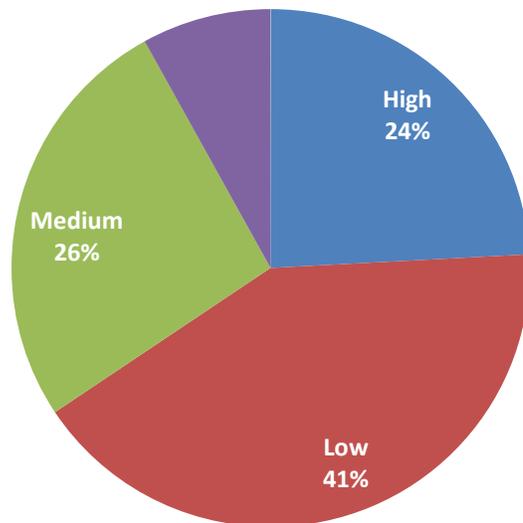
- 53%-- **Education/Employment** domain, indicating high levels of participation, involvement, achievement and commitment to the social institutions of education and employment; and
- 55%-- **Pro-Criminal Attitudes** domain, indicating that high levels of comprehension of the negative consequences of criminal activity on self, victims and community, and that they have positive attitudes towards conventional or noncriminal others.

Taken together, this suggests that outside of jail, the clients had a significant amount of free and idle time that could be filled with pro-social activities, alcohol and drug treatment, and possibly education/employment training opportunities, as well as a need for increased exposure to pro-social and productive peers. In addition, the high proportion of clients with low pro-criminal attitudes indicates the potential for the building of a positive, pro-social support system that can help reduce the client's future involvement in criminal activity.

### **Mental Health Status**

While being diagnosed as SMI was a requirement to enroll in MIOCR, Behavioral Health Care Services (BHCS) records were examined by the YFSB Manager to verify that clients had been clinically diagnosed as SMI. This audit found that 97% (87 of the 90) were indeed diagnosed as SMI.

**Figure 13. Level of Functioning for Seriously Mentally Ill MIOCR Clients, n=87**



**Source: OMHT-MIOCR Enrollment Data, July 2015-2018**

Of those who had been diagnosed as SMI, 41% were deemed to be low-functioning. (See Figure 13.) Individuals who are low-functioning may have significant impairments in the following:

- Self-care;
- Ability to maintain adequate nutrition, shelter and other essentials of daily living;
- Social-interpersonal functioning;

- Educational/occupational role; and
- Managing medications without support

These individuals may also experience symptoms despite medication treatment adherence. As a result, such individuals may require 24/7 crisis response, daily treatment (such as provided in residential treatment) and support staff available around the clock in addition to targeted case management provided several times per week.<sup>12</sup>

To understand the extent of mental health symptoms and severity experienced by clients during the implementation, the OMHT clinical case managers were instructed to administer the Brief Symptom Inventory (BSI) instrument to MIOCR clients at enrollment and six-months post-enrollment. The BSI is a commonly used, validated and reliable tool that has been tested in more than 400 research studies; it can be used to monitor change in mental health symptoms.<sup>13</sup> To administer the BSI, all clinical case managers had to receive training which was completed in the fall of 2015; the first BSI instruments were completed in February 2016. Of the 90 MIOCR clients, 61 had complete and valid baseline BSI assessments; only 9 had completed BSI assessments at the 6-month follow-up. Table 2 presents the baseline BSI results. Of the 61 clients with a valid BSI completed at baseline, 84% had mental health symptoms consistent with two or more psychological disorders. The most prevalent disorders (i.e., greater than 60% of clients had symptoms consistent with the disorders) were: psychoticism, paranoid ideation, obsessive-compulsive, and phobic anxiety.

**Table 2. Percent of MIOCR Clients with Symptoms Consistent with Specific Psychological Disorder (n=61)**

Disorder	N	%
Two or more disorders	61	83.6%
Psychoticism	59	88.1%
Paranoid Ideation	58	72.4%
Obsessive-Compulsive	58	69.0%
Phobic Anxiety	59	64.4%
Depression	58	50.0%
Interpersonal Sensitivity	60	50.0%
Anxiety	57	49.1%
Somatization	57	43.9%
Hostility	58	43.1%

Source: OMHT-MIOCR BSI Data, Feb 2016- June 2018

In a clinical case manager focus group held at the end of the grant (August 2018), there was further elaboration about how these mental health symptoms impact clinical case management. For example something as simple as administering the LS/CMI or BSI reportedly “can be triggering” for a client with psychosis, and then the results “may not always be accurate.”

<sup>12</sup> Anderson, A.J. (1999). Functional assessment of mental health and addiction: A treatment planning and evaluation strategy for clients suffering from co-morbidity. *International Journal of Psychosocial Rehabilitation* 4, 39-45.

<sup>13</sup> Pearson Clinical Psychology: Brief Symptom Inventory (BSI®) product page. Retrieved August 31, 2018, from <https://www.pearsonclinical.com/psychology/products/100000450/brief-symptom-inventory-bsi.html>

The case managers agreed that the high percentage of MIOCR clients with symptomatology of psychoticism, paranoid ideation, etc., calls for a different approach. As described by case managers:

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“I approach them similarly to my adolescent clients. Explaining things more, going into their world. More hands on. Even as simple as helping to make a phone call because they may have dissociative disorder and forget they ever made a call.”

“The literacy level of a MIOCR client could actually be the same as a typical reentry client, but with a condition like schizophrenia, it is functionally much worse.”

“Scheduling is a challenge. They need structure and immediate results. Their frustration tolerance is low.”

“Safety is a concern. I won’t be in a car or certain spaces with them because they can be impulsive. Even if they are in maximum security, it is a concern if they are triggered. They can have intense anger issues.”

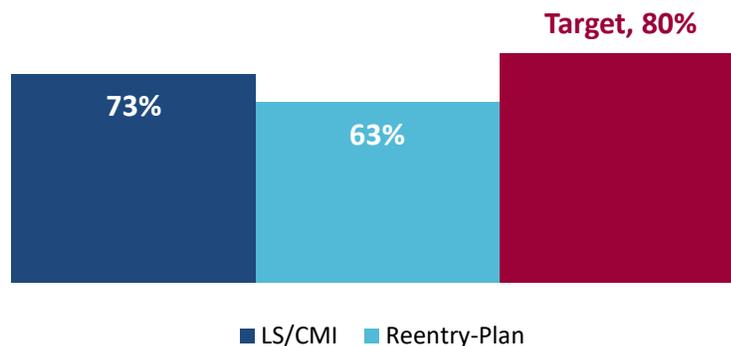
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## Case Management and Referrals

### Pre-Release Engagement

When the MIOCR expansion was first envisioned it was presumed that at least 80% of MIOCR clients would complete their reentry plan with their case manager (guided by results attained from the LS/CMI assessment). Often these reentry plans would be completed in partnership with the client before they were released from Santa Rita Jail. By the end of the grant period, 66 (or 73%) of the 90 clients completed the LS/CMI and 57 reentry plans (for 63% of clients) were completed. (See Figure 14.) This is close to the target that was set for the program; however, slightly fewer re-entry plans were completed than anticipated.

**Figure 14. Pre-release engagement with Case Managers**



**Source: OMHT-MIOCR Enrollment Data, July 2015-2018**

Anecdotally, clinical case managers reported that the primary reasons for incomplete LS/CMIs, included clients housed in restrictive/maximum security housing units or administrative segregation; clients always presenting in crisis and/or suffering from extreme paranoia; and general lack of

engagement. Additionally, some reentry plans were not developed for clients who were going to be transferred to prison, another county jail, or Napa State Psychiatric Hospital; clients whose legal cases were very slow moving for whom long-term plans could not yet be defined; or clients who were duplicatively and simultaneously engaged with other case management programs, such as Bay Area Community Services (BACS) or the Regional Center.

### **Post-release Engagement**

Post-release engagement with case managers ranged from 0 to 27 contacts (in person or via phone) and averaged 5 contacts per MIOCR client. More than two-thirds (69%) of the clients who had been released from jail (n=75) had at least one contact with their clinical case manager post-release. Engagement ranged between 2 and 480 minutes, and averaged approximately one hour (55 minutes to be exact). Approximately 13% of post-release contacts were in jail, as several clients recidivated relatively quickly, and were often more prone to engagement while in custody.

The “typical” MIOCR client is often far more demanding and requires much more time than the general reentry population, due in large part to the severities of their mental health conditions. As described by one MIOCR case manager:

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“One MIOCR client could take up a whole week of my time. That’s very unusual for an OMHT client. As their case manager we have to be far more mindful of their condition. Where they are in their medications – did they stop, are they tapering off? We have to be far more tolerant. It can be extremely frustrating because they can very quickly undo a lot of work (e.g., no shows, relapsing).”

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Much of the work with MIOCR clients involved making referrals to and encouraging engagement with support services throughout the Bay Area. Of the 90 clients enrolled in MIOCR, referral data was available for 49 individuals. Of these, 78% of clients reportedly followed up with at least one referral partner. Clinical case managers spoke of several referrals that were made for clients to a number of organizations which fell into the following categories:

- 30% - Training, Education, and Employment
- 20% - Housing and Support Services
- 16% - Mental Health Services
- 15% - Substance Abuse Treatment (residential and outpatient)
- 10% - Health
- 6% - Legal Assistance
- 2% - Income/Financial Services
- 1% - Food Services
- 1% - Parenting Services

Given that we did not ask about all referrals that were made, or whether clients always successfully engaged in services, it is challenging to know whether the referrals were always matching client needs, but some preliminary conclusions may be drawn from the LS/CMI criminogenic risk/needs data and the referral data collected for MIOCR clients. Overall the LS/CMI data suggested the need for pro-social activities, alcohol and drug treatment, and possibly education/employment training opportunities, as well as a need for increased exposure to pro-social and productive peers. The

referral data suggests that the majority of clients were indeed directed to job training, education and employment services; mental health services; and substance abuse treatment services. In addition, many clients were referred to housing and support services – perhaps not surprising given the large proportion of clients with family/marital challenges (based on the LS/CMI) and presumably unable to rely on their families for housing following release from jail.

## **Outcomes**

### **Housing**

Of the 90 clients enrolled in MIOCR, short term housing outcomes data was available for 59 individuals. Of these 59 clients, 81% reportedly secured at least some form of housing (i.e., not “on the streets”) upon release from jail. Housing status upon release fell into the following categories:

- 41% - treatment program/sober living environment/halfway house
- 19% - with family member(s)
- 19% - homeless
- 14% - with significant other
- 5% - used motel vouchers
- 2% - returned to own home
- 2% - not specified

Longer term housing outcome data (6+ months post-release) was only available for 37 of the 90 clients. Of these 37 clients, 62% were reportedly living in a stable housing situation six or more months post-release. Longer term housing status fell into the following categories:

- 38% - homeless/initial housing unstable (e.g., went AWOL, relapsed and back on streets)
- 27% - with family member(s)
- 14% - secured apartments (with support)
- 11% - treatment program/SLE/halfway house
- 5% - with significant other
- 5% - not specified

### **Financial Resources**

Of the 90 clients enrolled in MIOCR, short term income data was available for 37 individuals. Of these 37 clients, 92% reportedly applied for some type of benefits and/or employment within three months of release from jail. Outcomes for those applications were known for 32 individuals; 78% were reportedly able to secure some form of legal income, either from public benefits or employment. Approximately half (48%) of those who secured income received it in the form of public benefits (e.g., SSI, GA, food stamps, etc.). The other half secured at least temporary jobs, some with a combination of public benefits. One individual was supported by an allowance from his family.

Longer term income data (6+ months post-release) was available for 20 of the 90 clients. Of these 20 clients, 70% reportedly had a stable source of income in that they were able to maintain their source of income for the longer term.

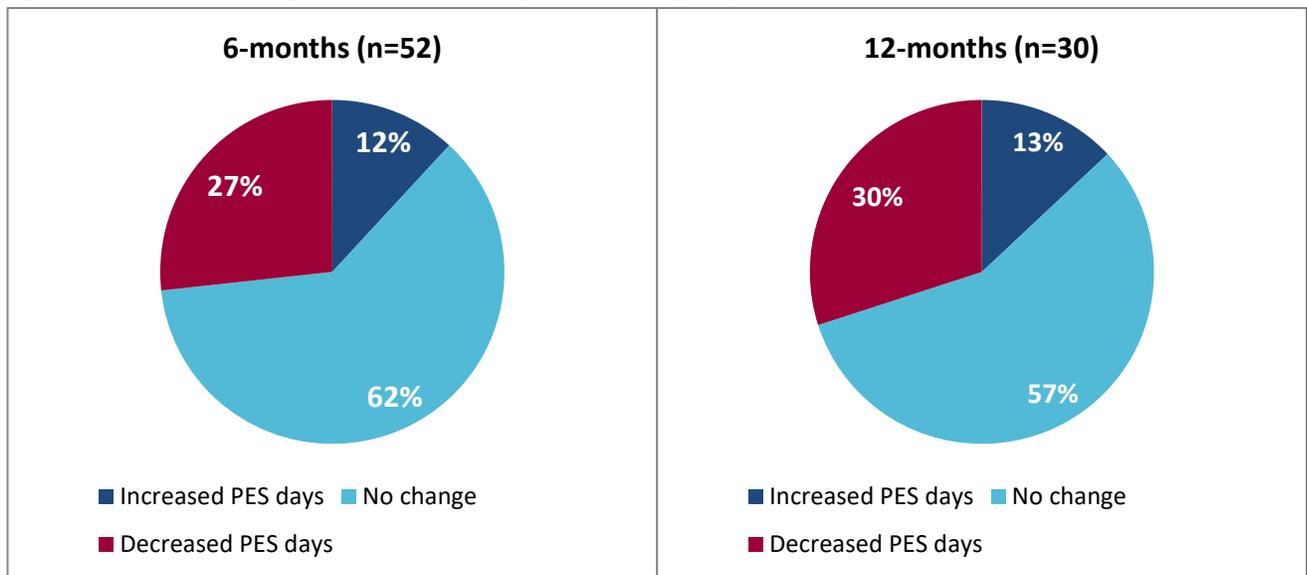
## Mental Health Symptoms

Of the 90 clients enrolled in MIOCR, short term mental health treatment data was available for 34 individuals. Of these, 74% were reportedly compliant with their psychiatric treatment and meds. Longer term (6+ months) mental health treatment data was available for 20 individuals. Of these, 70% reportedly remained compliant with their psychiatric treatment and meds.

It was presumed that utilization of psychiatric emergency services (PES) would be reduced in comparison to the time period before the individual was enrolled in MIOCR. To test this hypothesis, PES episodes and length of stay at John George Hospital<sup>14</sup> was collected for MIOCR clients from the period of July 1, 2014 through June 30, 2018 (n=90).

Six-month pre-/post-enrollment PES data for all clients who had been in the program for at least six months was examined (n=52). While the majority of clients (62%) showed no change in PES length of stay from pre- to post-enrollment, over one-quarter (27%) decreased days of PES hospitalizations. In fact, the findings indicated that the average length of stay decreased from 1.02 days in the six months prior to enrollment to 0.38 days in the six months following release from jail. (This was not statistically significant at the 0.05 level.)<sup>15</sup> (See Figure 15.)

**Figure 15. Pre-/Post-Change in Utilization of Psychiatric Emergency Services at 6- and 12-months**



**Source: Alameda County Behavioral Health Care Services (BHCS) records 2014-18 (N=90), retrieved by YFSB, August 2018**

Moreover, we found that the average days of PES hospitalization at John George decreased from 1.33 days to 0.73 days from the period twelve months prior to enrollment to the one-year period

<sup>14</sup> The local hospital used for the majority of psychiatric emergencies in Alameda County; where most clients would most likely be taken.

<sup>15</sup> A paired-samples t-test was conducted to evaluate the impact of the MIOCR program intervention on clients' length of stay. The change in length of stay was not statistically significant from pre- ( $M=1.02$ ,  $SD=2.762$ ) to post-enrollment [ $M=.38$ ,  $SD=1.105$ ,  $t(52)=1.544$ ,  $p=.129$ ].

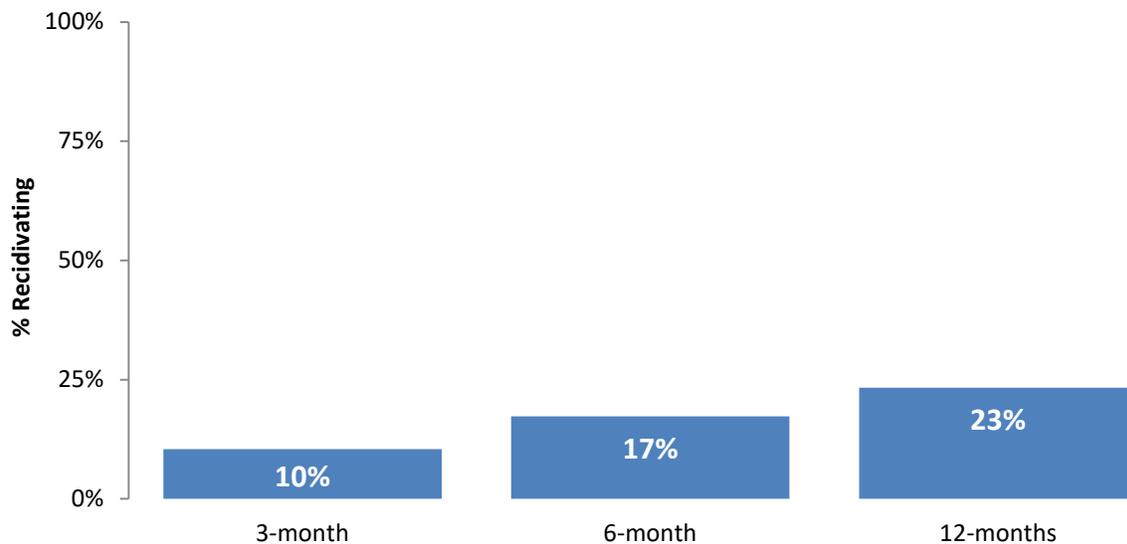
following release from jail (n=30). (This was not statistically significant at the 0.05 level.)<sup>16</sup> As with the six-month data, the majority of clients (57%) showed no change in hospitalizations before or after release; but nearly one-third (30%) of MIOCR clients showed a reduction in PES length of stay compared to the year prior to MIOCR enrollment. (See Figure 15.)

### Recidivism

From July 1, 2015 through June 30, 2018, recidivism data (i.e., return to jail/prison, arrests, violations of probation, and convictions) has been collected for MIOCR clients. Recidivism measures are based exclusively on official criminal records in CRIMS which the YFSB Sheriff Technician collected for this evaluation. This evaluation uses the following definition of recidivism: *Re-incarceration due to conviction for a new crime and/or violation of probation (VOP), within 12 months of release.*

Since clients were released from jail at different times throughout each program year; it is most useful to take into account the length of time an individual spent in the community. For example, an individual who was released three years ago cannot be compared equally with an individual who was released three months ago in regard to recidivism. The first individual has spent more time in the community, allowing for more opportunity to recidivate. Consequently, recidivism rates in this study are calculated *as if* they were follow-up rates. That is, they are calculated *as if* the researcher had individually followed up with each individual at 3-, 6-, and 12-months following their release from SRJ. As of this report, the longest period of time that recidivism rates could be calculated for a numerically-sufficient sample size was 12 months.

**Figure 16. Follow-up Recidivism Rates for Clients at 3-, 6-, and 12-months Post-Release (N<sub>3</sub>=67; N<sub>6</sub>=52; N<sub>12</sub>=30)**



**Source: Alameda County Recidivism data, 2015-18 (N=90)**

Figure 16 presents 3-, 6-, and 12-month recidivism rates for MIOCR clients. At 3-months post-release, 10% of the 67 clients released from jail at least three months prior had recidivated; at 6-months post-release, 17% of the 52 clients released from jail at least 6 months prior had recidivated.

<sup>16</sup> A paired-samples t-test was conducted to evaluate the impact of the MIOCR program intervention on clients' length of stay. The change in length of stay was not statistically significant from pre- ( $M=1.33, SD=2.869$ ) to post-enrollment [ $M=.73, SD=1.721, t(30)=1.095, p=.283$ ].

**By 12 months post-release, 23% of the 30 who had been released from jail at least one year prior had recidivated.** For comparison, the one-year recidivism rates seen for MIOCR clients are double the rate for OMHT clients and equivalent to the rates for “peers” based on the numbers reported in a 2016 OMHT evaluation report.<sup>17</sup> In this report, 10% of 91 OMHT clients released from jail at least one year prior had recidivated; 25% of the 67 peers<sup>18</sup> had recidivated.

**Table 3. Proportion of Recidivators by Offense Type**

Months since Release	N	Serious/Violent Offenses	Violation of Probation	Conviction for New Offense
3-months	7	57%	86%	14%
6-months	9	67%	67%	33%
12-months	7	57%	57%	43%

Source: Alameda County Recidivism data, 2015-18 (N=90)

Table 3 shows the proportion of MIOCR clients who recidivated at 3-, 6-, and 12-months post-release by the offense type. While the majority of MIOCR clients had not recidivated, those who did were more likely to be charged with serious, violent offenses. In addition, almost all individuals who recidivated had a VOP charge in addition to their other more serious charges. Moreover, all individuals who recidivated and were convicted for a new offense had been charged with a serious, violent offense.

### Client Stories: Case Studies

The stories behind each case can help to demonstrate the tremendous amount of work and care that is required to serve each individual. They can also demonstrate that when the work is implemented with care, positive results can emerge. The following case studies provide examples of the way in which the MIOCR expansion has continued to impact clients.



#### Case Study #1

Prior to his contact with OMHT-MIOCR, this 26-year-old African American male was on parole, residing in a Sober Living Environment. Within a few days of placement he connected with a friend and left. After using marijuana, cocaine, and alcohol, they stole a car and engaged in a high-speed chase, wrecking three other cars in the process. They were caught and arrested, and he was facing two years in jail with an option for half time.

His OMHT-MIOCR clinical case manager first engaged with him at the beginning of his first year back in jail. He was paranoid and had a mood disorder on the bipolar spectrum. His lawyer, a public defender, was of the belief that the client should serve the full two year sentence. However, the clinical case manager began to advocate for half time, believing that two full years in jail was not the best option for this young man. The public defender was not pleased with this advocacy, but the clinical case manager believed that this man would be destroyed in jail. Despite an attitude that he

<sup>17</sup> Toussaint, D. and Glatze, K. (2016). OMHT Evaluation, 2011-15, on behalf of the Youth and Family Services Bureau, Alameda County Sheriff's Office. Hatchuel Tabernik & Associates: Berkeley, CA.

<sup>18</sup> Based on a group of 67 individuals who were eligible to enroll in OMHT but declined to enroll. While this peer group is not the ideal match, no other peer group was available to compare.

could handle himself, within a few months he had a broken nose, two black eyes and knots all over his face.

The OMHT-MIOCR clinical case manager continued to meet with this client for several months, and also began to work with his parents, as without their cooperation family can become one of the biggest barriers to recovery. They began to understand how important it was for their son to get into a treatment program; how important it was for them to talk to him from the heart and set a good example for him. The clinical case manager came to court on his day of sentencing. It was not looking good. The lawyer was prepared to ask for the full sentence, but the judge let the clinical case manager speak. The court was moved, and a date was set for his half time release.

Before his release, the clinical case manager met with him to put the situation into perspective. He was being given an opportunity to move forward. He could go ahead and get killed in prison, or he could take some accountability for his recovery and get better. The clinical case manager was there to pick him up upon release. Hours passed, and what was meant to be a mid-day release became an 11:30pm release, but he was there the whole time. Being the middle of the night, his recovery program was not ready to take him in, so the clinical case manager had to bring him to his parents' home, trusting that they would take their work together to heart, and support their son in his recovery.

Today, this client is in Phase 3 of the Options recovery program, and is on track to graduate from the program in December. He holds a stable job, and goes to the gym religiously, wanting to keep himself strong and fit. He does not want to go back to jail, and is doing what he can to remain prosocial and healthy, maintaining a good relationship with his family. Through a partnership with Men's Warehouse, his OMHT-MIOCR clinical case manager got him some sharp new clothing. He is now looking good, feeling good, and on a positive course for a promising jail-free future.



## **Case Study #2**

This 25-year-old Mexican/Nicaraguan female is clinically schizophrenic and paranoid. Her schizophrenia began to manifest itself when she was 15, and had fully emerged by the time she was 19, at which point she had two young sons. She had no support systems in her life, and her illness left her “not fully present.” She began using drugs, and got into the jail system. Last year, she was on probation. She had been assigned a Social Worker, but with an overwhelming caseload the Social Worker had not made a connection. This woman was not remembering to take her medications, not showing up for meetings, and her situation became very serious, ultimately resulting in the involvement of Child Protective Services (CPS) and the subsequent removal of both of her sons.

Her OMHT-MIOCR clinical case manager met her when she was back in jail. She was completely zoned out, but somehow the clinical case manager was able to communicate to her how important it was for her to take her medication. “If you are interested in case management, I can help. But you have to help yourself too. You have to take your meds if you want things to happen.” With time, her clinical case manager found out about her children, and how much she wanted them back.

They went to behavioral health court together, and the clinical case manager agreed to transport her to an inpatient program. Everything was set up for her to be released to a small, community-based recovery house, but upon release, they suddenly decided that they did not want to take her. The clinical case manager urgently began to seek out another recovery program, but there were no beds

available. However, there was room in a one-month transitional program at Jay Mahler Recovery Center, a clean, safe place that provides three meals a day and requires residents to be med compliant. As is the case with many MIOCR clients, this woman had issues with trust, and having just been rejected from the other program she was reluctant to check in. However, with encouragement from the clinical case manager (“it will be wonderful for you; I will visit you; I will take you to appointments; you will be happy there...”) she went. Her clinical case manager checked in with her daily, hoping that within the month a bed would become available at Serenity House, a six-month to one-year program in Oakland, with room for 15.

After one month at Jay Mahler, the time limit there was reached, but there was no room yet at Serenity House. Again, another place had to be found for her. The clinical case manager acted on faith and asked her who she could trust to stay with. She said her father, who lived out of the county, in San Jose. Contacting the PO and agreeing to vigilantly monitor her whereabouts, the clinical case manager got permission to take her to her father, promising to provide transportation, promising she would stay put, promising she would take her meds, and promising that they would check in daily. As it turned out, the father spoke little English. Acting on faith again, the clinical case manager used the client as the translator to explain the situation to the father and emphasized the importance of taking meds, helping out around the house, and participating in recovery meetings at his church. She stayed there for three and a half weeks, sticking to the plan and checking in daily with the clinical case manager.

The call from Serenity House was sudden. A bed was available, but if she did not claim it immediately, it would be given away. The clinical case manager dropped everything and drove to San Jose to pick her up and get her to Oakland. Today she is doing wonderfully well. She has been fully compliant, and is now working with her clinical case manager to reunify with her children. The judge wants to hear her full story, and had scheduled a hearing for September 2018. She is a certified journeyman electrician, and has great potential for long-term, gainful employment. It has not been an easy road, but she is now well along the path to recovery.

## Conclusion/Recommendations

Overall, data from a wide range of sources pointed to a successful implementation of the MIOCR expansion, especially given the complexity of working with SMI clients. HTA recommends that OMHT continue to sustain and further develop components of the current MIOCR expansion to ensure alignment with best practices with the ultimate goal of reducing recidivism rates. The recognized eight principles of evidence-based practices<sup>19</sup> for reentry programs from the National Institutes of Correction are:

1. \*Assess actuarial risk and needs
2. Enhance intrinsic motivation
3. \*Target interventions in corrections (risk, need, treatment/responsivity, dosage)
4. \*Skill-train with directed practice
5. Increase positive reinforcement
6. Engage ongoing support in natural communities
7. \*Measure relevant processes and practices
8. Provide measurement feedback

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<sup>19</sup> National Institute of Corrections. (2004). *Implementing evidence-based practice in community corrections: The principles of effective intervention*. Washington, DC: Author.

The components that HTA recommends further development on are related to four of the principles, marked above with an asterisk (\*).

**Assess actuarial risk and needs.** Currently, OMHT uses the LS/CMI assessment to assess criminogenic risk and need factors for clients; moreover, internal processes and forms have been developed so that the LS/CMI results can drive the development of the reentry plan. However, we found that case managers were not always completing the LS/CMI assessment for all MIOCR clients (only 73% of the 90 MIOCR clients had a LS/CMI on file), or for those who received the assessment, the clinical case managers were not completing the LS/CMI with fidelity or in a timely manner. Therefore, we recommend that OMHT supervisors revisit the training schedule annually for all clinical case managers to ensure that the LS/CMI is being administered with fidelity as well as the results being linked to development of the re-entry plan. Also, we strongly suggest that the program incorporate quarterly audits of clinical case manager files to ensure the LS/CMI is being completed for all clients and with fidelity. (We acknowledge that there may be difficulties in administering the assessment while the client is in custody, especially if they are in the administrative segregation units; however, the assessment can be completed once they are released from jail.)

**Target intervention in corrections; Skill-train with directed practice.** The principle of targeting interventions has four components: risk principle, need principle, treatment/responsivity principle, and program integrity/fidelity principle. The goal of these principles is to match the appropriate treatment and dosage with the risk and needs of the offender<sup>20</sup>. For example, high-risk offenders should receive more intensive programming and for longer periods of time than low-risk offenders<sup>21</sup>.

As mentioned earlier, internal OMHT processes and forms were developed such that the LS/CMI results would drive the development of the reentry plan. In fact, the reentry plan incorporates the language of the LS/CMI so that the clinical case manager can rank the main risk/need factors and then write out how the client plans to address each of these areas. However, we found that re-entry plans were not always completed for all MIOCR clients (only 63% of the 90 MIOCR clients had a re-entry plan on file), and for some re-entry plans, the MIOCR client had not “signed off” on the plan, suggesting that the reentry plan may not have been developed in partnership with the client. Moreover as pointed out earlier, LS/CMIs were not always completed for all MIOCR clients or in a timely manner, so that the principle of matching appropriate treatment and dosage with the risk and needs of the client was not being met with fidelity. Therefore as was recommended previously, we strongly suggest that OMHT supervisors revisit the training schedule annually for all clinical case managers to ensure that the re-entry plans are being developed with fidelity and that the program incorporates quarterly audits of clinical case manager files to ensure re-entry plans are being completed for all clients.

To the extent possible, educational, employment, and substance abuse services need to be an integral component of the program, both pre- and post-release. According to the National Institute of Corrections, 40 to 70 percent of high-risk offenders’ free time should be occupied with prescribed services, such as treatment or employment or education assistance (NIC, 2011). Given

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<sup>20</sup> Judicial Council of California, Administrative Office of the Courts. (2012, February). *AOC briefing: How practices and programs become evidence based: A review of juvenile justice research*. San Francisco: Author.

<sup>21</sup> Lowenkamp, C.T., Pealer, J., Smith, P., & Latessa, E.J. (2006, December). Adhering to the risk and need principles: Does it matter for supervision based programs? *Federal Probation*, 70(3):3-8.

that all clients in the program are medium or high-risk individuals, a minimum-level of services, combined with a richer mix of services (substance use treatment, mental health, employment and education), should be built into the program. These services can be integrated into the program yet still allow for customization and targeting of interventions as needed. It is not enough to refer clients to a limited number of existing programs, some of which do not have sufficient openings. Clients need to be directly enrolled in programming that aims to teach the skills necessary to change criminogenic thinking; reduce drug and alcohol dependency; and avoid negative peers and situations which lead to re-offending. In addition as is apparent from the baseline mental health status of many MIOCR clients, the enrollment of low-functioning SMI clients directly into mental health residential treatment services (that also serve co-occurring substance dependency) may be required.

**Measure relevant processes and practices.** The principle of measuring relevant processes and practices is ensuring that those who give direct service are properly trained to deliver the evidence-based techniques that are true to the model and the research. While the number of hours of professional development have increased annually since FY2015, revisiting the annual training schedule for clinical case managers and other program staff would be a way to ensure that those who are providing the program are properly trained about the program and theories behind it. The training schedule should include regular “booster” sessions for previously trained clinical case managers in learning and practicing evidence-based techniques, such as the LS/CMI, cognitive behavioral methods and techniques (i.e., role-playing, practicing), the integration of the Risk-Needs-Responsivity principal in clinical practice, and other evidence-based practices underlying the OMHT program.