MIOCR Local Evaluation Report: Santa Clara County

Executive Summary –

The MIOCR grant was used to fund the creation of an In-Custody Reentry Team (ICRT) to support the successful reentry of inmates with serious mental illness (SMI). The ICRT employed incarceration-based, prevention-orientated case management and discharge planning to offenders with SMI. The approach focused on creating a release plan to link inmates to post-release services, treatment and support. The overall aim of the ICRT was to improve the quality of life for SMI offenders and to reduce their chances of recidivism.

The ICRT consisted of a clinician (Licensed Clinical Social Worker) and a community health worker (CHW). The team used the Assess, Plan, Identify and Coordinate (APIC) model as supported by the Substance Abuse and Mental Health Service Administration (SAMHSA) as best practice for case managing and planning reentry. The ICRT worked with SMI offenders from booking to release, establishing a reentry case plan within days of the mental health referral and following the client throughout their incarceration until they were released. A key component of the project was the direct link to post-release services and follow-up with clients to promote and support engagement. The ICRT built on existing collaborative reentry efforts and played a role at crucial points such as mental health assessments, case planning, service and treatment linkages and follow-ups.

1. Did the project work as intended? If not, explain why.

The project helped many SMI individuals to obtain services and access to resources they would otherwise have missed. The project also exposed many obstacles in the County ReEntry system and jump-started discussion across multiple departments to reduce barriers to success. While these improvements are ongoing, for many of the clients in the MIOCR project they were insufficient to ensure success at the time.

The County continues the process of reorganization and review of incarceration and release due to litigation brought about by multiple prisoner advocacy groups and inmate policy experts. Additionally, Santa Clara County Behavioral Health, the system for clients in the community, has serious deficits in providing for the most extreme cases, which constitute the primary MIOCR project caseload. Many of the issues in discussion include those uncovered/addressed through the MIOCR project and will improve future conditions and treatment for SMI individuals in custody. However, resolution of the many issues hindering clients from successful transition to the community was not yet in place during the project timeframe.

2. What were the project accomplishments?

Custody Health has been engaging with the County Office of Supportive Housing to use MIOCR-type dollars to fund emergency and short-term housing for clients leaving custody to provide stability while they navigate the often-complicated bureaucratic re-entry process and establish longer term benefits and housing.

Additionally, MIOCR-dedicated staff continue to locate clients in the jail and initiate engagement and marketing of MIOCR services. Those clients willing and able are referred to the ReEntry Resource Center (RRC). At release whenever possible they are accompanied to the RRC by MIOCR staff who help them through the orientation and intake process there. This can be an arduous process for a mentally ill client, and often requires a return to the RRC on additional days. Collaboration with Office of Supportive Housing has helped numerous clients obtain short-term and emergency beds for MIOCR clients at release. For other clients without housing options, the MIOCR team has partnered with community agencies to locate homeless clients after release and continue to assist them at the RRC until the “warm handoff” is complete.

3. What goals were accomplished?

The LEP goal of creating an In-Custody Reentry Team (ICRT) was to provide reentry planning and case management to inmates with serious mental illness (SMI). The goal of the project was met.

We have had our greatest success through simply helping clients reduce their stress and anxiety when at the ReEntry Resource Center. It can be overwhelming for the mentally ill to be met by law enforcement at the door, go through metal detectors, then have to explain their needs -- just to enter the building. Once inside there is a number of stations offering various services and entry points each with its own forms, rules and approachability level. By collaborating with the clients while in custody we were often able to assist them in navigating the re-entry process after release.

The two full-time staff dedicated to MIOCR services are able to account for the assessment and discharge assistance required for the revolving MIOCR population. The number of clients meeting MIOCR criteria who are not otherwise receiving discharge assistance, including those who have returned to custody, continues to average approximately 30 per quarter. We believe this is a sustainable and valuable model and intend to base the year 4 plan on continuing existing activities.

4. What problems/barriers were faced and how where they addressed?

Maintaining effective contact with a transient population once out of custody is extremely challenging. Many, if not most clients have a long history of homelessness and treatment non-compliance. Despite procurement of shelter or THU placements, redirecting clients toward positive activities, including remaining in assigned programs

and housing, remains challenging. Many clients agree to services and participation while in custody but renege or no-show after release. Additionally, spending grant dollars through the County can be an arduous and bureaucratic process. As community mental health services improve to serve those SMI individuals returning from custody, the outcomes can be expected to improve proportionally.

5. What unintended outcomes (positive and/or negative) were produced?

It was quickly discovered that the outcome measures were nearly impossible to analyze due to the individualized nature of the client issues. Because ours was not a “treatment program” per se, but an effort to assist with a “warm handoff” to community resources, the kinds of data tracking associated with traditional programming did not map in any meaningful way. Pre-tests, post-tests, etc were not useful and most of the criteria (homelessness, mental illness, difficulty following through and obtaining services) continue to plague the population we serve and were not eliminated via “once and done” treatment. Clients engaging who would not previously engage; clients beginning to receive services albeit temporarily who had never followed through previously; clients reporting hopefulness who had been only cynical. These measures became obvious to our staff and also those in the community at the RRC and other community programs who helped our MIOCR clients post release.

6. Where there any lessons learned?

We continue to believe that ongoing client contact pays dividends in the long run despite relapse and/or difficulty keeping up with clients who lose contact once in the community. Many clients in custody express willingness and an interest to participate. Some clients have returned to custody but remain interested to try again. We have learned to remain hopeful, and that human connection and compassion mean at least as much as traditional programming.

Project Description –

The MIOCR grant was used to fund the creation of an In-Custody Reentry Team (ICRT) to support the successful reentry of inmates with serious mental illness (SMI). The ICRT employed incarceration-based, prevention-orientated case management and discharge planning to offenders with SMI. The approach focused on creating a release plan to link inmates to post-release services, treatment and support. The overall aim of the ICRT was to improve the quality of life for SMI offenders and to reduce their chances of recidivism.

The ICRT consisted of a clinician (Licensed Clinical Social Worker) and a community health worker (CHW). The team used the Assess Plan, Identify and Coordinate (APIC) model as supported by the Substance Abuse and Mental Health Service Administration (SAMHSA) as best practice for case managing and planning reentry. The ICRT worked with SMI offenders from booking to release, establishing a reentry case plan within days

of the mental health referral and following the client throughout their incarceration until they were released. A key component of the project was the direct link to post-release services and follow-up with clients to promote and support engagement. The ICRT built on existing collaborative reentry efforts and played a role at crucial points such as mental health assessments, case planning, service and treatment linkages and follow-ups.

Data Collection –

Describe what data was collected and their data source(s), collection methods (tools used to collect data, data collection frequency, who and where the data was collected), and the methodology for analyzing the data. If there were any difficulties in collecting data, list them and describe how the difficulties may have influenced the final analysis.

Data was derived and collected from multiple sources: the Criminal Justice database (CJIC), Santa Clara Valley Health and Hospital System electronic medical records (ELMR and Healthlink), Santa Clara County housing and homeless database (HMIS), SCC ReEntry Resource Center database (IRTS), and Custody Behavioral Health Svcs client database (SQL). None of the systems communicate with each other, and some were not in existence at the beginning of the grant timeline. As new systems were introduced and/or replaced existing systems, hoped-for integrated data gathering and reporting features were difficult or impossible to implement and often had to defer to other higher profile technical modifications and enhancements.

Some data was simply not available, which was explained in each quarterly report. For example, number of prior felony/misdemeanor convictions is not tracked, only arrests and time spent in custody. Similarly, there was no way to clearly correlate recidivism to participation with MIOCR. Many clients returned to jail and the program will only know years from now if the long term trend of arrests declines. We believe that it will but the data do not show clear results during the time of the study.

Research Design –

Describe the research design used to assess the **process evaluation** and **outcome evaluation** of the program. Each is described below.

1. **Process Evaluation:** To document the program activities that were carried out. A good process evaluation will document the fact all the activities described in the proposal were indeed carried out. The process evaluation should also examine how well the project matches the theory behind its creation.

The ICRT used the APIC model to match client needs with available resources. This process was used for all participants.

- Initial health screening by CHS staff (existing service)
- Referral by CHS for mental health assessment, diagnosis and treatment plan (existing service)

- 1 hour mental health assessment to be conducted by ICRT clinician (existing service)
- Case planning meeting of an appropriate length with an ICRT clinician and CHW using the GAINS reentry checklist (new service)
- Monthly follow-up case planning meetings to update the case plan as needed (new service)
- A 'warm hand-off' to the RRC on release, including transportation and a warm introduction to the Behavioral Health Team (new service)
- Post-release follow-up to ensure service engagement (new service)

2. Outcome Evaluation: To determine if the program "*worked*" in terms of achieving the goals as stated in the proposal. In this section, list the outcome variables that were collected, the outcome measures, and a detailed description of the results for each measure. Describe the method by which the impact of the project/intervention(s) on the measured outcomes were determined. Include a description of the comparison group (i.e., a group that will not participate in the program) including the comparison group eligibility criteria and sample size, if applicable. Also include the operation definition of all independent and dependent variables.

Because the project connected clients in custody with services and resources post custody, tracking of "success" was not easily measured. Clients who previously had not been connected to benefits or services were helped to get established in the community. However, many clients remained homeless and impossible to contact in the community except when they did appear at the RRC or programs they had agreed to attend. There is no mechanism to track if a client is receiving Federal or State funding or other benefits unless the client reports back that information directly.

Many clients had emergency room visits post release, and although we believe the overall use of ER and Emergency Psych facilities decreased, it is impossible to know the long term outcomes or consistent trends for clients who have a lifetime of usage of emergency services and homelessness. As community policing practices have improved to include Crisis Intervention Training, for example, some clients who may have been arrested in the past are now brought to emergency or other rehabilitation centers. So what may appear to be fewer arrests results in what appears to be increased emergency interventions. But those increased emergency interventions may actually be a "success" in returning the client to re-entry services and continuation of existing benefits and programs.

By definition the population the MIOCR grant serves is the most difficult to monitor in the community as they are actively transient and difficult to reach. Once out of custody the MIOCR team worked with the clients at the RRC but often the connection could not be maintained due to the lengthy process of enrolling clients in services. Unless emergency housing was obtained for the immediate release date, clients obtained any benefits available that day and exited to find shelter on their own. It was nearly

impossible to determine if and when they returned to programs, emergency facilities or otherwise took advantage of opportunities available to them.

By helping clients at the ReEntry Center, MIOCR staff were able to get nearly all clients intake appointments for Behavioral Health and Substance programs, financial benefits and entitlement counseling, housing needs assessments as well as medical appointments at the onsite mobile medical clinic. These would not have happened without MIOCR assistance; this was the first time these MIOCR clients had ever been able to tolerate the bureaucratic processes required to successfully obtain services.

The actual interventions consisted of the process itself. The APIC model of assessment and connection required hours of human contact and therapeutic encounters with the clients. It is our conclusion that the human contact, regardless of the type of services needed or applied, was the agent of change that benefitted the clients the most. We believe this is true because a) clients reported feeling helped in ways they never had been before and b) clients were able to manage themselves in unfamiliar and difficult public settings long enough to begin to have some or all of their post-release needs met, something which rarely if ever happened for them previously.

Logic Model –

A visual representation of the project depicting the logical relationships between the input/resources, activities, outputs, outcomes, and impacts of the project. The logic model must be a representation of the program as of June 30, 2018

Logic Model for Santa Clara County DOC MIOCR

An In-Custody Re-entry Team will use incarceration-based, prevention-oriented case management and discharge planning with offenders with serious mental illnesses (SMI) in order to improve offenders' quality of life and reduce their chances of recidivism

<table>
<tr><th>Inputs</th><th>Activities</th><th>Outputs</th><th>Short-term Outcomes
(0-4 weeks post-release)</th><th>Intermediate Outcomes
(3-6 months post-release)</th><th>Long-term Outcomes
(1-3 years post-release)</th></tr>
<tr>
<td rowspan="2">Target Population
Inmates who: (1) have received a SMI diagnosis; (2) have received five or more bookings in the last three years; (3) charged or convicted of an AB109 offense or local misdemeanor; and (4) are positive or neutral towards case management services
Key Staff/Partners
<u>In-Custody Re-entry Team (ICRT)</u>
Clinicians
Clerical support worker
Community Health Worker (CW)</td>
<td>Existing activities incorporated into MIOCR Evaluation:
Initial health screening by CHS staff
Referral by CHS for mental health assessment, diagnosis and treatment plan
One hour mental health assessment conducted by ICRT clinician</td>
<td>Number of individuals screened
Number (percent) of individuals screened identified as having an SMI
Number of individuals referred
Percent of identified SMI clients who are referred
Number of individuals assessed within two weeks of entry</td>
<td rowspan="2">Participants
Reduction in days spent in jail
Connected to/engaged in appropriate services post-release
Participants engaged in appropriate services post-release as identified in the discharge and planning document
Attend post-release primary medical care appointment
Attend post-release behavioral health provider appointment</td>
<td rowspan="2">Participants
Continue to be engaged in services, adhere to treatment
Treatment adherence/ attendance
Medication adherence, if applicable
Participant has stable housing
Improved life functioning
Improved social support
Reduction in mental health symptoms</td>
<td rowspan="2">Participants
Reduced recidivism/time to recidivism
Reduction in new offenses
Increase participants' time in community prior to any re-arrest
Reduction in severity of offenses
System</td>
</tr>
<tr>
<td>Case planning meeting of an appropriate length with an ICRT clinician and Community Worker (CW) using the discharge and transition plan document within two weeks of entry</td>
<td>Number of individuals who have case planning meeting with ICRT clinician and CW present within 2 weeks of entry</td>
</tr>
</table>

• Custody Health Service (CHS) Staff
• Re-entry Resource Center (RRC)
• Community Mental Health Providers
  ▪ Momentum
  ▪ Community Solutions
  ▪ Gardner
• Faith Based Svcs
• Ofc of Supportive Housing
• Strategy Team
		• Number of participants with a completed discharge and transition plan document	• High-level of connection (trust) with CW
			
			System
			• Improved skill-set amongst ICRT staff (not measured)
				System
				• Improved organizational understanding of effective case management for specific client group
				• Evidence that ICRT assessments are used in court decisions to divert pre-trial mentally ill inmates to treatment and in sentencing decisions
					• Decreased social costs of repeat offending

	Follow-up case planning meetings to update the case plan as needed	• Number of follow-up case planning meetings with participant present • Number of follow-up case planning meetings without participant present • Average frequency of follow-up case planning meetings • Number of follow-up case planning meetings post-release			
	Warm hand-off to the RRC on release, including transportation and an introduction from a trusted CW to a post-release behavioral health team	• Number of participants who receive a warm hand-off to the RRC or other provider upon release (warm hand-off= in-person introduction from a trusted CW to the next provider)			

	Post-release follow-up by CW to ensure participant's service engagement	• Number of CW contacts with participant post-release, by type (behavioral health, basic needs, etc.) • Number of CW contacts on behalf of participant post-release, by type			

Results and Conclusions –

1. Results: Provide a detailed explanation of what happened using the data/information produced as a result of the intervention/project.

Given the unusual nature of the project itself and the difficulty capturing relevant data, clear results have not yet been determined. Because the project will continue, we expect to continue to monitor those MIOCR clients who participate in community services and housing, and to continue to work with those who return to custody. It will be many more years before any definitive correlations can be drawn between the warm handoff and recidivism reduction.

2. Conclusions: Provide a clear explanation of what the results mean and the project's ability to reduce recidivism as defined on page five (5) of the Request for Proposals (RFP).

Minimum Required Information to Be Addressed Within the Final LER–

Santa Clara County Custody Health Services believes strongly in the value of the principles and goals of the MIOCR program despite the challenges faced during the three year study. The ongoing project is expected to continue as designed in the original plan, with some modifications to be implemented as technological improvements allow better data gathering and as available community services for mentally ill clients expand.

1. **Project goals**

   The goal of creating an In-Custody Reentry Team (ICRT) is to provide reentry planning and case management to inmates with serious mental illness (SMI).

2. **Project objectives**

   The objectives of the ICRT are to:

   - increase post-release engagement with treatment
   - increase post-release engagement with services
   - reduce recidivism of participants
   - extend participants' period in community prior to any re-arrest
   - improve the quality of life for mentally ill adult offenders

3. **Definition of target population**

In years one, two and three, the ICRT target population has been inmates with a SMI diagnosis and who have received five or more bookings the last three years. This is in order to prioritize services for those with the greatest need. To be eligible for the ICRT, the inmate must have been charged or convicted of an AB 109 offense or local misdemeanor. Prospective participants will also need to be identified as positive or neutral towards case management services

It is intended that, in the fourth year and beyond, the target population will be extended to include other high-need mental health clients who may also benefit from involvement in the ICRT but whom do not meet the above criteria. The target population may be extended in the same way before the fourth year if local reentry efforts warrant the adjustment. This extended population is likely to include inmates whose diagnosis is not a SMI but who have high recidivism.

4. Estimated number of participants

Analysis of three years of Custody Health Services (CHS)'s data (January 2012 to December 2014) revealed that 1,626 inmates met the criteria outlined above. In order to match the number of participants to the capacity of the ICRT, CHS estimates that the team will have the following rolling caseloads[1]:

- Year 1- 50
- Year 2- 60
- Year 3- 70
- Year 4- 70

These numbers are consistent with the actual activities in years 1-3, and years 4 and beyond are expected to reasonably continue along the same lines.

5. Process for determining which intervention each participant receives

The Substance Abuse and Mental Health Service Administration (SAMHSA) recognizes the Assess, Plan, Identify and Coordinate (APIC) model as best practice for case managing and planning reentry. The ICRT, which will include clinicians, will use the APIC model to assess, plan and then manage and record the appropriate combination of interventions. The available interventions will include the following:

- Initial health screening by CHS staff (existing service)
- Referral by CHS for mental health assessment, diagnosis and treatment plan (existing service)

[1] The average length of stay is 154 days. It is therefore anticipated that caseload will turn over two to three times per year, resulting in an average annual caseload of between 150 and 300 participants.

- 1 hour mental health assessment to be conducted by ICRT clinician (existing service)
- Case planning meeting of an appropriate length with an ICRT clinician and CHW using the GAINS reentry checklist (new service)
- Monthly follow-up case planning meetings to update the case plan as needed (new service)
- A 'warm hand-off' to the RRC on release, including transportation and a warm introduction to the Behavioral Health Team (new service)
- Post-release follow-up to ensure service engagement (new service)

6. Documentation and tracking plans for each participant

The staff complement of the ICRT includes a clerical support worker, who will spend part of their time developing and maintaining comprehensive case files for program participants. Where possible, record keeping will be in line with best practice identified by the APIC model on case management.

7. Project oversight structure (plus monitoring, assessment and adjustment)

In order to provide sufficient governance and oversight, the MIOCR Strategy Committee will convene on a quarterly basis. The ICRT Steering Committee will meet monthly for the first year of the project and will provide quarterly reports to the Strategy Committee to enable them to monitor and assess the project and devise adjustments as necessary.

8. Process evaluation variables

Fidelity testing of staff will be a specific element of the evaluation. The approach of ICRT staff members will be the key process variable and the evaluation of the project will examine their adherence to the agreed APIC model.

9. Outcome variables to be tracked

Data on the following variables will be tracked throughout the project:

- post-release engagement with treatment
- post-release engagement with services
- recidivism
- period in community prior to any re-arrest
- quality of life for mentally ill adult offenders

10. Outcome measures to be tracked

The following outcome measures will be tracked:

- Percent increase in post-release engagement and retention in primary medical and psychiatric care for the target population
- Percent increase in engagement and retention in post-release services through the RRC
- Evidence that ICRT assessments are used in court decisions to divert pre-trial mentally ill inmates to treatment and in sentencing decisions

11. Definition of participant success/ failure in the intervention

The following measures will be used to define success or failure of each intervention:

- Initial health screening by CHS staff (existing service)
  - *Client participation with the screening*
  - *Client agreement to access of their community medical records*
- Referral by CHS for mental health assessment, diagnosis and treatment plan (existing service)
  - *Referral made for all identified SMI clients within agreed CHS timeframes*
- One hour mental health assessment to be conducted by ICRT clinician (existing service)
  - *Assessment carried out for all referred SMI clients within agreed CHS timeframes*
- Case planning meeting of appropriate length with an ICRT clinician and CHW using the GAINS reentry checklist (new service)
  - *Client attendance at case planning meeting*
  - *Case planning meet held within agreed ICRT/CHS timeframes*
- Monthly follow-up case planning meetings to update the case plan as needed (new service)

- *Client attendance at case planning meeting*
- *Case planning meet held within agreed ICRT/CHS timeframes*

- A 'warm hand-off' to the RRC on release, including transportation and a warm introduction to the Behavioral Health Team (new service)

  - *Client co-operation with warm hand-off*
  - *Service/treatment representative engagement with warm hand-off*

- Post-release follow-up to ensure service engagement (new service)

  - *Follow-ups conducted inline with agreed ICRT/ CHS timescales*

12. Definition of participant success/failure in the project

In order to define participant success or failure, there will need to be an analysis of whether the project objectives have been achieved for the participant. Each analysis will include an indication of whether the following objectives have been met:

1. Improved post-release engagement with treatment (as measured against participant's previous prior treatment engagement)

2. Improved post-release engagement with services (as measured against participant's previous prior service engagement)

3. Reduced recidivism (as measured against participant's previous recidivism rate)

4. Increased period in community prior to any re-arrest (as measured against participant's prior history)

5. Improved quality of life for mentally ill adult offenders (based on self-reporting of participant and reporting of case workers/ treatment providers)

13. Assessment plan for overall project and method for identifying if project achieved the set goal

The goal of the project is to establish a case management approach for high-need SMI clients from booking though to re-entry. The MIOCR Strategy Committee, which will convene on a quarterly basis, will monitor the project's adherence to the agreed goal throughout the project. They will do this through analysis of the reports provided by the ICRT Steering Committee and evaluator(s). An agreed set of reporting data (to include rolling number of participants and samples of (redacted) live case studies) will be established at the outset.

14. Research design of evaluation, including assessment of individual components

A mixed methodology of quantitative and qualitative analysis will be used to assess whether each stated objective of the program has been met. The following methodologies will be employed:

a) *Level of relevant referrals*
Data on number of referrals made for participant group

b) *Level of post-release engagement with treatment*
Data from relevant agency; qualitative analysis based on information from treatment provider (interview/ structured questions carried out by evaluator(s). (Note- patient confidentiality issues will need to be considered)

c) *Level of post-release engagement with services*
Data from relevant agency; qualitative analysis based on information from service provider (interview/ structured questions carried out by evaluator(s).

d) *Recidivism following program participation*
Data from relevant agency

e) *Length of time in community prior to any re-arrest*
Data from relevant

f) *Quality of life for participants*
Structured interviews with participants and/ or caregivers. Structured interviews with service/treatment providers. Interviews to be carried out by evaluator(s).

15. Documentation plan for evaluation costs and cost per participant

Evaluation:

- Any costs associated with the collection and analysis of the quantitative data- hours per week of any in-house statistics person who may contribute
- Any cost implications of accessing from partner agencies
- The cost of paying independent evaluator(s)

Cost per participant:

- Hours of clinician time
- Hours of administrative time to complete case management documents
- Transport costs