

**FINAL REPORT ON THE
MENTAL HEALTH SERVICES CONTINUUM PROGRAM
OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND
REHABILITATION—PAROLE DIVISION**

**SEMEL
INSTITUTE**

U C L A



**Submitted to
The California Department of Corrections and Rehabilitation
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PREFACE

In February 2007, the California Department of Corrections and Rehabilitation—Division of Adult Parole Operations modified existing Mental Health Services Continuum Program (MHSCP) services to increase the number of parole outpatient clinic sessions required for mentally ill parolees. CDCR selected the Integrated Substance Abuse Programs (ISAP) at the University of California, Los Angeles, to extend their ongoing evaluation of the MHSCP to assess the impact of these policy changes. This report summarizes findings from the final year of this evaluation, and is submitted pursuant to the approved scope of services, which calls for a final report by June 30, 2008.

Executive Summary

Background

In 1954, the California Department of Corrections and Rehabilitation established the Parole Outpatient Clinic (POC) program to assist parolees with mental health problems and, as a consequence, reduce recidivism rates among this population. From its inception until October 1, 2000, parole agents were primarily responsible for referring parolees to the POCs for services. Referrals would be made if the parolee had a history of mental illness (usually indicated by the receipt of mental health services while in prison), or if the parole agent perceived that the parolee showed signs of mental instability. However, under this approach a substantial proportion of otherwise eligible parolees were either not identified or not provided appropriate services.

To enhance the Department's ability to identify and treat mentally ill parolees, the Mental Health Services Continuum Program (MHSCP) was developed by the Division of Adult Parole Operations (DAPO) in July 2000. According to its design, the MHSCP was to be applied to all eligible inmates released on or after October 1, 2000.

The purpose of this report is to summarize the results of UCLA's ongoing process and outcome evaluation of the MHSCP and to assess the impact of the increased POC attendance requirements (and staffing increases) put into place beginning February 2007.

Program Design and Description

The MHSCP was designed to reduce the symptoms of mental illness among parolees by providing timely, cost-effective mental health services that optimize their level of individual functioning in the community and thereby reduce recidivism and improve public safety.

The MHSCP is designed to include:

- Pre-release needs assessment of paroling mentally ill inmates.
- Pre-release benefits eligibility and application assistance.
- Expanded and enhanced post-release mental health treatment for mentally ill parolees.
- Improved continuity of care from the institution's Mental Health Service Delivery System to the community-based parolee outpatient clinics.
- Increased assistance for successful reintegration into the community upon discharge from parole.
- A standardized program in all four parole regions.

According to the MHSCP design, regional Transitional Case Management Program—Mental Illness (TCMP-MI) social workers are to conduct face-to-face assessments with eligible inmates within 90 days of the inmates' estimated parole release date, and update this assessment information within 30 days of the inmates' release. The TCMP-MI social worker then merges the assessment information into the Parole Automated Tracking System (PATS) database. This information is verified by the TCMP-MI liaison, who forwards this information to the appropriate POC headquarters. Once received, a POC-MHSCP liaison consults with the inmates'

parole agent of record (AOR) and schedules an initial appointment. For Enhanced Outpatient Program (EOP) parolees, this appointment is scheduled to occur within 3 working days of release; for Correctional Clinical Case Management System (CCCMS) parolees, the initial appointment is scheduled to occur within 7 working days of release.

Upon leaving the institution, parolees return to one of four parole regions (typically based on the county of commitment). The headquarters for these regions are located in Sacramento (Region I), Oakland (Region II), Los Angeles (Region III), and Diamond Bar (Region IV). In general, the jurisdictions of the TCMPI-MI social workers are divided into northern and southern regions, with Kern County Department of Public Health serving as the headquarters for the northern region, and the University of California at San Diego serving as the headquarters for the southern region. Some exceptions to this regional approach (e.g., including San Quentin State Prison in the southern region) were made to achieve balance between the regional caseloads and to reduce costs.

Because prior evaluation reports revealed a strong, favorable correlation between the number of POC sessions attended by parolees and the likelihood of being returned to custody within a year of release, a new policy was established (effective February 5, 2007) requiring that EOP designees receive at least eight consecutive weekly POC appointments during the first 60 days following release. For CCCMS designees, the new policy (effective April 2, 2007) required at least four consecutive weekly POC visits to occur within the first 30 days of the initial appointment.

Impact Evaluation

The samples used for this evaluation depended on the outcome measure, and the sample criteria are explained at the beginning of each section. The overall population of subjects on which this evaluation was based consisted of inmates who were released from prison between January 1, 2003, and December 31, 2007 ($N=106,667$). Highlights of this portion of the evaluation are summarized below:

Pre-Release Assessments

- Overall, 43% of the inmates in the eligible pool of releases had received a face-to-face assessment prior to release.
- Beginning in July 2005, EOP inmates were significantly more likely to receive a pre-release assessment than CCCMS inmates.

Parole Outpatient Clinic (POC) Attendance

- Inmates who were assessed prior to release were significantly more likely to attend a POC at least once than those who did not receive a pre-release assessment (65.8% vs. 41.0%, respectively).
- Following the effective dates of the new policy, the percentage of EOP POC patients receiving at least eight sessions increased by approximately 7 percentage points (from 32.1% to 39.0%); for CCCMS parolees, the increase was more than 10 percentage points (from 48.6% to 59.4%).

- Controlling for the effects of other background variables, receiving a pre-release assessment by a TCMP-MI social worker was associated with more than double the odds of attending a POC at least once following release from prison.

Characteristics of TCMP-Assessed Inmates and Non-Assessed Inmates

- As found in the prior evaluation reports, the likelihood of an inmate's being assessed prior to release did not appear to be systematically related to his or her background characteristics. There was, however, a slightly higher percentage of EOP designees in the assessed condition than the non-assessed condition.

Outcome Evaluation

The analyses in this section focus on offenders who were released between January 1, 2003, and December 31, 2007.

- The likelihood of being returned to custody (for any reason) was associated with being younger, male, African American, having been initially committed for a property offense, and having more serious mental health problems. In fact, according to this analysis, EOP parolees had 51% greater odds than CCCMS parolees of being returned to custody within the first year following release.
- Parolees returned to Regions I and II were more likely (ORs: 1.46% and 1.22%, respectively) to be returned to custody within 12 months than those returned to Region IV, while the odds of those released to Region III were about 13% lower than those released to Region IV during this time frame.
- After controlling for these background variables, receiving a pre-release assessment by a TCMP social worker was associated with a significant reduction in the odds of being returned to custody within 12 months (7% reduction in odds), and having one or more POC contacts following release was associated with a 52% reduction in the odds of recidivating during this time period.

Time in Program

- Based on data on Offender Information Services Branch (OISB)-listed CCCMS/EOP releases from January 1, 2003–December 31, 2007 ($N=106,667$), 45.9% had no POC contact, 14.0% had one POC visit, 18.0% had 2–4 POC visits, 9.3% had 5–8 POC visits, and 12.8% had nine or more.
- Consistent with previous research, our analysis revealed a strong relationship (Spearman $r=-.26$, $p<.0001$) between the number of POC sessions attended and recidivism risk. Specifically, the greater number of POC contacts a CCCMS/EOP parolee had, the less likely he or she was to be returned to prison. For example, 40% of EOP parolees with 9 or more POC contacts were returned to custody within 12 months, compared to 79% of EOP parolees with no POC contacts.

Cost Analysis

- We estimate that pre-release assessments conducted by TCMP-MI social workers were

associated with an annual savings of \$2,357 for each EOP parolee and \$1,049 for each CCCMS parolee, relative to non-assessed parolees.

- Regarding the cost savings associated with POC attendance, we calculated that having one or more POC contacts following release was associated with an annual savings of \$4,881 per EOP parolee and \$2,861 for each CCCMS parolee, relative to those with no POC contact.

POC Clinician Interviews

To complement the quantitative data collected and analyzed for this evaluation, telephone interviews were conducted with POC-based clinicians (i.e., psychiatrists, psychologists, and social workers) from August 2007 to January 2008. The purpose of these interviews was to assess clinical staff's perceptions of the MHSCP and how the recent policy changes affected their perceptions.

- Five major themes ran through the majority of the 78 MHSCP POC clinician interviews: (1) The need for clinicians to be involved in treatment planning, based on clinical judgment, diagnosis, and patient needs; (2) The lack of resources (including transportation, housing, clerical staff, clinical staff, and clinical space) that are needed to successfully treat patients, particularly under the new guidelines requiring eight consecutive weekly sessions for EOP patients and four consecutive weekly sessions for CCCMS patients; (3) Lack of access to prior mental health, psychiatric medication, and other records from the prison; (4) The need to improve coordination and communication between clinicians within the institution and those at POC to ensure continuity of patient care; and (5) The need for improved functionality of the MHCAS computer database.

TCMP-MI Social Worker Interviews

The purpose of the TCMP-MI interviews was to gain a greater understanding of TCMP-MI social workers' experiences and gather their input on how the MHSCP could be improved. Interviews with TCMP-MI social workers were conducted from April to May 2007.

- When asked how the MHSCP transitional process might be improved, the most common responses dealt with providing inmates assistance with pre *and* post care. Approximately one-third of respondents mentioned that they would like to play a larger role in providing some type of continuum of care or assist inmates with access to comprehensive services and resources. Respondents expressed interest in following-up with inmates to find out whether they were able to successfully transition after release.

Telemedicine Satisfaction Questionnaire

Telepsychiatry (the application of telecommunications and computerized information technology as an alternative to face-to-face interactions between the psychiatrist and patient) has been well received with regard to its ability to increase access to care (Antonacci et al., 2008). To assess parolees' perceptions of telepsychiatry services they received while on parole, the Telemedicine Satisfaction Questionnaire was administered to 24 parolees in

Region I who had received post-release care under both traditional (face-to-face) and telemedicine conditions.

- Overall, the respondents gave favorable responses regarding their psychiatrists and telemedicine. Only two items (“I obtain better access to healthcare services by use of telemedicine than I did when I had face-to-face sessions” and “I meet with my doctor more frequently via telemedicine than I did when the visits were face-to-face”) had mean responses slightly below the neutral value (i.e., mild disagreement). These two items are designed to assess whether telemedicine is *superior* to face-to-face sessions. While this sample of parolees did not find telemedicine to be superior to face-to-face contact with their psychiatrists, they did seem to agree that telepsychiatry was as good as face-to-face contact.

Conclusions

Findings from the current evaluation replicated trends noted in previous reports. Namely, about half of eligible parolees received a pre-release assessment, and those who did were more likely than those who did not to attend a POC following release. Likewise, receiving a pre-release interview was significantly associated with attending a POC upon release, which, in turn, was significantly associated with lower risk of recidivism. With regard to the impact of CDCR’s new policy to increase POC attendance, the percentages of CCCMS and EOP parolees attending the requisite number of sessions (i.e., 4 and 8, respectively) showed a statistically significant increase after the effective dates for these changes. Unfortunately, due to the short overlap between the implementation of the new policy and the evaluation timeframe, we were unable to assess the impact of these changes on recidivism.

Lastly, semi-structured interviews conducted with a sample of POC clinicians indicated that 38% of clinicians thought that the new policy requiring eight consecutive weekly sessions for EOP patients was good or helpful, but a majority (55%) of clinicians thought that the new policy had a negative impact on patient care. Reasons given by the latter group included: a lack of resources to implement the new policy effectively (e.g., clinical space; clerical staff; bus passes/access to transportation, especially for rural or suburban areas; housing; and problems with the MHCAS system), and difficulty maintaining large caseloads and the associated paperwork. It should be noted, however, that these interviews took place in the early stages of implementation, before the planned staff increases were complete.

FINAL REPORT ON THE EVALUATION OF THE MENTAL HEALTH SERVICES CONTINUUM PROGRAM OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS—PAROLE DIVISION

The purpose of this report is to summarize the results of UCLA's process and outcome evaluation of the MHSCP during the first 4 years of implementation. Specifically, this report describes the historical context of the MHSCP project, effectiveness of the program with regard to ensuring continuity of mental health services for eligible parolees, and the association between MHSCP program participation and 12-month recidivism outcomes.

I. MHSCP: Historical Context and Overview

A. Background

The research findings regarding the relationship between mental illness and crime vary considerably—often as a function of the definitions used and the populations studied. Not surprisingly, the associations between mental illness and crime tend to be more pronounced when studied among the general population. For example, according to one analysis of the Epidemiologic Catchment Area (ECA) data from the early 1980s ($N > 10,000$), people with serious mental illness (i.e., Axis I diagnoses) were more than 5 times as likely to report engaging in violent behaviors as those without serious mental illness (see Monahan, 1996). In contrast, an attempt to predict general and violent recidivism among parolees from a maximum-security inpatient psychiatric unit showed that psychotic parolees were less likely than non-psychotic (but mentally ill) parolees to be rearrested for any offense, and equally likely to be rearrested for a violent offense (approximately 70% at 3 years post-release; Villeneuve & Quinsey, 1995). Similarly, Hodgins and Cote (1993) found that the criminal careers of mentally disordered and non-mentally disordered offenders differed little. However, the combination of antisocial personality disorder (ASP) and serious mental illness was associated with a significant increase in the frequency of non-violent arrests.

Other researchers have suggested that the presumed association between mental illness and criminality is an artifact of the use of arrest records as a proxy for actual offenses. Mentally ill offenders may be more vulnerable to detection and arrest than non-mentally ill offenders. Therefore, they are more likely to be cycled through the criminal justice system for minor offenses (Teplin, 1984). A possible moderating variable in these studies is the effect of post-release mental health services. If, in fact, serious mental illness is associated with risk of recidivism, then the ongoing provision of needed psychiatric services to mentally ill parolees should result in improved functioning and fewer arrests. Indeed, several studies have supported this relationship. In one study of post-release mentally ill offenders, recidivism was directly related to the receipt of fewer services that the clients reported they needed (Solomon, Draine, & Meyerson, 1994). More recently, Berecochea and Liu (1999) found that, among mentally ill parolees in California, each additional parole outpatient clinic service was associated with an increase of 21 days on parole (i.e., reduced risk of recidivism).

While the research findings regarding mental illness and criminality appear somewhat inconsistent, the association between substance use comorbidity and crime, particularly violent crime, is not. In a study of hospitalized psychiatric patients ($N = 101$), alcohol and cocaine abusers were significantly more likely to have homicidal ideation and homicidal plans (Salloum et al.

1996). Moreover, in a recent study of involuntarily admitted psychiatric patients with severe mental illness ($N=331$), Swartz et al. (1998) found that, whereas a diagnosis of schizophrenia or another psychotic disorder was not predictive of serious violence, the interaction of medication non-adherence and substance dependence was associated with a more than two-fold increase in the likelihood of committing violent acts, relative to those with either of these problems alone.

The Mental Health Services Continuum Program

In 1954, the California Department of Corrections established the Parole Outpatient Clinic (POC) program to assist parolees with mental health problems and, as a consequence, reduce recidivism rates among this population. From its inception until October 1, 2000, parole agents were primarily responsible for referring parolees to the POCs for services. Referrals would be made if the parolee had a history of mental illness (usually indicated by the receipt of mental health services while in prison), or if the parole agent perceived that the parolee showed signs of mental instability. However, under this approach a substantial proportion of otherwise eligible parolees were either not identified or not provided appropriate services.

To enhance the Department's ability to identify and treat mentally ill parolees, the Mental Health Services Continuum Program (MHSCP) was developed by the Division of Adult Parole Operations (DAPO) in July 2000. According to its design, the MHSCP was to be applied to all eligible inmates released on or after October 1, 2000. However, based on a preliminary evaluation of the MHSCP, the Bureau of State Audits (BSA; 2001) reported that (1) the program had failed to serve almost 40% of its target population, (2) clinicians were able to meet with their parolees during the scheduled time frame about 54% of the time, (3) the MHSCP database failed to identify almost 39% of the parolees who were eligible for MHSCP services, and (4) the MHSCP database did not allow for tracking of the time clinicians spent on each patient.

Recent Modifications to the MHSCP

Because prior evaluation reports revealed a strong, favorable correlation between the number of POC sessions attended by parolees and the likelihood of being returned to custody within a year of release, a new policy was established (effective February 5, 2007) requiring that EOP designees receive at least eight consecutive weekly POC appointments during the first 60 days following release. For CCCMS designees, the new policy (effective April 2, 2007) required at least four consecutive weekly POC visits to occur within the first 30 days of the initial appointment. These changes were accompanied by commensurate increases in staffing at the POCs.

B. Program Design and Description

The MHSCP was designed to reduce the symptoms of mental illness among parolees by providing them timely, cost-effective mental health services that optimize their level of individual functioning in the community and thereby reduce recidivism and improve public safety.

The MHSCP is designed to include:

- Pre-release needs assessment of paroling mentally ill inmates.
- Pre-release benefits eligibility and application assistance.
- Expanded and enhanced post-release mental health treatment for mentally ill parolees.
- Improved continuity of care from the institution's Mental Health Service Delivery System to the community-based parolee outpatient clinics.
- Increased assistance for successful reintegration into the community upon discharge from parole.
- A standardized program in all four parole regions.

Population Served

The MHSCP target population consists of parolees who were receiving mental health treatment in the institutions under the Mental Health Services Delivery System prior to release to parole. The MHSCP target population also consists of those parolees who have been in a Mental Health Crisis Bed and those releasing from any Department of Mental Health facility. The criteria for admission to both the institution's and parole's mental health treatment programs is a diagnosis of one or more of the following Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) psychiatric disorders:

- Schizophrenia (all subtypes)
- Delusional Disorder
- Schizophreniform Disorder
- Schizoaffective Disorder
- Substance-Induced Psychotic Disorder (exclude intoxication and withdrawal)
- Psychotic Disorder Due To A General Medical Condition
- Psychotic Disorder Not Otherwise Specified
- Major Depressive Disorders
- Bipolar Disorders I and II
- Medical Necessity (any other major mental illness diagnosis which requires treatment due to the acuity or severity of the illness)

The following mental health designations are used to determine the level of treatment need for inmates/parolees who require mental health services delivered by POC:

1. Correctional Clinical Case Management System (CCCMS) designation requires one or more of the above-referenced DSM IV diagnoses, and:
 - Stable functioning in the community;
 - Global Assessment of Functioning Score (GAF) above 50.

2. Enhanced Outpatient Program (EOP) designation requires one or more of the above referenced DSM IV diagnoses, and:
 - Acute onset or significant deterioration of a serious mental disorder characterized by increased delusional thinking;
 - Hallucinatory experiences, marked changes in affect and vegetative signs with definitive impairment of reality testing and/or judgment;
 - Dysfunctional or disruptive social interaction including withdrawal, bizarre or disruptive behavior, extreme defensiveness, inability to respond to instruction, or provocative behavior toward others as a consequence of a serious mental disorder;
 - Impairment of Activities of Daily Living (ADL), including eating, and personal hygiene, maintenance of dwelling, and ambulation as a consequence of a serious mental disorder; or
 - Global Assessment of Functioning Score (GAF) of 50 or less.

According to the MHSCP design, regional Transitional Case Management Program—Mental Illness (TCMP-MI) social workers are to conduct face-to-face assessments with eligible inmates within 90 days of the inmates' Earliest Possible Release Date (EPRD), and update this assessment information within 30 days of the inmates' EPRD. The TCMP-MI social worker then merges the assessment information into the Parole Automated Tracking System (PATS) database. This information is verified by the TCMP-MI liaison, who forwards this information to the appropriate POC headquarters. Once received, a POC-MHSCP liaison consults with the inmates' parole agent of record (AOR) and schedules an initial appointment. For EOP parolees, this appointment is scheduled to occur within 3 working days of release; for CCCMS parolees, the initial appointment is scheduled to occur within 7 working days of release.

In general, the jurisdictions of the TCMP-MI social workers are divided into northern and southern regions, with Kern County Department of Public Health serving as the headquarters for the northern region, and the University of California, San Diego, serving as the headquarters for the southern region. Some exceptions to this regional approach (e.g., including San Quentin State Prison in the southern region) were made to achieve balance between the regional caseloads and to reduce costs.

Upon leaving the institution, parolees return to one of four parole regions (typically based on the county of commitment). The headquarters for these regions are located in Sacramento (Region I), Oakland (Region II), Los Angeles (Region III), and Diamond Bar (Region IV).

II. Process Evaluation

While the primary purpose of this evaluation is to examine the impact of MHSCP participation on recidivism, it is also important to assess patient-level data, including background characteristics, program participation, services received, and program discharge status. It is also important to examine the characteristics of the otherwise eligible parolees who were not served by the MHSCP program to determine whether there are any systematic biases in the referral and screening process by which inmates take part in the MHSCP; this cohort will also serve as a

comparison group for the outcome evaluation.

It should be noted that the process evaluation is not directly concerned with determining the effectiveness of the program on recidivism; rather, the focus of this component is to describe the “pipeline” of patient flow and to characterize the continuity of services of MHSCP program participants relative to eligible parolees who do not participate in the program.

It should be noted that, except where otherwise indicated, the analyses below are based upon releases from January 1, 2003, through December 31, 2007. Thus, the primary analysis sample consisted of 106,667 cases. When appropriate, this aggregate sample is divided into 10 release cohorts:

- January 1, 2003–June 30, 2003 (Cohort 1; $n=3,048$);
- July 1, 2003–December 31, 2003 (Cohort 2; $n=4,210$);
- January 1, 2004–June 30, 2004 (Cohort 3; $n=5,041$);
- July 1, 2004–December 31, 2004 (Cohort 4; $n=9,343$);
- January 1, 2005–June 30, 2005 (Cohort 5; $n=11,206$);
- July 1, 2005–December 31, 2005 (Cohort 6; $n=12,692$);
- January 1, 2006–June 30, 2006 (Cohort 7; $n=13,820$);
- July 1, 2006–December 31, 2006 (Cohort 8; $n=15,217$);
- January 1, 2007–June 30, 2007 (Cohort 9; $n=16,402$); and
- July 1, 2007–December 31, 2007 (Cohort 10; $n=15,688$).

A. Identification and Assessment of Eligible Inmates

Initial identification of MHSCP-eligible inmates was based upon monthly listings generated by the Offender Information Services Branch (OISB). The OISB List provides basic information on CCCMS and EOP inmates who are within 120 days of their EPRD. However, because these estimated release dates are sometimes inaccurate, not all eligible inmates appear on the OISB List. As a result, the sample frame for the present evaluation is limited to those inmates who appeared on the OISB List prior to release.

Figure 1: Percentage of All CCCMS/EOP Parolees Receiving a Pre-Release Assessment (N=106,661)

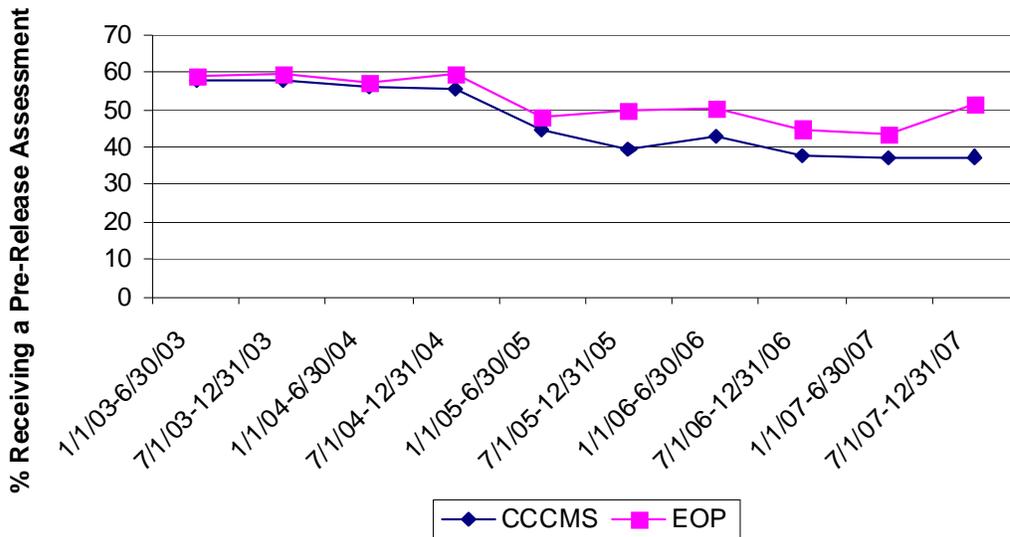


Figure 1 shows the percentages of CCCMS and EOP designees that received a pre-release interview by a TCMP-MI social worker. The percentages are disaggregated by release cohort. Overall, 43.0% of CCCMS designees and 50.8% of EOP designees received a pre-release interview. The results presented in the figure below indicate a shift beginning in the latter part of 2005 in which EOP designees were more likely to receive a pre-release interview than CCCMS designees. This trend was especially strong in the second half of 2007.

B. Clinic Attendance

To assess clinic attendance, we analyzed POC attendance as a dichotomous outcome, categorizing parolees by whether they had at least one POC visit following release versus none at all.¹ Although prior evaluation reports showed long-term patterns in POC attendance, the current evaluation focused on the changes in POC clinic attendance using the effective dates of the new policies. Specifically, we compared the percentages of EOP designees paroling after February 5, 2007, with those paroling prior to that date who attended at least eight POC sessions. Likewise, we compared percentages of CCCMS designees paroling before or after April 2, 2007, with regard to attending at least four POC sessions. As shown in Figure 2, the effective dates of the new policy were associated with slight—but statistically significant—increases in the

¹ It should be noted that these data are based on clinic attendance records as reported in the PATS database. Some POC psychiatrists have indicated having difficulty entering these cases on occasion. Therefore, our estimates of POC attendance may be lower than the actual rates. In addition, determining whether a parolee was admitted to a POC within the prescribed time period proved to be a difficult task, given that these appointments are based on the inmates’ earliest possible release dates (EPRD). EPRDs are not precise release dates, but rather serve as best estimates of an inmate’s anticipated release. As a result, these dates are often inaccurate, occurring well before or after the tentatively scheduled POC intake appointment.

percentages of parolees attending the required number of POC sessions (EOP: Chi-square [1, $N=13,472$]=20.2, $p<.0001$; CCCMS: Chi-square [1, $N=85,013$]=59.2, $p<.0001$).

Figure 2: Percentage of CCCMS/EOP POC Admissions Meeting New POC Session Attendance Thresholds Before and After Effective Dates of Policy Change ($N=98,485$)

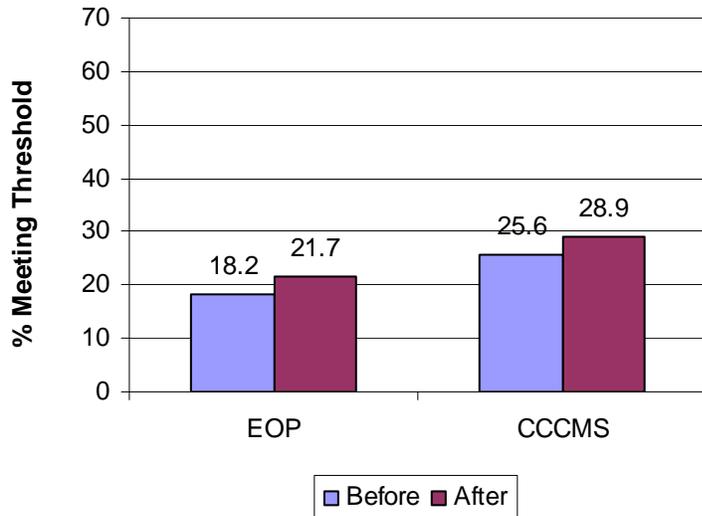


Figure 3 is similar to Figure 2, except that the sample excludes parolees who never showed up for their initial POC appointment. By limiting the analysis to parolees who were admitted to a POC upon release, the changes associated with the effective dates of the new policy are much clearer. In fact, the percentage of EOP-designated POC admissions receiving at least eight sessions increased by approximately 7 percentage points; for CCCMS-designated parolees, the increase was nearly 11 percentage points (EOP: Chi-square [1, $N=7,621$]=31.9, $p<.0001$; CCCMS: Chi-square [1, $N=44,333$]=243.8, $p<.0001$). It should also be noted that the POC attendance figures may be partially suppressed for parolees in the latter cohorts, since our data only capture attendance through May 2008. In other words, for parolees released in December 2007, we only have data reflecting 6 months of clinic attendance. On the other hand, the revised CDCR policy on POC attendance specified that the sessions should occur within 1 to 2 months of release (depending on whether the parolee is CCCMS or EOP).

Figure 3: Percentage of all CCCMS/EOP Parolees Meeting New POC Session Attendance Thresholds Before and After Effective Dates of Policy Change ($N=51,954$)

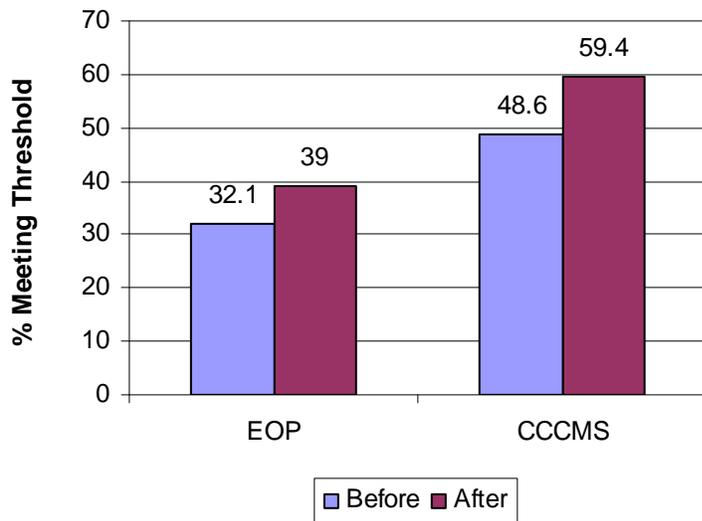
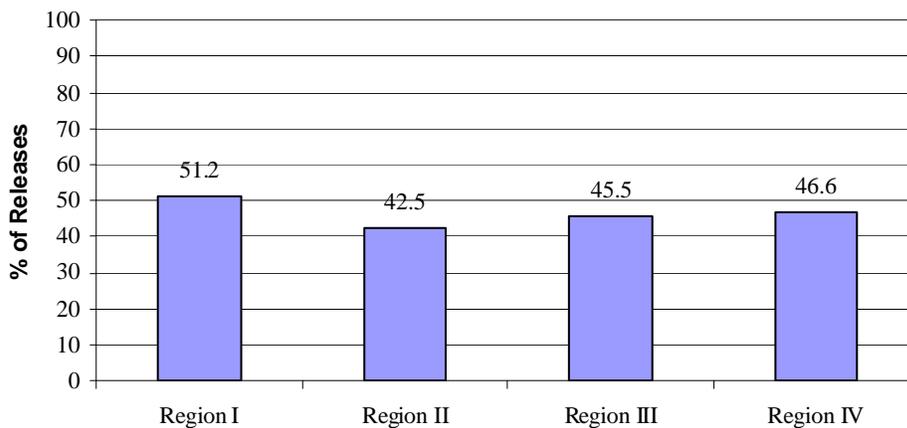
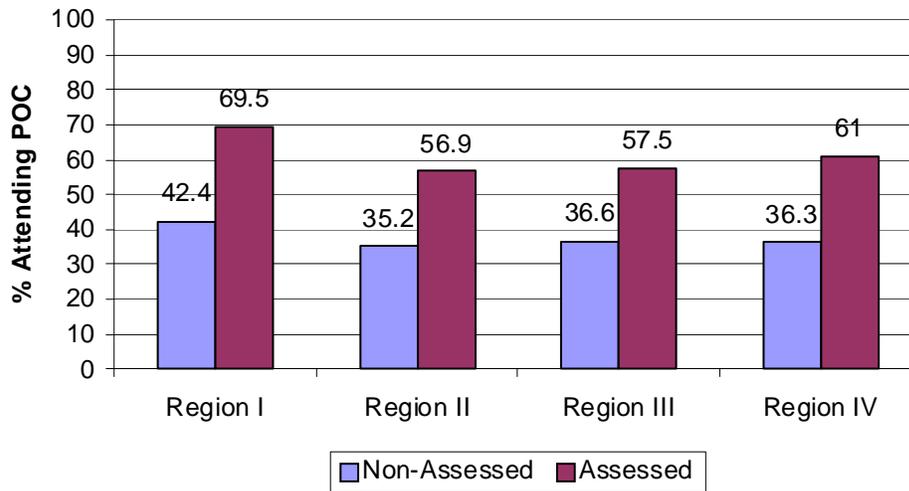


Figure 4: Percent of Releases with One or More POC Visits by Parole Region ($N=81,283$)



The above (see Figure 4) variations in POC attendance represent slight but statistically significant regional differences in attendance rates. For this reason, we controlled for region in the multivariate prediction models that appear below.

Figure 5: Pre-Release Assessment by POC Attendance Distributed by Region of Parole (N=81,193)



The impact of pre-release assessments on POC attendance. The bivariate relationship between pre-release assessments and POC attendance (defined as one or more visits) reveals that inmates who are assessed prior to release were significantly more likely (65.8%) to attend a POC at least once than those who did not receive a pre-release assessment (41.0; $\chi^2 [1, N=81,193]=6,459.6, p<.0001$). This analysis did not control for other differences between the assessed and non-assessed groups; however, it indicates that receiving a pre-release assessment is associated with a 60% increase in the likelihood of attending a POC at least once after release.² This effect was consistent across parole regions (see Figure 5).

Predicting POC attendance in a multivariate model. Because the assessed and non-assessed groups were not randomly assigned, it is important to control for the potentially confounding influences of other variables in order to isolate the effects of the intervention. Table 1 shows the results of a multivariate logistic regression model conducted to test the relationship between the pre-release assessments and POC attendance (as a dichotomous outcome), after controlling for the effects of age, gender, race, parole region, commitment offense, and severity of mental health problems (CCCMS vs. EOP).

² It should be noted that the 60% figure refers to the percent *increase*, rather than the percentage point difference (24.8%) between assessed and non-assessed groups.

Table 1: Odds Ratios Predicting Any POC Attendance Among Inmates Released Between January 1, 2003 and December 31, 2006 (N=74,015)

Variables	OR	95% CI
Age	1.01	1.00, 1.01 ***
Male (ref: female)	0.80	0.77, 0.83 ***
African-American (ref: all other races)	0.94	0.91, 0.97 **
Property Offender (ref: all other offenders)	0.87	0.84, 0.90 ***
EOP (ref: CCCMS)	1.13	1.08, 1.18 ***
Region I (ref: Reg. IV)	0.93	0.89, 0.96 ***
Region II (ref: Reg. IV)	0.62	0.60, 0.65 ***
Region III (ref: Reg. IV)	0.61	0.58, 0.63 ***
TCMP Assessed (ref: non-assessed)	2.46	2.39, 2.54 ***

** $p < .001$; *** $p < .0001$

The overall model was statistically significant (-2 Log L=102,209.5, Chi-Square [$df=9$]=4,726, $p < .0001$). All of the control variables were significantly predictive of POC attendance. Taken as a single profile, those who were admitted to a POC at least once tended to be older, female, non-African American, non-property offenders, classified as EOP (rather than CCCMS), and have been released to Parole Region IV. However, after controlling for these background variables, we found that receiving a pre-release assessment by a TCMP-MI social worker was associated with more than double the odds of attending a POC at least once following release from prison.

C. Characteristics of MHSCP and Non-MHSCP Parolees

Our assessment of the effectiveness of the MHSCP with regard to recidivism involved a comparison between TCMP-assessed and non-TCMP-assessed inmates. Given that only about 43% of eligible inmates were assessed by a TCMP-MI social worker prior to release, this afforded us the opportunity to estimate the impact of pre-release interviews on recidivism by comparing assessed inmates with non-assessed inmates. Obviously, such an approach assumes that whether an eligible inmate was assessed is essentially a random process (i.e., there are no systematic differences between those who are and those who are not assessed). To verify this assumption, we compared the assessed and non-assessed groups (collapsing across the 10 cohorts representing releases between January 1, 2003, and December 31, 2007) with regard to selected background variables, parole region, and mental health status.

Table 2: Comparability of Assessed and Non-Assessed Inmates, January 1, 2003–December 31, 2007($N=106,667$)

Variable	Non-Assessed	Assessed	Total
<i>N</i>	60,903	45,764	106,667
Demographics			
Gender (% male)*	85.9	84.0	85.1
Age (mean, <i>SD</i>) *	38.1 (9.6)	38.6 (9.7)	38.3 (9.6)
Race/ethnicity*			
African American	33.2	34.2	33.6
Hispanic	23.0	20.8	22.0
White	40.4	41.7	41.0
Other	3.5	3.3	3.4
Parole Region *			
Region I	31.5	25.7	29.3
Region II	25.0	21.4	23.6
Region III	17.0	21.3	18.6
Region IV	26.5	31.5	28.4
Offense Category*			
Violent	24.2	28.0	25.9
Property	37.0	34.6	36.0
Drug	28.7	27.5	28.2
Other	10.0	9.9	9.9
Mental Health Status*			
CCCMS	88.0	84.2	86.3
EOP	12.0	15.8	13.7

* $p < .0001$

As shown in Table 2, the assessed and non-assessed groups showed statistically significant differences on all five background domains. However, it is important to keep in mind that statistical significance is determined not only by the magnitude of differences, but by sample size as well. With large sample sizes such as this, even subtle group differences can be statistically significant. In such cases, it is more appropriate to examine these group profiles for patterns of differences that appear to reflect systematic biases in selection. Using this approach, we can see that whether an inmate is assessed prior to release appears to be minimally related to his or her background characteristics. In other words, assessments are not conducted on inmates who are considered most likely to succeed, nor are they biased toward those who are most impaired. The profiles in Table 2 indicate that non-assessments tend to occur randomly, or at least for reasons external to the inmate.

III. Outcome Evaluation (12-Month Return to Custody)

The three primary outcomes for this evaluation are (1) recidivism, (2) time to recidivism, and (3) correctional costs. It should be noted that *recidivism* is a general term referring to subsequent offending after release. For the present evaluation, analyses of recidivism outcomes are based on simple return to custody, regardless of the reason. In addition, recidivism is based on release

cohorts, rather than on individuals. Consequently, one parolee can account for multiple returns.

Regarding correctional costs, this evaluation includes an estimate of the incremental cost savings associated with avoided incarceration costs with the receipt of the MHSCP transitional services. This evaluation does not include a formal cost-benefit analysis, but rather provides an estimate of correctional costs saved based on the number of days in custody that are avoided as a consequence of participating in the MHSCP. Only correctional cost savings (rather than savings to other agencies or to society) are estimated.

A. Comparisons by MHSCP Participation Status

The analyses in this section focus on offenders who were released between January 1, 2003, and December 31, 2006. This cohort was selected to allow us to examine the overall effects of the MHSCP transitional process. Unfortunately, due to the time frame of the evaluation, data reflecting the hypothesized impact of the new policy changes to MHSCP in early 2007 are not yet available. (It is preferable to allow a parolee to be released for at least 18 months before assessing 12-month recidivism.). In the first analysis, we conducted a multivariate logistic regression to predict the likelihood that a CCCMS/EOP parolee would be returned to custody within 12 months of release. To accomplish this, we included six control variables (age, gender, race/ethnicity, commitment offense, parole region, and severity of mental health problems) and the two primary variables of interest with regard to the MHSCP transitional process: (1) whether the CCCMS/EOP inmate was assessed by a TCMP social worker prior to release and (2) whether he or she had at least one POC contact following release.

Table 4: Odds Ratios Predicting 12-Month Return to Custody for January 1, 2003–December 31, 2006, Release Cohort ($N=74,015$)

Variables	OR	95% CI
Age	0.99	0.98, 0.99 ***
Male (ref: female)	1.47	1.40, 1.53 ***
African American (ref: other races)	1.14	1.10, 1.18 ***
Property Offender (ref: other offenders)	1.17	1.13, 1.21 ***
EOP (ref: CCCMS)	1.51	1.44, 1.59 ***
Parole Region I (vs. IV)	2.46	1.35, 1.58 ***
Parole Region II (vs. IV)	2.22	2.12, 2.33 ***
Parole Region III (vs. IV)	0.87	0.83, 0.91 ***
TCMP Assessed (ref: non-assessed)	0.93	0.90, 0.96 ***
Attended POC (ref: did not attend)	0.48	0.47, 0.50 ***

*** $p < .0001$

The results of this analysis are presented in Table 4. The overall model was statistically significant ($-2 \text{ Log } L=65,797$, Chi-square [$df=10$]=1,690.5, $p < .0001$). Odds ratio estimates for the 10 predictors are shown in Table 4.

According to this analysis, the likelihood of being returned to custody (for any reason) was associated with being younger, male, African American, having been initially committed for a property offense, and having more serious mental health problems. In fact, according to this analysis, EOP parolees had 51% greater odds than CCCMS parolees of being returned to custody within the first year following release. (Overall, 73.6% of EOP parolees were returned to prison within 12 months, relative to 67.0% of CCCMS parolees; Chi-square [1, $N=69,407$]=170.9, $p<.0001$). In addition, using Parole Region IV as a reference point, we see that parolees returned to Regions I and II were more likely (ORs: 1.46% and 1.22% respectively) to be returned to custody within 12 months than those returned to Region IV, while the odds of those released to Region III were about 13% lower than for those released to Region IV during this time frame. For purposes of this outcome evaluation, our greatest interest lies in understanding how the MHSCP-related variables are associated with recidivism. After controlling for these five background variables, receiving a pre-release assessment by a TCMP social worker was, in fact, associated with a significant reduction in the odds of being returned to custody within 12 months (7% reduction in odds), but having one or more POC contacts following release was associated with a 52% reduction in the odds of recidivating during this time period.

Because recidivism risk has been shown to vary by parole region, additional bivariate analyses were conducted to ascertain the extent to which the effects of pre-release assessments and POC attendance occurred across all four regions on return-to-custody rates. As can be seen in Figures 6 and 7, the patterns are consistent across parole regions for POC attendance, though receiving a pre-release assessment was only associated with recidivism in Regions III and IV.

Figure 6: Return to Custody (12 Months) by Assessment Status and Parole Region, January 1, 2003–December 31, 2007 ($N=69,407$).

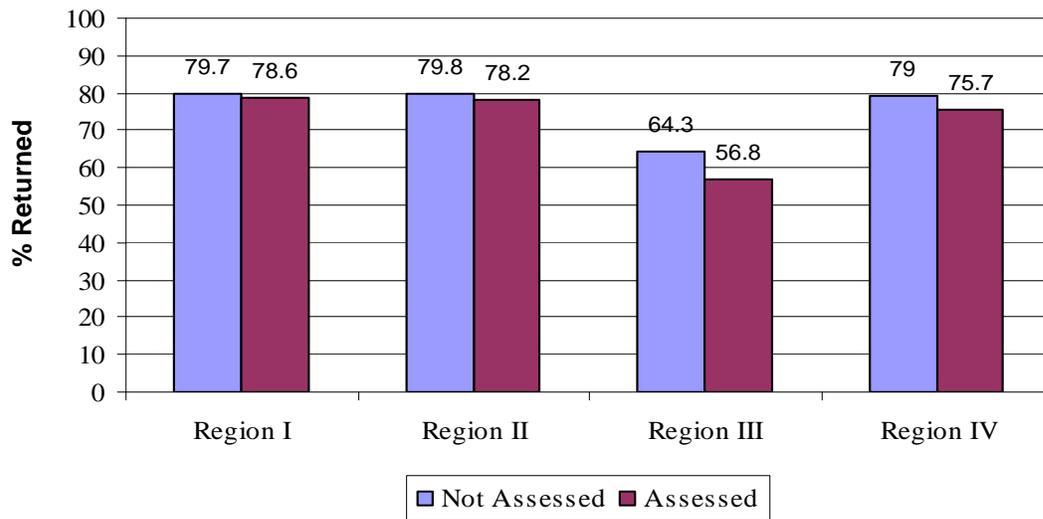
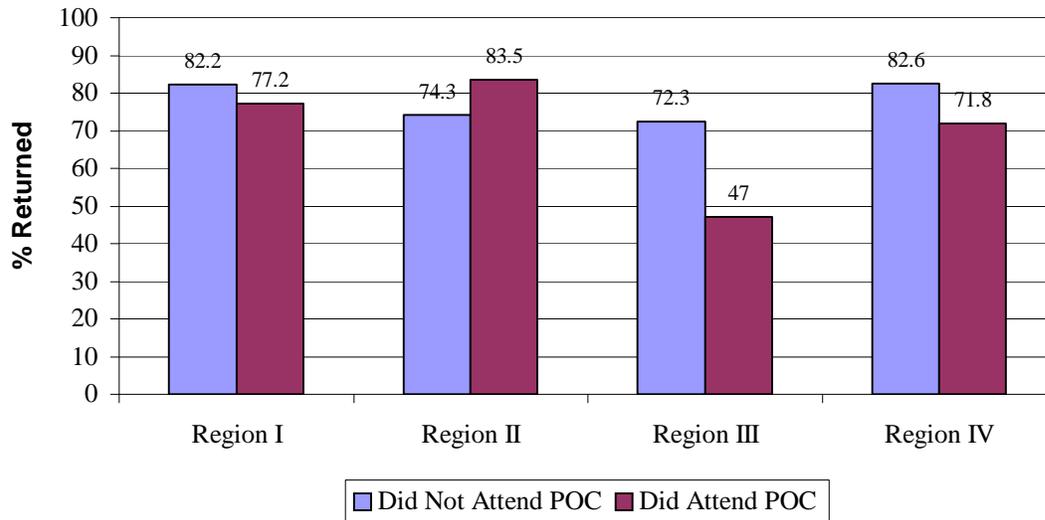


Figure 7: Return to Custody (12 Months) by POC Attendance and Parole Region, January 1, 2003–December 31, 2006 (N=55,822).



Another variable of interest is the length of time a parolee remains in the community prior to being returned to custody (if ever). Our comparison of group means revealed a statistically significant difference in parole days between assessed and non-assessed parolees, as well as between those who did and did not attend a POC upon release. Specifically, we found that parolees who had received a pre-release assessment had an average of 27.2 additional days on parole, and parolees who had one or more POC contacts had an additional 73.9 days on parole (see Table 5).

Table 5: Mean Number of Days on Parole by Assessment and POC Attendance, January 1, 2003–December 31, 2006 (N=74,586).*

MHSCP Variable	No	Yes	Difference
	Mean (SD)	Mean (SD)	
Assessed by TCMP-MI	201.58 (133.5)	228.80 (131.7)	27.20 ***
Attended POC	174.24 (133.7)	248.13 (123.2)	73.89 ***

*Maximum number of days is truncated at 366; Means are based on actual days not in custody for all releases, not estimates derived from the proportional hazard model described below; ***p<.0001

Using a proportional hazard model, the next analysis sought to predict the length of time CCCMS/EOP parolees successfully remained out of prison after their release. This analysis allowed us to test for the effects of the MHSCP transitional process on parolees’ *survival*, that is, time to first re-incarceration. Consistent with the logistic regression models summarized earlier in this report, this model included age, gender, race/ethnicity, region, and severity of mental health problems as control variables. In addition, the model included whether the inmate had received a pre-release assessment and whether he or she had attended a POC upon release from

prison.³ The results of the full Cox regression appear in Table 6. In addition, Figures 8 and 9 (Appendix A) depict the survival curves for OISB-listed CCCMS/EOP parolees by pre-release assessment status and POC attendance.

Table 6: Results of Proportional Hazard Model Predicting Risk of Recidivism Over Time Among CCCMS/EOP Parolees Released July 1, 2003–December 31, 2007 ($N=91,277$)

Variables	Parameter Est.	Hazard Ratio
Age	-0.01	0.99 ***
Male (ref: female)	0.33	1.39 ***
African American (ref: white)	-0.04	0.96 ***
Hispanic (ref: white)	-0.17	0.84 ***
Other Race (ref: white)	-0.17	0.84 ***
EOP (ref: CCCMS)	0.24	1.27 ***
TCMP Assessed (ref: non-assessed)	-0.11	0.90 ***
Attended POC (ref: did not attend)	-0.59	0.55 ***

*** $p < .0001$

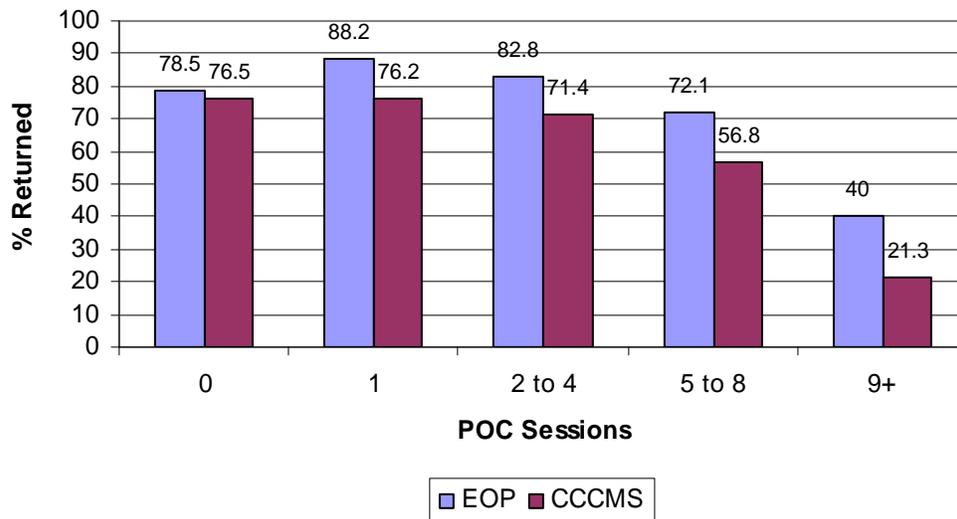
The parameter estimates in Table 6 represent the magnitude and direction of the effects of the independent variables on the outcome (i.e., days on parole). Parameters with a negative sign indicate a longer time on parole. As in the previous multivariate models, all of the background variables are statistically significant. However, even after controlling for these potentially confounding effects, we see that receiving a pre-release assessment was independently predictive of the number of days on parole. Likewise, attending a POC remained strongly predictive of days on parole. Specifically, parolees who attended a POC had a proportional hazard of only .59 of those who did not attend a POC.

B. Time in Program

As noted earlier, Berecochea and Liu (1999) found a positive relationship between the number of POC services and the length of time a CCCMS/EOP parolee remained out of prison. This time-in-program effect has been observed in other studies as well—particularly evaluations of substance abuse treatment. It should be noted, however, that this is a correlational finding, which makes it difficult to disentangle individual- and program-level effects.

³ The number of days on parole was fitted by a proportional hazard (Cox) model. The data were right-censored at 366 days.

Figure 10: Return to Custody (12 Months) by Number of POC Visits, January 1, 2003–December 31, 2007 (N=69,407)



In the current study, we examined the relationship between the number of times a parolee was present for a scheduled POC visit and the likelihood of being returned to custody within 12 months of release. Based on data on OISB-listed CCCMS/EOP releases from January 1, 2003–December 31, 2007 (N=69,407), 45.9% had no POC contact, 14.0% had one POC visit, 18.0% had 2–4 POC visits, 9.3% had 5–8 POC visits, and 12.8% had nine or more. Figure 10 shows 12-month recidivism results across these five groups and by EOP/CCCMS status.

Consistent with previous research, our analysis revealed a strong relationship between the number of POC sessions attended and recidivism risk (Spearman $r = -.28$, $p < .0001$). Specifically, the greater number of POC contacts a CCCMS/EOP parolee had, the less likely he or she was to be returned to prison. Interestingly, the greatest decline in recidivism risk occurred for parolees who attended a POC more than four times.

IV. Cost Analysis

As we have seen above, inmates who received MHSCP transitional services were less likely than inmates who did not receive these services to have been returned to prison during the 12 months following release. Overall, based on the January 1, 2003–December 31, 2007, release cohort, TCMP-assessed parolees spent an average of 27.2 more days on parole during the year following release than did non-TCMP-assessed parolees. Likewise, parolees who attended a POC one or more times following release spent 69.1 more days on parole than did parolees with no POC contact. However, because CCCMS and EOP differ substantially in their incarceration costs, we have calculated number of days on parole separately for these groups (see Table 7).

Table 7: Additional Days on Parole and Estimated Correctional Costs by Mental Health Status*

Classification	TCMP-Assessed (Days)	Any POC Contact (Days)	Est. Daily Incarceration Costs	Est. Daily Parole Cost
EOP	28.3	58.6	\$93.3	\$9.99
CCCMS	27.1	73.9	\$48.7	\$9.99

*Maximum number of days is truncated at 366

To estimate annual correctional cost savings associated with the MHSCP, we assumed daily incarceration costs of \$93.30 per day for EOP inmates and \$48.70 per day for CCCMS inmates (CDCR, 2003). From these figures, we subtracted the estimated daily cost of parole supervision (\$9.99), which resulted in estimated daily cost savings of \$83.31 for each additional day an EOP parolee remains under community supervision (relative to being incarcerated), and \$38.71 for each additional day a CCCMS parolee remains under community supervision. Based on these assumptions, we calculate that pre-release assessments conducted by TCMP-MI social workers resulted in an annual savings of \$2,357 for each EOP parolee and \$1,049 for each CCCMS parolee, relative to non-assessed parolees. Regarding the cost savings associated with POC attendance, we calculated that having one or more POC contacts following release was associated with an annual savings of \$4,881 per EOP parolee and \$2,861 for each CCCMS parolee, relative to those with no POC contact.⁴

V. POC Clinician Interviews

To complement the quantitative data collected and analyzed for this evaluation, telephone interviews were conducted with POC-based clinicians (i.e., psychiatrists, psychologists, and social workers) from August 2007 to January 2008. The purpose of these interviews was to assess clinical staff’s perceptions of the MHSCP and how the recent policy changes affect it.

A 50% sample was drawn from each of these three staff categories in each of the four parole regions. This resulted in a sample frame of 105 subjects. Of these, 78 clinicians completed the interview (a 74% response rate). We have included these findings to provide a forum in which POC clinicians could voice their opinions regarding the MHSCP program and how it might be improved.

Clinicians were primarily asked open-ended questions. Their responses were typed into a data entry form. After all responses were gathered, they were reviewed and coded into corresponding categories.

Five major themes ran through the majority of the 78 MHSCP POC clinician interviews: (1) The need for clinicians to be involved in treatment planning, based on clinical judgment, diagnosis, and patient needs; (2) The lack of resources (including transportation, housing, clerical staff, clinical staff, and clinical space) that are needed to successfully treat patients, particularly under

⁴ Because these values reflect both the independent effect of pre-release assessments and the self-selection effects of POC attendance, they should not be combined into a single measure of savings.

the new guidelines requiring eight consecutive weekly sessions for EOP patients and four consecutive weekly sessions for CCCMS patients; (3) Lack of access to prior mental health, psychiatric medication, and other records from the prison; (4) The need to improve coordination and communication between clinicians within the institution and those at POC to ensure continuity of patient care; and (5) The need for improved functionality of the MHCAS computer database. The following summary provides more details about these major themes and clinicians' suggestions to improve the MHSCP program.

- *Are you aware of the CDCR's recent policy changes designed to enhance the effectiveness of the MHSCP program?*

The majority of respondents responded affirmatively (95%); 5% said either "No" or "I don't know."

- *(If "yes,") In your opinion, how have the recent changes to the MHSCP program affected services for parolees with mental illness?*

Overall, 38% of clinicians thought that the new policy requiring eight consecutive weekly sessions for EOP patients was good or helpful. A majority (55%) of clinicians thought that the new policy had a negative impact on patient care. About 21% were either too new to comment on whether the policy was effective; thought that the policy was helpful in some situations, or with certain patients, but not with others; or felt that the policy may not be effective in reducing recidivism (note that some respondents may have been "double-counted" if they mentioned traits that were characterized as "positive" and "negative." Therefore, percentages add up to more than 100%)

Specific positive characterizations of the new policy included: (1) It is a good policy overall (27%); (2) More patient contact is beneficial to the patient (12%); (3) It helps to provide the patient with services (6%); (4) It helps to develop a better relationship between the patient and the clinician (5%); and (5) It makes patients more accountable and motivated (3%).

Specific negative perceptions of the new policy included: (1) There is a lack of resources to implement the new policy effectively (e.g., clinical space; clerical staff; bus passes/access to transportation, especially for rural or suburban areas; housing; and problems with the MHCAS system; 27%); (2) It is difficult for the clinician to implement the new policy (e.g., caseloads are too high; there is too much paperwork, which backs up clinicians' schedules; and some patients are noncompliant; 21%); (3) The clinician should decide how often to see the patient based on his/her clinical judgment, the diagnosis, and patient needs (13%); (4) The new policy interferes with patients' work schedules or hinders patients from seeking employment (9%); (5) It is burdensome to the patient because it detracts from other essential things that the patient needs to do (e.g., locate housing, apply for social services and welfare benefits, etc.; 8%); (6) There is no difference in patient attendance compared to patient attendance before the new policy (6%); (7) Patients are not designated correctly (i.e., A clinically CCCMS patient may be designated as an EOP in the institution and vice-versa; 6%); and (8) Line staff were not consulted before the implementation of the new policy, or were not included in the treatment planning (3%).

In addition, 21% of clinicians expressed doubt or did not have a frame of reference concerning the new policy. Specifically: 8% thought that the policy may be effective for some patients, but not for others; 6% were not at POC long enough to determine whether the new policy had a positive or negative impact; 4% said that some patients do not want services or that making the

patients come in to POC is frustrating for the patients and the clinicians; and 3% thought the new policy may not be effective at reducing recidivism.

- *What is your typical response if a parolee does not keep his or her scheduled appointment?*

About one-third of clinicians mentioned that their response depends on the situation. For example, if the patient calls in ahead of time, notifying the clinician that s/he will not be able to come into POC, the clinician will usually mark that as “excused.” However if the patient willfully misses the appointment and does not call in, then s/he would be recorded as “absent.” This absence would be counted as a violation of the patient’s parole. Often patients are unaware of their POC appointments. Some are homeless and have no stable address. Others may not be homeless, but their address changes frequently and they do not receive their appointment letter.

Most clinicians reported that they generally notify the parole agent and request that the agent tell the patient to come in to the POC for their appointment (76%). Clinicians also reschedule the appointment and send the patient an appointment notice (68%). If the patient misses the first appointment, some clinicians also send a notice to the Parole Agent Supervisor (5%). About 23% of clinicians call the patient, 8% make a note in the MHCAS system, and 12% check the Cal Parole database or other source of information to track down the patient’s current address and find out if the patient is still incarcerated. After three non-excused absences, the clinicians usually close the case.

- *What are the most important barriers that keep patients from attending their scheduled appointments?*

According to clinicians, transportation-related issues were the most common barriers that kept patients from attending their scheduled appointments—83% said that lack of bus passes, lack of transportation, and the long distances patients needed to travel to get to the POC were major barriers keeping patients from their appointments. Other important barriers included: (1) Lack of motivation or personal responsibility (26%); (2) Poverty (no money), or unstable housing and environment (24%); (3) Work conflicts (19%); (4) Substance abuse (13%); (5) Problems with patients not receiving appointment notices when auto-generated appointments are mailed to incorrect addresses (12%); (6) Patients’ forgetfulness (often due to mental health or substance abuse problems; 10%); (7) Patients’ lack of life skills, including time management skills (8%); (8) Patients’ mental illness/cognitive impairments (5%); and (9) No dedicated clerical staff for POC (3%).

- *For what percentage of new admissions to your POC are you able to access parolee data collected by a TCMP social worker as part of the pre-release interview?*

There was wide variation in clinicians’ responses; however, over one-third of respondents reported being able to access information collected by the TCMP social worker for 50%-85% of their new admissions. The breakdown of other responses is as follows: (1) 19% of respondents were able to access little or no useful information; (2) 18% said that they were able to access

TCMP information from 10%-49% of their new admissions; (3) 17% could not provide an estimate; 6% were able to access TCMP information for all or almost all of their new admissions; and (4) The question did not apply for 3% of respondents.

While some of the clinicians found that the TCMP notes were not necessarily useful or accurate (21%), others said that the information has improved over time and that some of the TCMP social worker notes are very helpful (5%).

- *How does having this information impact the way you conduct the Initial Mental Health Examination?*

About one-third (36%) of respondents generally reported that the TCMP social worker notes gave them an idea of what to expect before conducting the Initial Mental Health Examination (IE) with the patient. An equal number of respondents reported that having the information had little or no impact on how they conducted the IE. The reasons for this included that the TCMP notes are sometimes not available, or little information was included regarding the patient's mental health treatment and medication history while in the institution. About 25% of respondents said that it would be more helpful if there were more detailed mental health treatment, diagnosis, and/or medication information in the TCMP notes; if the POC clinician could communicate directly with prison mental health personnel; or if the TCMP notes could be imported into the MHCAS.

- *Is your clinic currently serving EOPs?*

The vast majority (96%) of respondents said that their clinic serves EOPs.

- *On average, for what percentage of EOP parolees are you able to hold an Interdisciplinary Treatment Team meeting within the 30 days following completion of an Initial Mental Health Examination?*

This question did not apply for 14% of respondents because they did not carry a caseload, did not have EOPs on their caseload, or were not the primary clinician. An additional 11% did not provide an estimate, and 8% said they did not know the percentage. The remaining responses on how often the IDTTS are held within the timeframe are as follows: (1) Always/almost always (90% or more of the time): 21%; (2) Regularly (50%–89% of the time); 22%; (3) Sometimes (10%–49%); 6%; (4) Never/almost never (less than 10% of the time); 8%.

Some clinicians reported that the IDTT is not a formal face-to-face meeting with the clinician, parole agent, client, or psychiatrist (10%). Small, informal meetings between the primary clinician and agent, primary clinician and parolee, and primary clinician and psychiatrist/psychologist are held instead (9%). Some clinicians reported that it is difficult to do the IDTT within the timeframe due to scheduling conflicts, or client no-shows (14%).

- *Who normally participates in these meetings?*

Forty-one percent of respondents reported that the parolee, parole agent, the psychiatric social

worker, and either a psychologist or psychiatrist normally attend the IDTT. The next most common response was “the primary clinician (usually the psychiatric social worker), parole agent, and the patient” (10%). Eight percent of respondents reported that the meetings occur among the primary clinician, parole agent, and psychiatrist (without the parolee). Another 8% percent reported that the IDTT involves the parolee and clinician and/or psychiatrist; 4% reported that the meeting involves only the psychiatric social worker and the psychologist/psychologist; and 4% said that the meeting only involves the clinician and the agent. The remaining 25% either said that formal team meetings are not conducted, or did not comment on this question.

- *For what percentage of the patients on your caseload do you participate in a discharge planning process within 120 days of discharge from parole?*

Generally, respondents reported that they conducted a discharge planning process for all patients who they knew were going to be discharged (47%). About 18% of respondents either did not carry a caseload, or had no formal meetings, but had informal meetings with the parolee, agent, or another clinician. Some clinicians reported regularly having discharge planning with 50% or more of their patients (12%). Others said that discharge planning occurred for less than 50% of their patients (8%). Some clinicians reported that they never, or almost never do discharge planning because most of their patients never get discharged (they return to custody), or the clinician is not notified early enough that the patient is discharging (12%).

- *Who normally participates in these meetings?*

Most respondents said that generally, the same people who participate in the IDTT participate in the discharge planning meetings. These are generally not formal meetings, as it is difficult to schedule all participants in the same room together with the patient. Often, the primary clinician will discuss discharge planning informally with the parole agent, other clinicians (e.g., psychologists, psychiatrists, psychiatric social workers), and the patient.

- *What information in the MHCAS do you find most helpful?*

Overall, clinicians found that past case notes (65%), prior evaluations (51%), medication history (51%), and DSM-IV diagnosis (21%) contained the most helpful information in the MHCAS. Other helpful information included: (1) The appointment log (15%); (2) The patient's current address and phone number (10%, however, 4% of clinicians noted that this information is most current in Cal Parole, not MHCAS); (3) Parole agent information (10%); (4) Caseworker information (5%); and (4) Discharge date (4%).

Nearly one-quarter (23%) of respondents mentioned that, often, there is little or no prerelease data, or prior information regarding diagnosis, psychiatric medication, current medications, or past psychiatric history/treatment. Some clinicians stated that all of the information that is actually in the MHCAS is helpful (9%), and others reported that the information often lacks the detail necessary to be useful for the clinician (9%).

- *What, if any, information in the MHCAS do you not find helpful?*

Again, clinicians reported that any information in the MHCAS is helpful (18%). The problem is that the information is often not entered into the system, lacks sufficient detail about the patient's psychiatric history and medication history, or is sometimes inaccurate.

The following are the most commonly reported unhelpful characteristics about the MHCAS: (1) Many tabs are not used (including: body marks, goals, release needs assessment, revocation codes, children, alias; 45%); (2) Tabs are not filled in (including psychiatric history from the institution; 35%); (3) The MHCAS is often overloaded and slow, and sometimes does not allow the clinician to work efficiently (15%); (4) The MHCAS sometimes has inaccurate or outdated information (8%).

Some clinicians suggested that it would be more helpful if the MHCAS were integrated with other criminal justice systems (4%). Similarly, some thought that some of the tabs in MHCAS were redundant since they are available in Cal Parole (3%). About 18% found the MHCAS to be mostly helpful and 4% said that unused tabs would be helpful if information was entered in these tabs. In addition, 4% of respondents reported that some of the case notes in the MHCAS were not helpful because they lacked detail or were too "generic" or "boilerplate."

- *Is there any additional information you would like to see included in the MHCAS database?*

Once again, respondents reported that they would like more information about patients' prior psychiatric history and mental health treatment while they were in the institution (42%). Having this information would inform clinicians of what worked well and what did not work well. Respondents would also like to access more current information in the MHCAS (22%). Of these, some suggested employing clerical staff to make sure that records are current. Access to an integrated database system that would link the institution and Cal Parole was mentioned by 17% of respondents. Some suggested the MHCAS auto-populate fields from Cal Parole, including current address. About 12% of respondents characterized the MHCAS as either "overloaded" or "slow," and would like the MHCAS to run faster and more efficiently. Respondents also wanted more information on patients' criminal history (6%); improved functionality (e.g., correcting a date, going to another case note while in a separate case note, the ability to enter group information; 5%); the addition of a place in the system to review lab results (4%), and the elimination of some tabs (4%). Approximately 8% of respondents said that they did not want to see any additional information in the MHCAS.

- *How has the increase in POC staff affected your workload and patient outcomes?*

Approximately 22% of respondents did not feel that their workloads had been affected by the increase in POC staff, and 8% reported that their offices did not receive a staff increase. Of those that did see staff increases in their offices, 23% said that the increases helped reduce their caseloads to manageable levels, 15% said that they are able to spend more quality time with patients, and 8% said the increase was somewhat helpful. Others were not as positive about the increases, reporting that the increases have not really helped to reduce workload (5%), there is

not enough office space for new hires (6%), and caseloads are still not manageable (4%). Three percent of respondents said that client outcomes were better (e.g., the patients are staying out of prison longer).

- *What is the impact of the new guidelines requiring 8 consecutive weekly sessions for EOP patients and 4 consecutive weekly sessions for CCCMS patients?*

Slightly more than one-quarter of respondents reported that the new guidelines have had a mostly positive impact on patients, 14% said that the impact was generally negative, and 10% said that the guidelines had pros and cons. Many respondents reported that the new guidelines were difficult to implement (28%). Some reported that the guidelines were too rigid and should allow clinicians to use clinical judgment on how often patients should come in based on their individual needs (14%). Respondents reported that clients sometimes have difficulty with work-related conflicts (5%) and access to transportation/money (8%), and need other services (3%). Some respondents reported that there has been little improvement as a result of the new guidelines (4%), that EOPs are already seen weekly (3%), and that it is too early to know the impact of the new guidelines on patients (5%).

- *In your opinion, how could the MHSCP program be further improved?*

Respondents mentioned that increased access to community resources and services for patients were essential to improving POC services (27%). These resources include: bus passes, food vouchers, substance abuse treatment placement, employment services, intensive day programs, and residential mental health programs. Some clinicians reported that having trained clerical staff handle scheduling and data entry would be very helpful (14%). Regular meetings and communication with parole agents, including setting up automated communications through MHCAS was also suggested by respondents (14%). About 13% of respondents mentioned that the MHCAS could be improved; 10% suggested hiring more clinical staff; 9% reported that additional clinical space was needed (some clinicians do not have a desk or office space, and waste time looking for a place to see patients); and 9% mentioned that a better system of communication between the POC and the institution would be helpful.

Additional suggestions for improvement included: more training across different regions and standardization of expectations and guidelines (6%); more manageable caseloads (4%), increased clinician accountability (4%), materials (4%), and more flexibility in terms of use of clinical judgment based on patient needs and the discretion to focus on clients who want services (4%). Three percent of respondents said that policy decisions should be made after soliciting input from the line staff.

VI. TCMP-MI Social Work Interviews

The purpose of the TCMP-MI interviews was to gain a greater understanding of TCMP-MI social workers' experiences and gather their input on how the MHSCP Program could be improved. Interviews with TCMP-MI social workers were conducted from April to May 2007. TCMP-MI program directors were faxed a memo from Robert Storms dated April 18, 2007, that

explained the purpose of the Evaluation of the MHSCP program and the telephone interviews with the TCMP-MI social workers.

Thirty-eight interviews were conducted with TCMP-MI program directors, supervisors, and social workers (out of a total population sample of 42). Among these 38 interviews, two pilot test interviews were conducted before contacting the other TCMP-MI staff. One of the pilot tests was not included in the analysis as the respondent quickly read a copy of the questions, but did not provide responses for many of them. Thus, 37 interviews (accounting for 88% of TCMP directors, supervisors, and social workers) had sufficient data to be analyzed. The sample did not include staff on leave during this time period.

All of the interviews were conducted over the telephone and lasted approximately 10 to 15 minutes each. The interviewer typed staff responses into a word processing program while conducting the interviews. Responses were coded question by question. Results were tallied and analyzed using a spreadsheet program.

The following is a summary of responses to the (bulleted) interview questions.

- *How would you describe your interaction with correctional staff?*

Overall, more than 81% of respondents described their interaction with correctional staff as generally good or positive. Several mentioned that even though, once in a while, institutional staff who are unfamiliar with the TCMP-MI program can be uncooperative, for the most part, staff are very helpful and/or cooperative (30%). Correctional staff were also described as friendly (11%), nice (8%), and accommodating (8%). Three TCMP-MI social workers described their relationship with correctional staff as great or excellent (8%).

- *How could staff at these institutions help you to be more effective?*

While about 16% of respondents had no suggestions on how institutional staff could help them to be more effective, and felt that staff were already quite helpful, approximately one-third of respondents felt that staff at the institutions could help them by reducing their waiting time or by making sure that the inmates were available at their scheduled time. Another 24% felt that providing training or education to the institutional staff about the TCMP program and the roles of the TCMP-MI social workers would be helpful. Sixteen percent expressed a desire for more interaction and collaboration with the mental health staff. About 14% felt that having a space or area to work in would help to make their job more effective. These social workers have no dedicated area to conduct face-to-face interviews with inmates or to review their files. Access to and availability of inmates' files was another important issue for social workers—about 8% said that this access would help them to be more effective.

- *How many hours, on average, do you spend traveling to and from institutions?*

The average time respondents spent traveling to and from institutions was 6.9 hours/week. TCMP-MI staff working out of the Kern office spent about 2.3 hours more time, on average, traveling to/from the institutions than those working out of the San Diego office.

- *How often do you interact with the mental health staff in the prison?*

	Total (N = 37)	Kern (N = 22)	San Diego (N = 15)
Often	54%	64%	40%
Sometimes	19%	14%	27%
Rarely	27%	23%	33%
Never	0%	0%	0%

The main reason respondents gave for rarely interacting with mental health staff in the institutions was that they do not work in the same areas where mental health staff are working. One clinician said:

“They're really not all that visible. I see the inmates in their dorms. A lot of times they [mental health staff] are seeing the inmates in their offices. They're doing their thing and I'm doing mine for the most part.”

- *What is the impact of lock downs (or fog days) on conducting the pre-release interviews?*

Approximately 40% of respondents said that when there is a lock down at the prison they are unable to see the inmates and cannot do the pre-release interviews with them. About 11% however, said that completion of the pre-release interviews depends on the type of lock down and/or the prison. Sometimes they are able to go to the inmate’s housing unit and do the pre-release interview in front of the cell, other times the correctional officers are able to escort the inmates to the TCMP-MI social worker to do the face-to-face interviews. Overall, approximately 35% of respondents said that lock downs usually have little or no impact on conducting the pre-release interview. A few said that they had not yet experienced a lock down. Nearly 19% of respondents said that lock downs increase the time that it takes to see an inmate. One social worker said that in the event of a lock down, he does his work at other yards and waits for the lock down to be lifted. Another said, “It doesn’t keep me from seeing my inmates, it just makes it harder.” This feeling is echoed by another social worker who said:

“[Having a lock down] becomes a big impact. I can’t pull the inmate out of their cells when there’s a lock down. I’ve had to go to their cell door to give them information about going to POC and hand them their paperwork under the door. I haven’t encountered any problem with fog days, but I can’t take the laptop in there during lock downs.”

- *How common is it for someone in the institution to refer inmates to you that are not on the OIS list?*

	Total (N = 37)	Kern (N = 22)	San Diego (N = 15)
Often	19%	23%	13%
Sometimes	8%	9%	7%
Rarely	41%	41%	40%
Never	27%	23%	33%

At least 2 TCMP-MI social workers reported that they receive self-referrals from inmates. One said, “Inmates self-refer, too, and I’ll go and find out if they’re CCC, and they are, but they’re not in the computer.”

Some problems were pointed out by another social worker:

“...sometimes people in the reception center don’t show up on the regular list, or the OIS list. We do the best we can, but they just don’t show up for us. Another problem is that some inmates are released and returned to custody quickly so they don’t have enough time to appear on the OIS list...but the biggest problem is that people don’t get on the OIS list from the reception center.”

- *Do you conduct pre-release interviews with parole violators who have been returned to custody for a technical violation (e.g., not attending a POC appointment)?*

All respondents said, “Yes.”

- *In what ways do you think that the TCMP-MI Social Workers’ roles and responsibilities should be changed to improve the effectiveness of the MHSCP program?*

The most common responses dealt with providing inmates assistance with pre and post care. Roughly one-third of respondents mentioned that they would like to play a larger role in providing some type of continuum of care or assist inmates with access to comprehensive services and resources. Respondents expressed interest following up with the inmates to find out whether the inmate was able to successfully transition after release. One social worker expresses this sentiment:

“The only thing is to have more follow-up with them when they get out. See if they’re making the [POC] appointments. To research better what works and what doesn’t work.”

Similarly, another social worker emphasized the need for a continuum of care saying:

“Well what I would like to see happen, because right now we serve as the liaison between the prison and POC, but if there was some way we could transfer information from POC back to prison when the inmate is reincarcerated, so that there is a transfer of information, a continuum of care, it would be helpful.”

About 11% of respondents did not feel that their roles and responsibilities should change. One said:

“I don’t really think that the role itself should be changed so much, but if we had more time with the individual inmate I think we could provide better services. But that’s just a problem of too many inmates and not enough social workers.”

Nearly 19% of respondents felt that their roles and responsibilities should include more regular communication with POC staff and/or more access to POC staff notes.

- *More generally, how could the CCCMS/EOPs’ transition process from the institution to POC be improved?*

One main theme found throughout the TCMP-MI interviews was the importance of understanding that paroling EOP/CCCMS inmates’ priorities are safety and basic needs, not their POC appointment. If the inmates’ basic needs are first met, they are more likely to attend their POC appointments. About 30% of respondents touched on this point. The following is one response from a social worker:

“Discharge planning. Any kind of discharge planning—as far as getting them referrals for housing, transportation, and supports. Meds are important, but a lot of times it goes a lot further than that. A lot of times homelessness is the only choice that they have.”

Again, providing paroling inmates a continuum of care was a common response that social workers emphasized would help inmates with the transition to POC.

“A lot of times they really do want to succeed and don’t want to go back, but they don’t have the support when they get out. They go back to their old ways and wind up back in. Support when they parole is important. Ideally, it would be great if there were aftercare, if there were a continuum of social work available to them.”

Nearly 38% of respondents reported that set appointment dates/times with specific POC clinicians was important in improving the transition process for EOP/CCCMS inmates. One social worker said that more timely POC appointments would improve the effectiveness of the MHSCP Program and went on to explain:

“We print them [POC appointments] off from the PATS [MHCAS] system if they’re available, but often they are not available, so we have to print a general letter. It’s better if they have a concrete appointment date, time, and location.”

More personal attention and meaningful contact with EOP/CCCMS inmates was suggested by over 10% of respondents. One social worker suggested:

“More meaningful contacts with social workers. We all have extremely high caseloads and we can’t see the inmates as often as we would like. If we had more hands to do the work, that would make it a lot easier.”

Efforts to bring TCMP-MI, POC, and parole together have begun. According to one social worker:

“We had a conference last August. It was the first time that parole, POC, and TCMP got together...We worked out some computer issues and made some connections. So the attempts to communicate are there.”

VII. Telemedicine Satisfaction Survey

Telepsychiatry (the application of telecommunications and computerized information technology as an alternative to face-to-face interactions between the psychiatrist and patient) has been well received with regard to its ability to increase access to care (Antonacci et al., 2008). Questions remain, however, about its effectiveness because there are few clinical outcome studies concerning this practice. Even less is known about the effectiveness of telepsychiatry among parolees. Although the current project did not involve a rigorous evaluation of the effectiveness of telepsychiatry for CDCR parolees, the growing reliance on this approach for parolees returning to remote areas, where access to traditional psychiatric care is limited, prompted a collaboration between the UCLA evaluation team and Dr. Grant Jordan (chief psychiatrist at the Region I parole outpatient clinic headquarters in Sacramento).

The purpose of this study was to assess parolees' perceptions of telepsychiatry services they received while on parole. To facilitate this, Dr. Jordan and his staff identified 24 parolees in Region I who had received post-release care under both traditional (face-to-face) and telemedicine conditions. These parolees were administered an anonymous, 11-item survey that was a modified version of the Telemedicine Satisfaction Questionnaire (TSQ) developed by Yip et al. (2003; see Appendix B). Data were collected in May and June of 2008.

Table 8 presents single-item response values (means and standard deviations), with higher scores indicating higher levels of agreement. Any mean response value over 3.0 indicates at least some level of agreement with the corresponding statement. Overall, the respondents gave favorable responses regarding their psychiatrists and telemedicine. Only two items (“I obtain better access to healthcare services by use of telemedicine than I did when I had face-to-face sessions” and “I meet with my doctor more frequently via telemedicine than I did when the visits were face-to-face”) had mean responses below 3.0. These two items are designed to assess whether telemedicine is *superior* to face-to-face sessions. While this sample of parolees did not find telemedicine to be superior to face-to-face contact with their psychiatrists, they did seem to agree that telepsychiatry was as good as face-to-face contact with their psychiatrists. Two scales derived from these items support this contention: *Quality of Care* (Mean=3.5; SD=1.1) and *Similarity with Face-to-Face Sessions* (Mean=3.8; SD=1.1).

Table 8: Mean Response Values to Individual Items of the Telemedicine Satisfaction Questionnaire ($N=24$)

Question	Mean	SD
I can easily talk to my psychiatrist	3.4	1.5
I can hear my psychiatrist clearly	3.8	1.3
My psychiatrist is able to understand my condition	4.3	0.8
I can see my psychiatrist as if we met in person	3.5	1.5
I feel comfortable communicating with my psychiatrist	4.0	1.1
I obtain better access to healthcare services by use of telemedicine than I did when I had face-to-face sessions	2.6	1.6
I receive adequate attention at telemed sessions	3.7	1.1
Telemedicine provides for my mental health needs	4.0	1.2
I meet with my doctor more with telemed than when my visits were face to face	2.5	1.3
Telemed is an acceptable way to get psych services	3.7	1.5
Overall, I'm satisfied with the quality of service I receive via telemedicine	3.7	1.4

Note: Response options ranged from 1 (*strongly disagree*) to 5 (*strongly agree*)

VIII. Conclusions

Findings from the current evaluation replicated trends noted in previous reports. Namely, about half of eligible parolees received a pre-release assessment, and those who did were more likely than those who did not to attend a POC following release. Likewise, receiving a pre-release interview was significantly associated with attending a POC upon release, which, in turn, was significantly associated with lower risk of recidivism. With regard to the impact of CDCR's new policy to increase POC attendance, the percentages of CCCMS and EOP parolees attending the requisite number of sessions (i.e., 4 and 8, respectively) showed a statistically significant increase after the effective dates for these changes. Unfortunately, due to the short overlap between the implementation of the new policy and the evaluation timeframe, we were unable to assess the impact of these changes on recidivism.

Lastly, semi-structured interviews conducted with a sample of POC clinicians indicated that 38% of clinicians thought that the new policy requiring eight consecutive weekly sessions for EOP patients was good or helpful, but a majority (55%) of clinicians thought that the new policy had a negative impact on patient care. Reasons given by the latter group included a lack of resources to implement the new policy effectively (e.g., clinical space; clerical staff; bus passes/access to transportation, especially for rural or suburban areas; housing; and problems with the MHCAS system), and difficulty maintaining large caseloads and the associated paperwork. It should be noted, however, that these interviews took place in the early stages of implementation before the planned staff increases were complete.

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**Appendix A:
(Figures 8 & 9)
Survival Curves Predicting 12-Month Recidivism as a Function of TCMP Assessment
and POC Attendance**

Figure 8

Estimated Survival Function for
TCMP Pre-Release Assessment

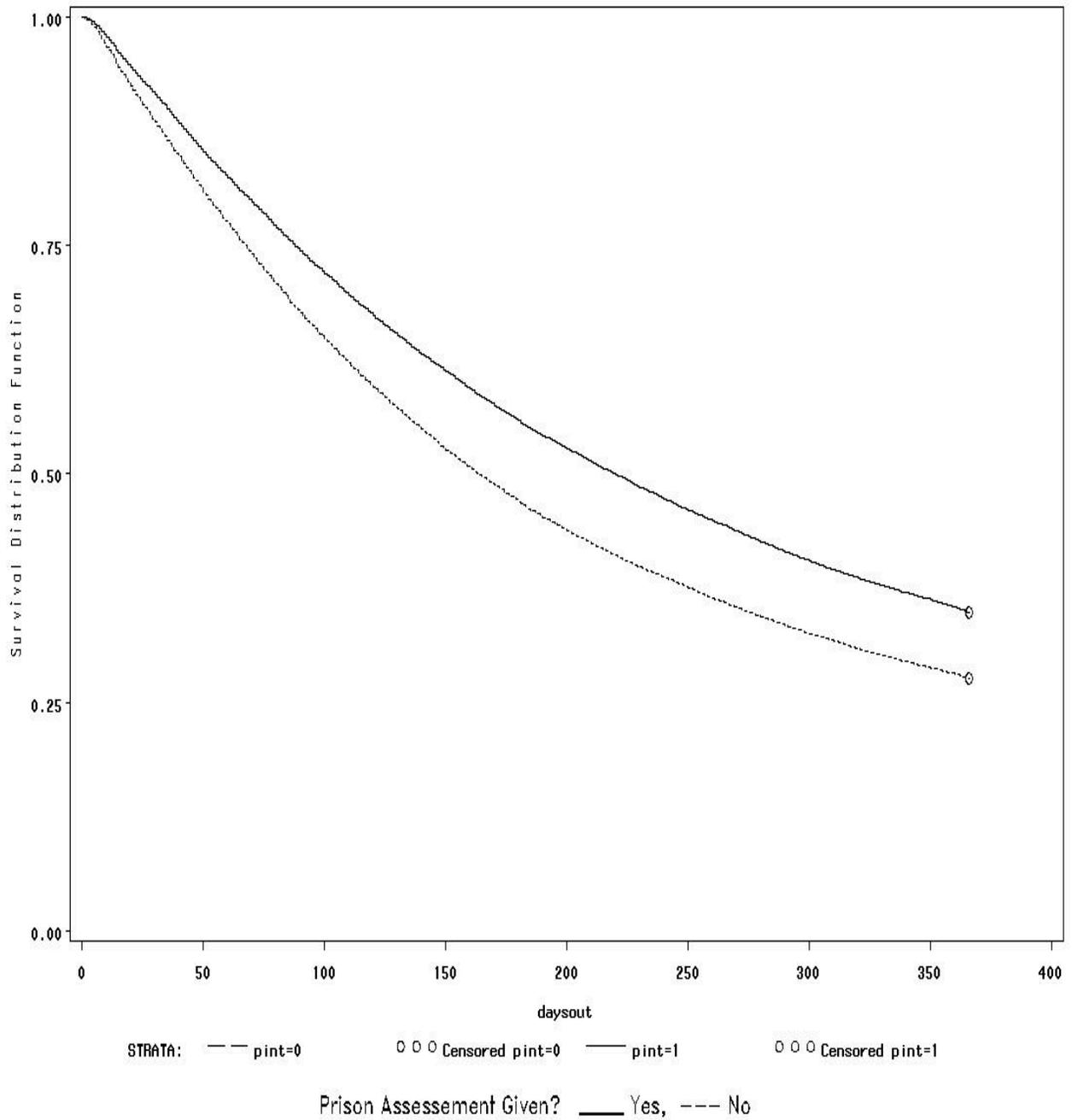
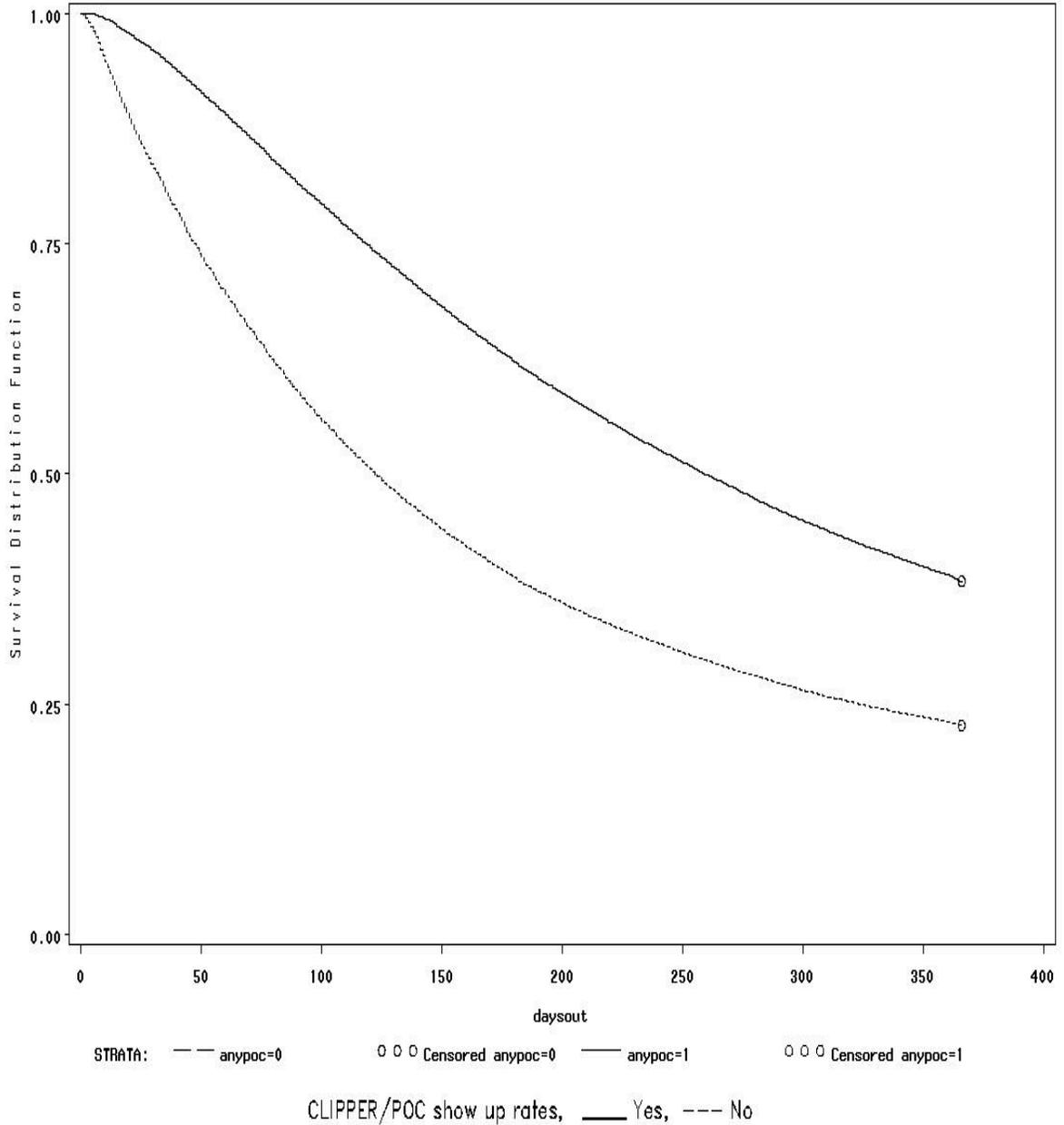


Figure 9:
Estimated Survival Function for
One or More POC Contacts



Appendix B:
Telemedicine Satisfaction Questionnaire
(Modified Version)

Telemedicine Satisfaction Survey

On a scale from 1 to 5 (“1” being “strongly disagree” and “5” being “strongly agree”), please circle the number that indicates the extent to which you agree or disagree with the following statements.

	Strongly disagree				Strongly agree
1. I can easily talk to my psychiatrist.	1	2	3	4	5
2. I can hear my psychiatrist clearly.	1	2	3	4	5
3. My psychiatrist is able to understand my condition.	1	2	3	4	5
4. I can see my psychiatrist as if we met in person.	1	2	3	4	5
5. I feel comfortable communicating with my psychiatrist.	1	2	3	4	5
6. I obtain better access to health-care services by use of telemedicine than I did when I had face-to-face sessions.	1	2	3	4	5
7. I receive adequate attention at telemedicine sessions.	1	2	3	4	5
8. Telemedicine provides for my mental health needs.	1	2	3	4	5
9. I meet with my psychiatrist more frequently via telemedicine than I did when the visits were face to face.	1	2	3	4	5
10. I find telemedicine an acceptable way to receive psychiatric services.	1	2	3	4	5
11. Overall, I am satisfied with the quality of service being provided via telemedicine.	1	2	3	4	5