Mentally Ill Offender Crime Reduction Grant Program

Legislative Report
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California Board of Corrections

MENTALLY ILL OFFENDER CRIME REDUCTION GRANT PROGRAM

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EXECUTIVE SUMMARY

The California Legislature established the Mentally Ill Offender Crime Reduction Grant (MIOCRG) program in response to a concern that jails are among the primary (or only) treatment facilities for an increasing number of mentally ill people. The MIOCRG program's ultimate goal was to test, determine, and document "what works" in reducing recidivism among these offenders.

This initiative directed the Board of Corrections (Board) to award grants supporting the implementation and evaluation of projects that demonstrated locally identified strategies for helping mentally ill offenders avoid further involvement in the criminal justice system. Funds appropriated to the MIOCRG program – nearly $81 million over five years – represented the most money spent anywhere in the United States on mental health issues for people in jail. These grants supported 30 collaborative demonstration projects involving over 8,000 mentally ill individuals in 26 counties across California.

The enabling legislation for the MIOCRG program (SB 1485, Chapter 501, Statutes of 1998) also directed the Board to evaluate the overall effectiveness of these projects. In fulfilling this mandate, Board staff developed a research design that required participating counties to collect and report common data elements about the target population, the services participants received and the effects of the various interventions on curbing recidivism. Counties submitted their common data element files every six months and produced final evaluation reports at the conclusion of the MIOCRG programs, the last phase of which ended June 30, 2004.

The Board's analysis of the local research findings confirms that the enhanced treatment and support services offered through the MIOCRG program made a positive difference. The statewide research shows that program participants were: 1) more comprehensively diagnosed and evaluated regarding their mental functioning and therapeutic needs, 2) more quickly and reliably provided with services designed to ameliorate the effects of mental illness, 3) provided with more complete after-jail systems of care designed to ensure adequate treatment and support, and 4) monitored more closely to ensure that additional illegal behavior, mental deterioration, and other areas of concern were quickly addressed. As a result, MIOCRG participants were booked less often, convicted less often, and convicted of less serious offenses when they were convicted than were those receiving treatment as usual (TAU). Fewer participants served time in jail and, when they did serve time, they were in jail for fewer days than were TAU participants. MIOCRG participants improved in 'Quality of Life' outcomes including Global Assessment of Functioning (GAF) scores, reduced substance use/abuse, having housing, and economic self-sufficiency.

Subgroup analysis revealed that, for the most part, the MIOCRG projects had greater positive effects for mentally ill offenders who were 1) older and 2) more seriously criminally involved. These findings suggest the need for further research to determine their full implications and to suggest modifications in future programs to also impact younger and/or less seriously criminally involved offenders.

On the whole, the Legislature's investment in the MIOCRG Program has paid meaningful dividends. Thousands of individuals and hundreds of communities have benefited directly from the demonstration projects. Mental health and criminal justice agencies have learned to work together to maximize funding and fill service gaps. Clear evidence has been generated as to the effectiveness of Assertive Community Treatment (ACT), Mental Health Courts and wrap around, targeted, flexible services. A rich store of data has been developed for future exploration. Thus, the MIOCRG program has achieved its primary objective of enhancing understanding about effective strategies for successfully intervening with mentally ill offenders to help them live and participate in the community rather than cycling in and out of jail. These achievements benefit all Californians.

CHAPTER 1: INTRODUCTION

BACKGROUND

Recognizing that jails have become the treatment facilities of last (or first) resort for an increasing number of mentally ill people, the California Legislature, in 1998, established the Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program to determine what works in reducing recidivism among offenders with serious mental illness. The Legislature wanted to learn what programs, interventions and strategies could be shown to be most effective in keeping mentally ill jail inmates from returning to jail time after time.

From both a human and a fiscal perspective, the need to improve California's response to mentally ill offenders had become clear. Studies had repeatedly confirmed that a growing number of jail inmates suffered from severe mental illness and that schizophrenia, major depression, bipolar disorder and other mental illnesses often result in hallucinations, impaired judgment and criminal behavior. According to the Pacific Research Institute, California's annual jail and probation costs for mentally ill offenders exceeded $300 million a year.

**** Nationally, it is estimated that at least 16 percent of jail inmates are mentally ill.***

**** This translates into over 12,000 mentally ill inmates in California's jails.***

**** Jails are neither designed nor equipped to handle this population, yet these local detention facilities have become the primary source of treatment for the mentally ill.***

Law enforcement officials and mental health experts agree that most mentally ill offenders could avoid further involvement in the criminal justice system if they receive appropriate community based treatment and support services. However, targeted and coordinated services have not been available for the vast majority of offenders. Most jurisdictions are unable to focus already limited resources on this particularly needy population. The result is a costly cycle that adversely impacts not only offenders with mental illness but also local corrections and society as a whole. With little or no treatment, many of these individuals end up incarcerated time and time again for crimes that grow out of their illnesses.

In an effort to slow this "revolving door," the California State Sheriff's Association and the Mental Health Association of California co-sponsored SB 1485 (Chapter 501, Statutes of 1998), which created the MIOCRG Program (see Appendix A). The measure sought to reduce the number of mentally ill people repeatedly moving between the criminal justice system and the community due in large part to inadequate mental health treatment and support services.

PROGRAM STRUCTURE

The framework for the MIOCRG program involved three components that the Legislature deemed critical to reducing crime among mentally ill offenders: 1) interagency collaboration; 2) local discretion; and 3) rigorous evaluations.

Interagency Collaboration: Prior to the MIOCRG Program, local efforts to address the needs of mentally ill offenders were, by and large, compartmentalized and disjointed. With research increasingly pointing to the added value of an integrated and coordinated approach to addressing the treatment needs of people who are mentally ill, the Legislature structured the MIOCRG Program to compel collaboration among the criminal justice, mental health and other local agencies that come in contact with mentally ill offenders.

Collaboration was essential to the problem identification, the planning and gap analysis and the design and implementation of MIOCRG projects. To be eligible for a demonstration project grant, counties were required to form a multi-disciplinary Strategy Committee, chaired by the Sheriff / Director of Corrections, and including membership of, at a minimum, the chief probation officer, mental health director, a superior court judge, representatives from a local law enforcement agency, a mental health service provider, and a client / consumer.

In addition to being represented on the Strategy Committee, these different interests came together in the majority of MIOCRG demonstration projects to provide services, create and oversee support for project participants and build or enhance the jurisdiction's capacity to address the complex and varied needs of the target population. Although the 30 projects differed by virtue of their having been designed to address the unique needs and resources of each county, most employed multi-disciplinary teams and on-going inter-agency partnerships to accomplish their projects' intended outcomes.

Local Discretion: Because the availability of resources and scope of issues in California's counties preclude any predetermined, single response to mentally ill offenders, the Legislature also structured this program to maximize the ability of counties to design projects tailored to each jurisdiction's specific needs. As a result of the local planning and decision making built into the MIOCRG Program, the projects addressed a range of service gaps, offered a wide array of in-custody and/or out-of-custody interventions, incorporated diverse strategies and dealt with a variety of target populations.

The MIOCRG Program supported 30 demonstration projects in 26 counties. In-depth summaries of these projects (see Appendix C) show the variety of approaches used by participating agencies, as well as their findings as to effective strategies. The locally designed demonstration projects have not only improved service delivery in the counties in which they were implemented, but also have provided valuable research-based models for other jurisdictions to consider. Chapter II of this report describes the strengths of the individual projects, highlighting what was successful – and sometimes not so successful – in helping to prove what works to reduce the criminal justice involvement of mentally ill offenders.

Rigorous Evaluation: The third key to improving California's response to mentally ill offenders was to learn what programmatic strategies and treatment interventions are most effective with this challenging population. For that reason, the Legislature required thorough research into the MIOCRG projects at both the State and local levels. The Board of Corrections (Board) was charged with conducting a statewide evaluation of the program. With the support of the Board's research staff, counties compiled data on agreed upon common data elements and reported on a semi-annual basis throughout the life of their grants. Chapters III and IV of this document describe the statewide research and present findings based on the data submitted by the project counties.

California's MIOCRG Program serves as the model for a national initiative to improve treatment for, and curb crime among, persons with a mental illness.

In addition to contributing to the statewide research, each county was required to assess its specific project or projects. The local evaluations examined the unique aspects of each project and included a process evaluation focusing on how the program operated as well as outcome and cost effectiveness findings. The local evaluations were required to include sufficient information about the participants, research design, treatment interventions, and data analysis procedures to permit replication of the program and the research by others. In most cases, the evaluation model was one in which eligible individuals were randomly assigned to the demonstration project or to a "treatment as usual" group so that the subsequent criminal justice involvement and other behaviors of the two groups could be compared.

Planning Grants

In developing the framework for the MIOCRG Program, the Legislature required local law enforcement, corrections and mental health agencies and other community based service providers to work together to address the challenge posed by mentally ill offenders. Additionally, aware that California counties have a diverse palette of strengths and resources, the Legislature required that a collaborative, concerted planning process be undertaken in jurisdictions that intended to apply for a Mentally Ill Offender Crime Reduction grant. Each county seeking to apply for a demonstration grant was required to form a Strategy Committee. The Strategy Committee was responsible for:

- developing a local plan describing the county's existing responses to mentally ill offenders,
- identifying service gaps, and
- outlining strategies for achieving a cost effective continuum of graduated responses for this population.

To help support the local planning process, the Legislature earmarked a portion of each of the MIOCRG appropriations for planning grants. In 1998, the Board awarded over $1.2 million to 45 counties and in 2001 awarded nearly $1 million more to the 25 counties requesting planning funds for the second set of grants. Many counties, including several that did not receive funds for a demonstration project, reported benefiting from this planning process because it enabled them not only to identify strategies for safely reintegrating mentally ill offenders into the community but also to establish ongoing collaboration among the agencies that interface with these individuals in and after custody.

Demonstration Grants

SB 1485 directed the Board to award and administer grants supporting the development, implementation and evaluation of demonstration projects designed to curb crime among people with a mental illness. The grants were to be awarded on a competitive basis. The Board was to consider, at a minimum, the following criteria in evaluating the merits of projects proposed by the counties:

- percentage of the jail population with severe mental illness;
- demonstrated ability to administer the type of program proposed by the county and to provide treatment and stability for people with severe mental illness;
- demonstrated history of maximizing federal, state, local and private funding sources; and
- likelihood that the program would continue after state funding ended.

To ensure that its Request for Proposal (RFP) process was equitable, the Board relied on the Executive Steering Committee (ESC) process, a decision making model the Board uses when it is involved in an activity or program that will be implemented and managed by others. The ESCs, comprised of state and local subject matter experts (see Appendix B), provided input on the technical requirements of the Mentally Ill Offender Crime Reduction Grant Program RFP, established the method for rating applications and selecting the best proposals, and recommended grant awards.

FUNDING AND SUPPORTING THE INITIATIVE

The MIOCRG Program represents the most money spent anywhere in the United States on mental health issues for people in jail.

The Legislature's commitment to improving the way California responds to mentally ill offenders is evident in the amount of state funds – a total of nearly $81 million over 5 years – allocated to the MIOCRG Program.

SB 2108 (Chapter 502, Statutes of 1998) and the 1999/00 State Budget Act supported 15 demonstration grants, including grants to Los Angeles and San Francisco Counties for "high risk" projects targeting mentally ill offenders likely to be committed to prison. These grants, known for administrative purposes as MIOCRG I, were 4-year projects that began July 1, 1999 and ended no later than June 30, 2004. (See table below, MIOCRG I Counties)

A $50 million augmentation in the 2000/01 State Budget Act, although subsequently reduced by $18 million in the 2002/03 Budget in response to the State's fiscal crisis, supported another 15 grants. These were 3-year efforts, known as MIOCRG II; they began in July 2001 and ended no later than June 30, 2004. (See table below, MIOCRG II Counties.)

Like the State, counties also made a significant financial commitment to responding more effectively to mentally ill offenders. While the MIOCRG enabling legislation required a minimum match of 25% in local funds, all of the counties that mounted demonstration projects exceeded this minimum.

MIOCRG I COUNTIES	AWARD	MIOCRG II COUNTIES	AWARD
Humboldt	$2,268,986	Alameda	$3,122,064
Kern	$3,098,768	Butte	$1,796,746
Los Angeles	$5,000,000	Kern	$1,224,970
Orange	$5,034,317	Los Angeles	$3,122,064
Placer	$2,139,862	Marin	$2,650,399
Riverside	$3,016,673	Mendocino	$1,241,037
Sacramento	$4,719,320	Monterey	$1,627,858
San Bernardino	$2,477,557	San Bernardino	$2,752,610
San Diego	$5,000,000	San Francisco	$2,178,201
San Francisco	$5,000,000	San Joaquin	$2,607,436
San Mateo	$2,137,584	Santa Clara	$ 747,312
Santa Barbara	$3,548,398	Solano	$3,108,840
Santa Cruz	$1,765,012	Tuolumne	$ 520,266
Sonoma	$3,704,473	Ventura	$1,536,396
Stanislaus	$1,713,490	Yolo	$1,688,750
TOTAL	**$50,624,440**	**TOTAL**	**$29,924,949**

Project Support and Oversight

The Board of Corrections has a long history of working in partnership with sheriffs, chief probation officers and other local stakeholders. In the MIOCRG Program, this collaborative approach involved also working closely with mental health agencies, project managers, financial officers, evaluators and community-based organizations to help them achieve each county's programmatic objectives and meet all contractual obligations related to the grant.

Throughout the life of the MIOCRG Program, Board staff provided technical assistance, consultation and training on issues related to interagency collaboration, program implementation and data collection. They convened and facilitated Project Manager Meetings that served as forums for sharing information, discussing challenges and addressing questions. Board staff also regularly conducted site visits to observe program operations, review financial records and monitor data collection efforts. In addition, Board staff received semi-annual progress reports from counties identifying issues that may have warranted additional technical assistance.

Board staff worked with participating counties in their efforts to meet contractual obligations related to project expenditures and evaluation activities. The Board's contracts with counties outlined specific requirements regarding the use of state grant and local match funds and included an exhibit, prepared by the county, addressing the 'nuts and bolts' of the local research plan. In addition to providing quarterly invoices, each county was required to submit a final audit within 120 days of the grant ending date. The Board retained a percentage of each project's grant until satisfactory submission of both the audit and the final evaluation report was accomplished.

CHAPTER 2: WHAT WORKED

THE MIOCRG PROGRAM IN BRIEF

The Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program was an effort to reduce recidivism and enhance community reintegration of mentally ill offenders who cycle through California's local jails. A comprehensive undertaking, the MIOCRG Program was created by the Legislature to enable counties to learn how best to improve service delivery, support offenders' crime-and-drug-free return to the community, reduce mentally ill offenders' repeat crime and thereby enhance public safety while also saving the dollars currently spent on arresting, adjudicating and housing offenders who recidivate because of their mental illness. The law called for local mental health agencies and criminal justice agencies – sheriffs', police, and probation departments as well as judges -- to partner with each other, as well as with service providers and consumers, to address the complex issues of mentally ill people who come in contact with the criminal justice system in their communities.

The MIOCRG Program encompassed 30 projects in 26 counties. The initial fifteen demonstration projects, known as MIOCRG I, operated from July 1999 through June 2004 and another 15 demonstration projects, called MIOCRG II, operated from July 2001 through June 2004. While the 30 demonstration projects were unique in that each was designed to deal with the specific service gaps and needs of its jurisdiction, all used their grants to maximize local resources, incorporate evidence-based "best practices" and design service delivery systems that would enhance local capabilities. Some projects focused on mental illness as the primary diagnosis only, without requiring a secondary diagnosis; others sought to address dually diagnosed offenders, i.e., those with both a serious mental illness and a substance abuse diagnosis. In more than half of the projects, participation was voluntary; clients agreed to participate and signed a consent form to that effect. In other projects, participants were ordered into the program by the court, generally as a condition of probation. Regardless of the models, approaches and elements it chose, each jurisdiction built on local strengths to design and deliver collaborative, sustainable strategies for dealing with mentally ill offenders.

Most projects incorporated service needs assessments as well as mental health assessments. These multiple assessments gave projects the information they needed to tailor appropriate interventions to individual participants, enabling the flexibility that has been shown to be most effective in working with people who are mentally ill. The majority of counties developed treatment plans that addressed the issues identified in clients' assessments, thereby using their MIOCRG projects to reinvent service delivery in their jurisdictions.

Counties employed a variety of different approaches. Some of the projects emphasized enhanced in-custody services, such as counseling and discharge planning, and one – Riverside County – focused the majority of its project on in-custody interventions. The majority of MIOCRG projects involved a combination of in-custody and post-custody, community-based services and identification of resources to support offenders' progress toward independent, crime-and-drug-free lives.

Several projects operated out of community based centers or clinics; others worked with clients 'where they were' in the community. Some delivered services directly; others were designed to broker and/or link clients to existing public and/or private sector treatments, services and interventions. Treatments varied from short-term (two to six months in duration) to those that lasted a year or more.

Regardless of their design or approach, all MIOCRG projects delivered enhanced services. The kinds of enhanced services and/or interventions generally included:

- assistance in securing disability entitlements, housing, vocational training, and employment;
- residential and out patient mental health treatment;
- individual and group counseling;

- substance abuse education and counseling;
- life skills training;
- medication education/management/support;
- transportation services;
- socialization training and support;
- advocacy; and
- crisis intervention.[1]

Primary Elements

The rich diversity of models and elements piloted in the 30 MIOCRG demonstration projects is illustrated by Table 1, ***Distinguishing Features of MIOCRG Projects.*** This table highlights the creativity, thoughtfulness and attention to research findings with which counties designed their projects, mixing and matching components to address local needs, capabilities and target populations.

Please note that the table describes the models and areas of emphasis of the MIOCRG projects, but does not seek to identify the interventions, i.e., specific services, each provided. For information about the array of services a project delivered and/or details of the design and implementation for replication purposes, readers are encouraged to contact the project manager and request the project's final evaluation report (See Appendix E for Contact information for MIOCRG Project Managers)

The major models counties employed – displayed in red – are described below. They were Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT) and Mental Health Courts. The table identifies projects by model based on the jurisdiction's description. In other words, if a project had the elements of ACT models but the county said it was based on a template other than ACT, it is not shown as an ACT project. Note that some projects used both the ACT and Mental Health Court models in conjunction.

Within the major models, counties emphasized different strategies. While most MIOCRG projects provided services for mentally ill offenders who had substance abuse issues, more than a third of the projects, as the table indicates, specifically targeted dually diagnosed offenders. Three projects were gender specific. Three projects – Kern's MIOCRG I JAILink, San Francisco's MIOCRG II Connection Program and Santa Barbara's Mental Health Treatment Courts – described themselves as diversion programs, while two others – Los Angeles County's MIOCRG I Community Reintegration of Mentally Ill Offenders (CROMIO) Program and San Francisco's MIOCRG I Forensic Support Services Program – were directed by the Legislature to work with offenders at high risk of being sent to prison. Each of these efforts had somewhat different emphases; nonetheless, as Table 1 indicates, they employed many of the same approaches.

Table 1 further demonstrates that nine counties built projects with intensive in-custody service components. Most of these functioned in conjunction with community-based follow-up and aftercare.

Nearly two-thirds of all projects relied on enhanced probation supervision and support to help clients accomplish their (and the programs') dual public safety and treatment goals.

While almost all of the projects made efforts to facilitate temporary and/or crisis housing for participants, nearly half – 14 projects – included a component that actually provided or arranged for housing.

[1] In addition to the Project Summaries in Appendix C, please see project descriptions prepared by the counties on the Board of Correction's web site at www.bdcorr.ca.gov. For more information about a specific project, contact the project manager via the directory in Appendix E, also available on the web site.

Table 1 – Distinguishing Features of MIOCRG Projects

	ACT	FACT	MENTAL HEALTH COURT	Court Ordered	Voluntary	Dual Diagnosis	Gender Specific	Diversion	Short Term Intensive	Linkage	Strong In-Custody Component	Strong Probation Involvement	Center or Clinic Based	Provided Housing	Family Involved
Alameda	●					●			●		●	●	●	●	
Butte	●		●		●	●						●		●	
Humboldt			●		●	●					●	●	●		
Kern I				●				●	●	●		●		●	
Kern II					●	●	●		●					●	
Los Angeles I	●				●	●	●				●	●			
Los Angeles II	●					●				●	●	●			●
Marin		●			●							●			
Mendocino			●		●	●						●			
Monterey		●	●		●							●		●	
Orange	●				●					●		●			●
Placer			●			●						●		●	
Riverside				●		●					●	●			
Sacramento	●				●	●						●		●	
San Bernardino I				●		●			●	●			●	●	●
San Bernardino II						●	●				●	●		●	
San Diego	●			●						●		●			●
San Francisco I	●				●								●		
San Francisco II	●				●			●		●				●	
San Joaquin	●		●												
San Mateo	●					●						●		●	
Santa Barbara	●		●		●			●		●					
Santa Clara									●	●					
Santa Cruz	●											●	●		
Solano			●		●								●	●	●
Sonoma		●	●		●						●	●	●		
Stanislaus		●			●							●		●	
Tuolumne				●							●	●			
Ventura	●			●	●						●	●		●	
Yolo	●									●					

Eight projects emphasized what the mental health literature describes as "linkage" – short–term, intensive case managed strategies to link clients to existing community resources so as to build a base of on-going engagement with service providers the client is likely to need over a long period of time.

Counties employed additional strategies that are not displayed in the table. These were so universally used in MIOCRG projects that their presence in the table would not have helped to distinguish one project from another. Key among these strategies was the use of multi-disciplinary teams (MDT), intensive case management and flexible service delivery, each of which played vital roles in most, if not all, MIOCRG demonstration efforts.

Key Models

Assertive Community Treatment (ACT): Nearly two-thirds of the 30 MIOCRG projects drew upon the ACT model. ACT relies on multi-disciplinary teams to provide individualized services directly to clients, ideally with around-the-clock availability, and using a strong case management approach particularly for crisis intervention and crisis resolution. The ACT model involves intensive case management delivered through reduced caseloads to ensure that clients receive the kinds of services and level of support they need to function in the community.

While there are variations in how this intervention is implemented, it is defined by a team approach to case management, a small manager-client ratio and case managers who work in an "assertive" manner to engage weakly motivated clients in treatment by meeting them where they live in the community and assisting them in gaining access to basic services including medication, housing, medical care and job placement.

(McGrew & Bond, 1995)
Santa Barbara Final Report, page 2

Forensic Assertive Community Treatment (FACT): In several counties, which modified the ACT model by adding a probation officer or officers to the treatment team, counties called their project Forensic Assertive Community Treatment or FACT programs. In these, as well as the ACT-design programs that incorporated probation and/or other criminal justice personnel but did not call their programs FACT models, the blend of mental health and criminal justice perspectives combined intensive probation supervision, support and advocacy with the overarching ACT components of intensive case management, services and treatment to encourage comprehensive engagement of and support for mentally ill offenders.

Mental Health Courts: Nine of the 26 counties created a mental health court or mental health calendar. Although there were different designs among these courts and several incorporated ACT model components for service delivery, the piloted mental health courts typically involved judges, defense attorneys, prosecutors, probation officers and mental health professionals collaborating in the belief that effective community-based treatment was an appropriate and viable option for some mentally ill offenders. The mental health courts often involved the use of case conferencing to discuss treatment options and progress, and monitored defendants through subsequent hearings (i.e., weekly or monthly court appearances, depending on the case and/or jurisdiction). These mental health courts, also known as 'therapeutic courts' or 'problem solving courts,' were so promising that two counties – Kern and Marin – initiated locally funded mental health courts at the conclusion of their MIOCR

Recognition of the link between criminal activity and bio-psychosocial factors has led to the development of specialty courts for the mentally ill. These courts create a special docket for those mentally ill offenders who have committed non-violent crimes in order to give them special consideration within the court system. Mental health courts are less punitive than conventional judicial proceedings and focus on treatment for the mental illness and not on incarceration. These courts commonly emphasize the defendant's access to treatment and support through a team composed of law enforcement officers and behavioral health workers.

Butte County Forest Project
(Final Report, page 11)

grants and several others have expressed the intention to do so when their fiscal circumstances allow them to initiate new programming.

Major Strategies

Multi-Disciplinary Teams: Most of the projects, regardless of model, relied on multi-disciplinary teams (MDTs) to deliver program services. These teams consisted of combinations of mental health clinicians and/or case managers, sheriff's personnel, drug and alcohol treatment counselors, probation officers and other social services practitioners. In several counties, the MDT also included a psychiatrist, nurse, substance abuse specialist, housing specialist, benefits specialist and/or occupational therapist. Members of MDTs partnered in the development and provision of services as well as in the supervision of clients in the community.

The team achieves what individual agencies can't.
Butte County Forensic Resource Team (FOREST) Final Report, page 73

Intensive Case Management: Whether long-term or short, most of the projects' interventions were based on intensive, assessment-driven case plans and case management, provided by mental health or social service personnel with small caseloads. Case managers generally had no more than 15 clients each and most case managers had other treatment team members to support their work with clients. Case management included assistance with housing, transportation, medication management, family concerns, substance abuse issues, job training and education as well as counseling and treatment.

Intensive case management allowed for both support and accountability.
Humboldt County MIOCR Program Final Report, page 57

Flexible Service Delivery: A hallmark of MIOCRG projects was providing services that fit individual clients' needs rather than expecting clients to adapt to a pre-designed program or array of services. Rejecting a 'one size fits all' approach, most counties sought individualized solutions to, and resources for, addressing clients' problems and/or treatment requirements. Staff noted that flexibility was necessary to address the complex and varied needs of their clients, while clients said it was projects' and staffs' flexibility that helped them feel respected and valued in ways that encouraged them to participate in their treatment and recovery.

The [crucial factor] was flexibility and truly honoring the concept of starting where the client is… [Our program] embodied harm reduction and prevention by truly rearranging our methods to the needs of the client.
Mental Health Practitioner / Case Manager Marin County STAR Project *Final Report, page 38*

Populations Served

MIOCRG projects differed, not only with regard to program models and elements, but also in terms of the populations they served. As noted previously, two projects dealt with high risk, prison-bound mentally ill offenders. One dealt only with females and two only with males. Several targeted offenders with co-occurring disorders i.e., dual mental health and substance abuse diagnoses, while others required that the primary diagnosis be a mental health disorder.

The Legislature had specified that the MIOCRG projects must address offenders with serious mental illness as defined in Section 5600.3 of the Welfare and Institutions Code (see Appendix A). Counties knew this meant that their programs must address people with mental illnesses that were "…severe in degree and persistent in duration, [so as to] cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation…."[2] Nonetheless,

[2] Welfare and Institutions Code Section 5600.3, Subdivision (b), paragraph (2)

as they designed and implemented their demonstration projects, counties found it necessary to make decisions about a wide range of eligibility issues. They had to determine what specific *Diagnostic and Statistical Manual of Mental Disorders (DSM IV)* diagnoses were appropriate given their program design. They had to decide what levels and kinds of commitment offenses and/or criminal histories would fit and give consideration to age, gender, and exclusions, i.e., potential criteria that would render candidates ineligible for their programs.

Mental Health Diagnoses: Serious mental disorders include, but are not limited to, schizophrenia, major affective disorders, and other severely disabling disorders. Schizophrenia and other psychotic disorders are the most chronic and disabling of severe mental illnesses. Hallucinations, delusions, disordered thinking, unusual speech or behavior, and social withdrawal seriously impair the ability of persons with these brain disorders to interact with others. People with bipolar disorder, which causes extreme shifts in moods, energy levels and functioning, may also experience hallucinations and delusions. In addition to interfering with a person's ability to function, bipolar and other mood disorders typically involve recurrent thoughts of death or suicide. The overwhelming majority of primary diagnoses among MIOCRG participants fell into these two diagnostic categories.

For mental health clinicians, one indicator of the extent of psychiatric impairment is a person's score on the Global Assessment of Functioning (GAF) Scale, which measures psychological, social and occupational functioning ability on a scale of 0-100. Three-fourths of the MIOCRG participants had GAF scores between 10 and 50. The average GAF score for mentally ill offenders entering MIOCRG programs was 46. GAF scores at those levels indicate serious symptoms (e.g., suicidal ideation, severe obsessive rituals) or serious impairment in functioning (e.g., no friends, unable to keep a job).

Dual Diagnosis / Co-occurring Disorders: As previously noted, the majority of mentally ill offenders also had problems with substance abuse and/or a DSM IV substance abuse disorder. Thirteen of the 30 MIOCRG counties elected to target their projects specifically to those mentally ill offenders who also had substance abuse diagnoses and for whom the mental health and substance abuse diagnoses were clinically described as 'co-occurring,' i.e., offenders who were dually diagnosed.

Gender/Age: Although the majority of individuals participating in the MIOCRG program were male (over 57%), all but three projects involved both male and female clients. Los Angeles County's FORward MOMentum was the only project targeted exclusively to women. Notably, it focused on incarcerated female offenders who were dually diagnosed, homeless and mothers.

As did gender issues, age differences among participants also gave rise to treatment challenges. While the average age of participants was 39, their ages ranged from 18 to 75. Different interventions and services were needed for clients of different ages. Interventions appropriate for and effective with offenders in their teens or 20s often were not viable for those in their 50s and 60s.

Criminal Justice History: In order to ensure that their projects would serve mentally ill offenders without endangering public safety, most counties focused on particular subsets of offenders. Some counties required participants to have two or more previous arrests while others deemed one prior arrest or even no prior arrests (given a likelihood for returning to jail) sufficient for program participation. Several jurisdictions limited eligibility only to offenders with misdemeanor charges while others allowed property, substance abuse and other non-violent felonies. Most of the counties opted to exclude offenders who were in jail at the time of program entry for a violent or serious felony; some excluded those who had any history of violence; other counties excluded offenders with any past felony arrests and/or convictions. Some projects did not exclude offenders based solely on current or historical violent offenses.

Exclusions: In addition to violent and serious offenses and/or histories, other exclusions – in place in at least one and sometimes in multiple counties – included: not being a county resident or being released to

another jurisdiction; being on parole; being under conservatorship; being a third strike candidate; having been found not guilty by reason of insanity, having been found incompetent to stand trial, or unable to give informed consent due to organic brain syndrome, active psychotic condition or developmental disability; having an Immigration and Naturalization Service (INS) hold, Welfare and Institutions Code Section 5150 hold[3], felony warrant or any other hold; needing supervision by a sex offender program or gang unit, receiving services through AB 34 / AB 2034,[4] drug court or other drug program; and having a primary diagnosis of a personality or substance abuse disorder.

CHALLENGES

Designing and delivering programs to positively impact the recidivism of mentally ill offenders was a daunting challenge in and of itself. Doing so in the context of carefully crafted evaluation studies to determine what works, for whom and under what circumstances escalated the degree of difficulty. With support from the Board of Corrections and its researchers, counties met these imposing hurdles, building evidence-based yet innovative, multifaceted projects and studying their implementation and outcomes.

The projects' final evaluation reports, which as mentioned previously describe the projects, their research designs and findings, also reveal several difficulties common to many if not all of the 30 MIOCRG projects. Given the complexity of the task, it is remarkable that there were not more commonly experienced obstacles. While each project had its own difficulties, the most universally reported major implementation and/or operational challenges included issues related to:

- The random assignment of participants;
- Changes in the services available to those receiving treatment as usual;
- The eligibility of offenders with violent charges or violent histories;
- Interagency collaboration;
- Staffing;
- The availability of services for offenders with co-occurring disorders;
- The availability of housing for mentally ill offenders; and
- Involving clients' families in program activities.

Random Assignment: The majority of MIOCRG projects utilized a research model involving random assignment to either an enhanced treatment (ET) group or a treatment as usual (TAU) group. Several jurisdictions expressed discomfort with random selection because it meant not providing needed service to people -- sometimes as many as half of the population -- who had been determined to meet eligibility criteria. Program staff were faced with the challenge of having to advise a mentally ill offender who might benefit from enhanced services that, although the enhanced services existed, the individual would not have the opportunity to participate in them. While it is important to note that no one was denied whatever services were regularly available to mentally ill offenders in the jurisdiction, not being able to provide every additional service piloted in MIOCRG projects was difficult for staff and program designers whose orientation was to help as many clients as possible. There are indicators that, in some instances, this difficulty led to 'contamination' or confounding of projects' treatment as usual (TAU) groups (discussed below) with the unintended consequence of decreased differentiation between pilot and TAU participants.

[3] This statute allows peace officers and other designated individuals to take a person who, as a result of a mental disorder, is a danger to himself/herself or others, to a specified mental health facility for 72-hour treatment and evaluation.

[4] Assembly Bill 34 (D. Steinberg) Chapter 617, Statutes of 1999 and Assembly Bill 2034 (D. Steinberg), Chapter 518, Statutes of 2000 requiring services to homeless mentally ill adults and providing funding.

Confounding Issues: Closely related to the matter of random assignment was a concern about maintaining the content and consistency of treatment of usual, i.e., continuing to do what had been done at the start of the project. During the life of the MIOCRG program, circumstances occurred that made enhanced services available to mentally ill offenders including those in MIOCRG projects' treatment as usual groups. While individual counties may have experienced their own confounding issues in the form of other-than-MIOCRG locally created intensive service programs, two initiatives offering enhanced services and operating in nearly all of the MIOCRG project counties are likely to have had the most significant effect. These were AB 34/AB 2034, and Proposition 36, the Substance Abuse and Crime Prevention Act of 2000. No doubt a percentage of participants in MIOCRG treatment as usual groups may have received services from at least one of these programs.

AB 34/AB 2034

Assembly Bills (AB) 34 and 2034 (Steinberg, Chapter 617 and 518, Statutes of 1999 and 2000, respectively) provided funding to 32 cities and counties to provide comprehensive services to adults with severe mental illness who were homeless, at risk of becoming homeless, recently released from a county jail or state prison, or others who were untreated, unstable and at significant risk of incarceration or homelessness unless treatment was provided to them. Services included outreach programs and mental health services along with related medications, substance abuse services, housing assistance, vocational rehabilitation, and other non-medical programs necessary to stabilize this population.

Proposition 36/Substance Abuse and Crime Prevention Act

Since fiscal year 2000-2001, funding has been provided to each county as a result of voter approval of Proposition 36, the Substance Abuse and Crime Prevention Act of 2000 (SACPA). Under SACPA, first or second time non-violent offenders who use, possess, or transport illegal drugs for personal use were to receive drug treatment rather than incarceration. This proposition required collaboration between the criminal justice system and public health agencies to provide services such as drug treatment, vocational training, family counseling and literacy training. Since the majority of mentally ill offenders have substance abuse issues as well, it is likely that some MIOCRG treatment as usual clients received Prop. 36 services. Moreover, at least one and perhaps other MIOCRG projects used Prop. 36 treatment services as part of those available to demonstration project clients.

Violent Offenders: The issue of whether or not to accept violent offenders into the program was one with which many projects grappled. At times this matter elicited very different and opposing views from the district attorney, public defender, judges, sheriff's department, probation department and/or mental health agency. For some projects, a decision to exclude offenders with a history of violence resulted in recruitment difficulties; the projects could not accomplish the population size they had committed to in their grant application. One project, Humboldt County's MIOCRG Program, for example, began by disallowing sexual or other violent felony crimes, whether current or historical, but quickly realized a significant portion of mentally ill offenders were being rejected from participation based on their criminal backgrounds. Within a few months of program start-up, the entrance criteria for this project were changed to allow consideration of each mentally ill offender and assessment of each person's violence in conjunction with his/her mental health history and treatment needs. This resulted in many offenders with violent histories being allowed to enter the program over time. Other counties had similar experiences and modified their criteria to enroll mentally ill offenders with elements of violence in their histories that were determined to not threaten public safety.

Collaboration: While collaboration among partners from different disciplines was one of the most notable strengths of MIOCRG projects, it also proved to be among the most challenging things to accomplish. Individuals working as multi-disciplinary teams brought their varied backgrounds and expertise to the common goal of helping the target population. Nonetheless, with the variety of backgrounds come diverse viewpoints, differing expectations, occasionally opposing cultures and

practices, and sometimes conflicting perspectives. Given this mix, many projects reported having to overcome team and/or collaborative members' differences in order to move forward in productive ways. This was particularly evident early on when, having very little if any prior experience working together, probation and mental health personnel were especially wary of one another. There was very little trust and a good deal of concern that the two disciplines with their very different perspectives could coalesce into viable mutually supportive teams. Most projects found, however, that, with time, close professional relationships were formed across disciplines, and true respect emerged for the contributions each partner brought and the challenges each faced in his/her given profession and agency.

Staffing: The recruitment, hiring and training of staff (jail personnel, probation officers, clinicians, case managers, case workers and others) proved to be very time-consuming start-up activities for projects, and were ongoing challenges as staff turnover occurred. County employment practices, the at-times limited pool of qualified candidates and the nature of the projects themselves (i.e. offering clients 24/7 access to staff coupled with the high intensity of the work) all contributed to staffing difficulties.

Co-occurring Disorders: Given the MIOCRG program goal of providing effective treatment for mentally ill offenders, the majority of whom presented with co-occurring disorders (dual substance abuse and mental health diagnoses), the lack of pre-existing integrated services for this population was particularly frustrating. While inroads were made to joining substance abuse treatment and mental health treatment into one realm for this population, delivering effective treatment remained a challenge and 'work in progress' for many counties.

Housing: Homelessness is a major issue for large numbers of mentally ill offenders and one that almost all of the MIOCRG projects sought to address. For most projects, the dearth of available and/or affordable housing – both transitional and long-term – for their mentally ill offender clients created a significant challenge. Counties implemented a variety of creative solutions to this dilemma, such as establishing and/or expanding ties with homeless shelters and board and care homes and partnering with nonprofit agencies to rent homes or apartments, among others.[5] Nonetheless, homelessness and the lack of available living units continued to present obstacles to successful community reintegration for many clients and made the delivery of other services that much harder for program staff seeking to ensure clients' ongoing stability.

Family Involvement: Several projects' designs specifically included goals related to normalizing clients' relationships with their support systems/families. In these projects, clients were offered family counseling and/or group sessions on family relations and there were opportunities for socialization activities with family members. However, the majority of projects had neither the resources nor the opportunity to do extensive outreach to clients' families or involve them in project activities. Those that did not involve families often reported that they perceived the inability to do so as a shortcoming of their projects.

[5] See Chapter 2, What Worked, Assistance Arranging Housing, for more details.

HIGHLIGHTS OF WHAT WORKED

Despite the many challenges associated with the MIOCRG program, its evaluation, and the complex issues facing the population it targeted, case studies and evaluations performed by counties show that the projects had a positive impact on many (though not all) participants. With assistance, support and encouragement from project staff, clients complied with medications, stayed sober, returned to school, found jobs, learned basic life skills and, in some cases, reunited with family members. For individuals who suffer from and struggle with serious mental illness, these were major accomplishments.

The case studies required in counties' final evaluation reports, as well as their assessments of the most effective elements of their programs, yield strong commonality about some aspects of what worked. The most universally mentioned factors included:

- Interagency collaboration/multi-disciplinary partnerships;
- Comprehensive and flexible services;
- Intensive case management;
- Involvement of and with the court;
- Mental health courts;
- Assistance securing benefits;
- Use of flex funds; and
- Assistance arranging housing.

Interagency Collaboration/Multi-Disciplinary Partnerships: Without exception, every project relied on some sort of multi-agency cooperation, collaboration or partnership to accomplish its goals. The multiple and complex needs of mentally ill offenders required the expertise and involvement of a variety of disciplines. Dealing with the treatment, security, custody, reentry, substance abuse, housing, transportation, educational, vocational, family and other issues facing mentally ill offenders demanded that projects build collaborative, multi-agency relationships, structures and/or teams. Although difficult at first, these interagency collaborations were often reported to have been very productive. In fact, the vast majority of counties reported that interagency collaboration – in the planning and oversight of projects, as well as in the multi-disciplinary teams delivering services – was one of the most valuable features of their programs.

Regular – in some cases, daily – team meetings were acknowledged as having been key in maintaining collaboration and enhancing its effectiveness.

Mendocino County said what worked was "first and foremost … interagency collaboration and intensive case management."[6]

Sonoma County attributed its clients' 81% reduction in jail days, 50% reduction in hospitalization, 66% reduction in failures to appear in court, 80% reduction in convictions and 95% reduction in new felonies to, among other things, the cohesiveness of the team and its frequent formal and informal communications, which resulted in successful cross-agency collaboration.

Sonoma County Forensic Assertive Community Treatment Program (FACT) Final Report, abstract

Collaboration was identified by Santa Cruz County as an especially effective element of its program because, among other advantages, it allowed the team to quickly determine and respond to issues related to clients. The team atmosphere of shared goals and responsibilities was said to have contributed to better staff cohesiveness and morale, thereby

[6] Mendocino County, *Mentally Ill Offender Therapeutic Court (MIO TC)* Summary, page 2

not only providing a positive environment for team members and clients, but also yielding a benefit for supervisors and management.[7]

Along with others, Humboldt, Marin and Tuolumne Counties also said collaboration was key, with Humboldt adding that its team having operated out of a center allowed staff members to meet daily to work on case plans and resolve any differences that arose. "Communication between staff was direct and did not have to be routed through agencies, e-mail messages, phones, and faxes. Staff members had a sense of what one another were doing. They developed a greater understanding of each other's jobs and an appreciation for each other's roles and responsibilities. There were also cross trainings to help corrections professionals understand the mental health professionals and vice versa."[8]

Other jurisdictions described what they called multi-disciplinary partnering as the most important factor in the viability of their programs' service delivery. San Diego, for example, recognized its "interdisciplinary teams as the primary strength of [its program] both for combining two different disciplines and for increasing the availability of staff to clients."[9]

In Ventura County, Behavioral Health staff housed in the jail were said to have facilitated the timely processing of referrals as well as increasing understanding of the respective agencies' cultures and mandates. The program's two full-time probation officers were described as having "[embodied] the entire criminal justice system, serving as the ambassadors of that system, not only to the clients, but to the Behavioral Health treatment staff as well. [They also helped] their colleagues in the criminal justice system understand the dynamics of mentally ill offenders."[10]

Orange County reported that "probation treatment clients were more likely than comparison group clients to obtain psychotropic medications and receive services from treatment clinics, so there was some treatment effect arising from the pairing of the case managers with specially trained probation officers."

Orange County, Immediate Mental Health Processing, Assessment and Coordination of Treatment (IMPACT) Program summary, page 2

For Kern County's MIOCRG I *JAILink* project, having a probation officer on the team increased clients' accountability. The project's case manager/probation officer teams were credited with greatly increasing the awareness of mental health issues among probation officers as well as enhancing mental health personnel's understanding of the criminal justice system.

Placer County noted that, "having the onsite support of probation for its residential program, and support from the Sheriff when clients were non-compliant, made a big difference in the project staff's ability to work with mentally ill offenders in the *PC CCARES* study."[11]

It was the uniform agreement of program staff and many of the clients that probation was one of and at times the most important aspect of the program. We had numerous testimonials from clients that they had never had such positive interactions with probation officers in their lives, and more critically, that this impacted their propensity toward criminal behavior and their desire to clean up their act and become more stable and law abiding. To some degree, the fact that clients were on probation seemed to increase treatment compliance, at least enough where medication and other treatments could begin to have an effect.

Los Angeles County CROMIO Project Final Report, page 75

With regard to its high-risk offender *MIOCRG I Forensic Support Services (FSS)* component, San Francisco found that collaboration "shifted the relationships between parole and probation officers and their mentally ill clients from antagonistic to more trusting and

[7] Santa Cruz County, *Maintaining Ongoing Stability through Treatment (MOST)* Final Report, page 9
[8] Humboldt County, *MIOCR Program* Final Report, page 69
[9] San Diego County, *Connections Program* Final Report, page 7
[10] Ventura County, *Multi-Agency Referral and Treatment (MART) Program* Final Report, page 94
[11] Placer County, *Placer County Continuum to Avoid Re-Arrest and Enter Society (PC CCARES)* Final Report, page 30

collaborative." As a result, San Francisco said, officers worked through non-compliance issues with their clients rather than automatically violating them and clients were more likely to keep appointments with officers because they were less fearful of being returned to jail or prison.[12]

Reporting on its MIOCRG II *Connections Program,* San Francisco summarized a commonly reported benefit of interagency collaboration – the care and attention clients felt from multi-disciplinary staff. San Francisco reported that 84% of clients surveyed said being in *Connections* made them feel like somebody cared about them. This was attributed to the high-quality relationships with and among program staff and was described as key to the program's success.

Comprehensive and Flexible Services: The majority of MIOCRG projects were based on the premise that "… individuals come in contact with the criminal justice system as a result of fragmented service systems, the nature of their illnesses and the lack of social support and other resources. By organizing a comprehensive array of mental health and other support services … programs can break the cycle of decompensation, disturbance and rearrest."[13] MIOCRG projects clearly demonstrated that coordinating, providing, brokering and/or linking participants to a wide range and variety of treatments and services was necessary in their efforts to move mentally ill offenders toward stabilized, healthy, law abiding lives.

Every project sought to employ a comprehensive array of services to address the target populations' multiple needs. San Diego County's *Connections Program,* for example, provided a particular type and intensity of service in each of its four three-month phases (see box on the left).

Pre-Release: Preliminary service planning; plan for immediate housing.

Engagement and Assessment: Level of Service Inventory (LSI) Assessment; identify stable housing options; planning services; client meets with Employment Specialist; meeting with family members; conducting substance abuse testing if court ordered; providing transportation assistance; drafting a financial plan; providing medication management; and linking client with community resources, including mental health and substance abuse treatment and medical resources.

Support and Monitoring: Emphasis placed on crisis prevention and intervention; long- term goals and planning; substance abuse testing on a monthly basis; continued vocational development; money management; and continued support and monitoring of services initiated earlier.

Transfer of Care: Planning for on-going support from outside agencies and post program mental health support; providing continued vocational development, money management, and support and monitoring of services initiated in the previous phase.

San Diego County Connections Program
Final Report, page 33

Other projects, similar to San Diego's in their emphasis on linkage to needed services, included Santa Clara County's *Providing Assistance with Linkage to Services (PALS) Program*, Kern County's MIOCRG I *JAILink* program and Yolo County's *Project NOVA,* among others. These programs all sought to put clients in touch with existing community resources so as to ease the transition from incarceration and build a base of on-going engagement with service providers the client was likely to need over a long period of time. Linkage programs, as well as those providing services directly, through interagency agreements and/or via contracts with private providers, sought to incorporate the broadest possible spectrum of interventions for their clients.

[12] San Francisco, *Mentally Ill Offender Crime Reduction Grant Program* Final Report, page 33
[13] Steadman HJ, Morris SM, Dennis DL: The diversion of mentally ill persons from jails to community based services; A profile of programs. American Journal of Public Health 85: 1630-1635, 1995

Los Angeles County, which offered a range of services, said that its MIOCR II *FORward MOMentum* program that provided continuous, integrated care starting while the participant was incarcerated and continuing after release worked in reducing criminal recidivism, preventing relapse into substance abuse, reducing homelessness and facilitating psychiatric stability.

Butte and Humboldt Counties utilized the Wraparound approach. Wraparound is "a method for 1) collaboration among agencies to 2) construct individually tailored case plans, which 3) clients are motivated to follow because they fill the clients' self-defined needs."[14] Wraparound incorporates a wide array of services – public and private, residential and community-based – to meet the goals set out in participants' case plans. Both Butte and Humboldt Counties reported that the Wraparound approach was valuable in reducing criminal justice/jail and psychiatric hospital involvement by successful program participants and/or graduates.

Flexibility in service delivery was also deemed important in a majority of projects. Marin County's Final Report of its *STAR Program* emphasized "the crucial role of providing flexible services. More specifically, the importance of identifying consumer needs on a continual basis and generating team-driven solutions during daily team meetings." [15]

"Most often this flexibility was evidenced on a case by case basis (e.g. providing a tent to one homeless consumer and a semi-supervised living situation to another….) This flexibility was also evident at the program level with the creation of a Young Men's Group (led by the two mental health practitioners) and a Peer Support Group (led by a peer counselor). Regular social functions and taking consumers to lunch were seen as 'humanizing experiences that build trust and hope.'"

Marin County, STAR Program Final Report, page 38

"In order to serve clients well, [San Mateo County's *Options Project* found] it necessary to be flexible in the kinds of solutions sought to meet the needs of the MIO population. … Case managers were particularly adept at accurately identifying a client's most relevant need, then finding a creative resource to meet that deficiency." "…Case managers did an outstanding job of adapting what resources they could find to fit the needs of clients."[16]

Intensive Case Management: Discussed previously, intensive case management was a feature of most if not all MIOCRG projects, and for most it was considered highly effective. Although the Orange County's *IMPACT* project found that "case management does little to reduce jailing of the mentally ill,"[17] Orange County did credit case management with helping dients form positive relationships with case managers and probation officers and described this as "substantial given that many of the clients have had difficulty forming relationships. Another benefit, the County said, was that clients were informed about resources available to them. Also many were helped with residential services, sources of income, transportation and so on." [18]

Other jurisdictions had quite a different, more positive sense of the value of case management. Humboldt County praised what it called its program's "platform of case management coupled with intensive probation supervision," and Mendocino County said that intensive and collaborative case management allowed "essential services [to be] provided to a very needy, underserved population in a coordinated comprehensive manner." [19]

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[14] Humboldt County, page 25
[15] Marin County, *Support and Treatment After Release (STAR)* Final Report page 38
[16] San Mateo County, *The Options Project*, Final Report page57
[17] Orange County, *Immediate Mental Health Processing, Assessment and Coordination of Treatment (IMPACT) Program* Final Report, page 30
[18] op. cit., page 31
[19] Mendocino County, *The SOLUTIONS Program* Summary, page 2

Sacramento County reported that its "three core components – housing, integrated mental health and substance abuse treatment and intensive case management, worked well. The transition to a team case management service delivery model enhanced the program's effectiveness with the target population." [20]

San Mateo County's view was that *The Options Project's* "intensive case management in collaboration with intensive probation/court supervision" clearly demonstrated its efficacy by producing a "reduction in incarceration days, reduction in court costs as well as improved quality of life for *Options* clients."[21]

Ventura County concurred, saying, "Intensive case management worked. The low client-to-staff ratio allowed staff to address client needs that had been left unattended for years." [22]

Involvement of and with the Court: Many MIOCRG projects, whether mental health courts or not, found that close working relationships with court officers and ongoing communication with the court were instrumental in clients' achieving successful outcomes. Especially in those projects emphasizing intensive case management and/or ACT principles, close collaboration with courts and court processes was considered both vital and effective.

Noting that fewer clients in its *Community Reintegration of Mentally Ill Offenders (CROMIO)* high risk offender project's Enhanced Treatment (ET) group went to prison than did TAU group members, Los Angeles County attributed this success to the project's close working relationship with the court. The County suggested that one of the reasons almost twice as many mentally ill offenders from the TAU group as from the ET group went to prison was that judges were "less likely to send someone to prison who was actively involved in a program, especially if various representatives from that program, including a probation officer, spoke and acted on the client's behalf… [and were] able to tell the Court exactly what services were actually being provided." Doing so, Los Angeles suggested, provided the court with an option "about what to do with a particular client, especially if it was perceived to be a … viable option" to sending the person to prison.[23]

In San Mateo County interagency cooperation and collaboration was noted as particularly effective in accomplishing intended outcomes and helping to build credibility for *Options*' services with the judiciary. One of the County's judges was reported to have been not only "effusive in his praise of the program," but also convinced to introduce the idea of a mental health court for San Mateo County as a result of his experience with *Options*.[24]

Mental Health Courts: Mental health courts are less punitive than conventional judicial proceedings and focus on treatment for the mental illness, not on incarceration. These courts also commonly emphasize the defendant's access to treatment and support from a team composed of law enforcement/corrections and behavioral health workers.[25] As mentioned previously, the mental health court model is so attractive, and proved so promising, that two counties – Kern and Marin – initiated locally funded mental health courts at the conclusion of their MIOCR grants and several others have expressed the intention to do so when fiscal circumstances permit.

During the life of the MIOCRG program, nine counties – Butte, Humboldt, Mendocino, Monterey, Placer, San Joaquin, Santa Barbara, Solano and Sonoma – piloted mental health courts or, in the case of Humboldt County, a specialized mental health calendar.

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[20] Sacramento County, *Project Redirection* Final Report, page 60
[21] San Mateo County, *Options Project*, Summary, page 2
[22] Ventura County, *MART Program*, Summary, page 2
[23] Los Angeles County, *CROMIO Project* Final Report, page 73
[24] San Mateo County, page 2
[25] Butte County *FOREST Program* Final Report, page 11

MHTC	TAU
Non-adversarial Court Proceedings	***Adversarial Court Proceedings***
-Decisions made by team consisting of judge, district attorney, public defender, probation officer and mental health staff *-Intensive court supervision & drug testing* *-Charges dropped or conditions of probation reduced with program completion*	*-Decisions made by judge* *-Regular court supervision and sentencing* *-Same judge as MHTC (often)*
Intensive Case Management	***Long Term Care Team***
-Case manager with 1:15 client ratio *-Access to housing* *-Horticulture vocational program* *-Transportation* *-Group skills training on substance abuse management/community re-entry*	*-Case manager with 1:50 client ratio* *-Wait list for housing* *-Department of Rehabilitation programs* *-Other County programs*
Time in Treatment	***Time in Treatment***
-18-month enhanced treatment and a 24-month follow-up assessment period	*-24-month long term care receiving the usual services provided by the county*

Santa Barbara County Mental Health Treatment Court
Power Point Summary of Final Report

While these counties developed variations to accommodate the needs and resources of their jurisdictions, they employed most of the elements characteristic of therapeutic court models. These relate to the nature of the court process, intensive supervision and an array of treatment and socialization services built into court-supervised treatment plans.

Designed to reduce recidivism and improve psychosocial functioning for non-violent mentally ill offenders, Santa Barbara County's *Mental Health Treatment Court (MHTC)* project demonstrated the key attributes of the model. Santa Barbara operated two courts, one in the city of Santa Barbara and the other in Santa Maria. Its study found conclusively that "integrating mental health and criminal justice systems and providing mentally ill offenders with a treatment alternative to jail time, were effective interventions for helping individuals live more satisfying and independent lives. A variety of community efforts appear to have been associated with this change, including broad based trainings on how to work with this population, and specific efforts by staff in both mental health and criminal justice systems to increase the use of ... services by offenders...."[26]

Two of Santa Barbara's findings were particularly informative. The first, that both TAU and *MHTC* clients experienced improvements in functioning, seemed to be related to increased engagement in treatment. Possible reasons for this unexpected outcome included that judges trained for the *MHTC* often saw offenders assigned to the TAU as well, and "used their training to recommend non-grant funded public and private interventions." Moreover, because all study participants were asked to sign a consent form and most were brought to the treatment center for their first appointment, even TAU participants "were contacted, assessed, and paid

While participants in the MHTC demonstrated predicted improvements in global functioning and life satisfaction, as well as predicted reductions in psychological distress and drug and alcohol use after entering the program, unexpectedly, so did participants receiving treatment as usual, although their improvements were lower than those of MHTC participants.

Santa Barbara Mental Health Treatment Court
Final Report, page 65

[26] Santa Barbara County, *Mental Health Treatment Courts with Intensive Supervision*, Final Report, pages 70-71

for their assessments every six months. Anecdotal reports … suggest that many of these participants felt they were getting special treatment by virtue of being a part of the project." [27]

There were 10% of mentally ill offenders in both groups who ended up going to prison and an additional 10% across both groups who accounted for over 50% of all post-treatment jail days. Thus for approximately 20% of the offenders entering this program, neither form of treatment (MHTC or TAU) was sufficient to prevent them from going to either prison or jail for longer periods of time than had been the case prior to program entry.

Santa Barbara MHTC Final Report, page 66

Santa Barbara's second unique finding was that the reduction in jail days the project sought to accomplish occurred only for participants who were not the most serious offenders. The County's conclusion was that "… some of the offenders who entered the program were not helped. Approximately 10% … ended up in prison, despite efforts to engage them in treatment. An additional 10% … accounted for over 50% of all jail days accrued. Thus, while there were statistically significant reductions in jail time for the remaining offenders, those who were not helped actually appeared to be getting worse over time. The needs of these clients may not be well met by this type of outpatient program, suggesting the need for other types of more intensive programming for some individuals." [28] *[Emphasis added]* This suggestion provides valuable guidance for jurisdictions seeking to initiate a mental health court and/or to avoid what didn't work in one such effort.

Relative to its mental health court, Placer County attributed success to the dedicated judge, mental health services liaison, public defender and district attorney, who made "an invaluable contribution to better outcomes for the mentally ill offenders."[29] Placer further said, "the court calendar devoted only to mentally ill offenders was an important cornerstone for the project," as well as an indicator of Placer County's commitment to the mentally ill offender population in the County. [30]

Butte County observed that its mental health courtroom 'worked' because it "felt like a safe place, not adversarial." Moreover, Butte added, "the presiding judge for the mental health court served as the lynchpin … assimilating *FOREST* staff knowledge and therapeutic recommendations into the otherwise conventional court proceedings."[31]

Monterey County shared a similar sentiment, identifying the "firm and caring staff (including social workers and the probation officer); a judge who was fair, perceptive and set appropriate limits; the program's structured schedule and its cognitive skill building class" as among the key elements that 'worked' in the *MCSTAR Project*.[32]

Assistance Securing Benefits: The ability to help clients establish or reestablish their eligibility for SSI, Medi-Cal and/or other benefits was considered one of the most productive functions of a number of MIOCRG projects. Several counties made a point of reporting that helping mentally ill offenders secure SSI and/or other benefits produced positive treatment effects and was a valuable element of their programs.

The MIOCR In-custody Service's intensive efforts to obtain benefits for inmates, a process which it initiated while they were still in custody, resulted in securing benefits for a much higher percentage (about 70%) of clients than [was] expected." Alameda considered this service "absolutely necessary to replace" after the end of its grant funding necessitated the closure of the program.

Alameda County MIOCR Program Summary, page 2

[27] Santa Barbara County, page 67
[28] op. cit., page 71
[29] Placer County *Continuum to Avoid Re-arrest and Enter Society (PCCARES) Program* Summary, page 1
[30] op. cit., page 30
[31] Butte County, pages 88 and 107
[32] Monterey County, *Supervised Treatment After Release (MCSTAR) Program* Final Report Summary, page 1

Los Angeles County, for instance, reported that its *CROMIO Program's* concerted efforts to get SSI benefits for clients paid off in clients' improved functioning and reduced recidivism. Securing benefits enabled clients to find housing and/or to enter residential treatment programs and therefore was directly correlated to the fact that psychosocial functioning improved for the treatment group over time. Clients who had benefits were less often homeless or were homeless for less time, and they were significantly less likely to go to prison than those without SSI. In fact, of the 88 participants who obtained Social Security Disability benefits, only 7% were sentenced to prison, whereas of those without SSI, 34% were sentenced to prison.[33]

San Francisco's MIOCRG II project, *Connections*, included a "component that provided benefits advocacy, money management and representative payee services. The Sheriff's Department contracted with Lutheran Social Services (LSS) to hire a caseworker to provide these services. All *Connections* clients not receiving social security income (SSI) were referred to the caseworker for benefits counseling and payee services. The caseworker assisted clients in applying for SSI and helped them attain General Assistance benefits through the Department of Human Services while the SSI application was pending. LSS also assisted clients in accessing other entitlements as appropriate, including social security disability income (SSDI) and Veteran's Administration support."[34]

Under the heading "Program Successes," Santa Cruz County's final report said, "By the end of the grant period, nearly all *MOST* clients had SSI/Medi-Cal; all had received some sort of income assistance. With stable income, clients could apply for permanent housing; in fact, more than half received HUD Section 8 vouchers, entitling them to access Federal housing and requiring that they spend no more than 30% of their income for housing costs. In addition, a 'flex fund,' established to assist clients with security deposits and initial rent payments, became a budget-learning tool for many clients, who were paying back their first-ever loans. Eventually the flex fund was also used for the purchase of consumer goods, most often computers. The vast majority of loans were repaid, most in a timely fashion." [35]

Use of Flex Funds: Like Santa Cruz, San Joaquin and Stanislaus Counties also validated the utility of having a flex fund or revolving account to help support clients' housing and other needs. As did Santa Cruz, these other counties noted the importance of helping mentally ill offenders learn to manage their money, develop and live within a budget, repay loans and prepare for future eventualities, such as down payments and/or the purchase of big ticket items like televisions and computers.

A particularly striking example of the value of flex funds came from Stanislaus County, which has continued its *FACT Program* beyond the end of the MIOCRG grant period. The project manager's request (excerpted at right) underscores the uses and benefits of such a fund.

> ** Flex Funds will be available for the exclusive use of FACT Team clients…for the acquisition of basic living necessities such as food, clothing and shelter, including security deposits, utility expenses, basic household furnishings and supplies. These funds may also be used to assist with tuition and educational materials. These funds will not be given directly to clients but to vendors or in the form of purchase orders or vouchers which clients can use with their case manager's assistance. …*
> ** Flex Funds may be expended as loans or grants, depending on the client's situation. Our preference is to establish an agreement for the client to repay a loan…. Historically, we have been able to recoup approximately 60% of expended flex fund … dollars annually."*
>
> **Letter from Stanislaus County**
> **FACT Project Manager, March 2004**

[33] Los Angeles County, *CROMIO*, page 59
[34] San Francisco, *Connections Program* Final Report, page 22
[35] Santa Cruz County, page 114

Assistance Arranging Housing: Because homelessness is so prevalent among mentally ill offenders, most of the MIOCRG projects included among their goals locating and/or providing housing for clients. As noted previously, counties used a variety of creative strategies to help stabilize clients' housing situations, including establishing and/or expanding ties with homeless shelters and board and care homes, leasing single occupancy hotel rooms, partnering with local non-profit agencies to rent homes or apartments, using Section 8 rental assistance vouchers and using 'flex funds' to help clients with security deposits and/or initial rent payments.

The combination of housing with intensive case management and psychiatric treatment provided an unprecedented level of attention and structure … and an opportunity for therapeutic change that would never be available in an inpatient or jail setting. Clients had the opportunity to experience some freedom while still having intensive support to help them develop new ways of coping.

Ventura County MART Program Final Report, pages 78-9

Nearly half (14) of the MIOCRG projects either provided housing for clients or contracted for space in residential treatment programs/facilities to address their housing and treatment needs.

Placer County established Cedar House, a residential treatment program serving up to 15 mentally ill clients at a time, to provide a safe, supportive environment in which clients could develop and practice interpersonal and independent living skills.

One crucial aspect of the Passages Program was transitional housing upon release from custody. There were many participants that would have been homeless upon release, and transitional housing gave them time to reintegrate into the community without the worry of finding housing.

San Bernardino County, Passages Program Summary, page 2

Kern County's MIOCRG II project, the *Rural Recovery Treatment Program (RRTP),* was a sober living residence to which clients were admitted upon release from jail and from which they were transported daily to a community mental health clinic for intensive day treatment.

The *Solano Mental Health Court Project* created Solano Community House, a highly structured social rehabilitation program in which clients stayed an average of three months. These efforts and the others like them were found to be important as they resulted in improved functioning, increased stability and pro-social connections to the community.

In its *JAILink* (MIOCR I) project, Kern County found that arranging housing through providers who were willing to take criminal offenders was effective because it allowed case managers to be notified immediately when their clients were having problems and positioned treatment team members to respond before difficulties escalated.

About Southside House, the 12-bed short-term housing element of Sacramento County's *Project Redirection,* the final evaluation report said, "The housing component was critical on several levels: it was a safe and welcoming environment for individuals who were accustomed to the disorder, chaos and harshness of the streets; it was a clean and sober place for individuals to return to if needed; and it functioned as a crisis stabilization facility. The primary use of the housing component, however, was so that the individual released from jail did not have to return … to the environment in which he/she had offended and/or become homeless. An additional role emerged for the housing component – the coordination that occurred between the residential staff and case managers regarding the participant's treatment plan and services was essential for client progress."[36]

Noting that it is "often difficult to advocate for mentally ill offenders in the general community," Ventura County pointed out that "Community housing resources, in particular, are often restricted to those

[36] Sacramento County, *Project Redirection* Final Report, pages 60-61

without a criminal background. In Ventura County where there is a lack of housing for the mentally ill, private providers can easily fill their homes with residents with no criminal background. A major thrust of the *MART* program was to recruit housing for these clients. Negotiating for housing as a block allowed the program to offer stable funding to the housing provider, and to promise the accessibility of *MART* case managers and probation officers for quick response should any problems arise. Without these inducements, housing and the added stability it provides would have been much less accessible." [37]

Monterey County found that "providing housing in treatment furlough beds, augmented board and care beds, supportive housing beds, single room occupancy units, and rent subsidies where clients could live together was an important factor in their stabilizing and supporting one another."[38] However, *MCSTAR* also noted, "...housing with 24-hour staffing would have provided more support and probably would have enhanced program compliance." [39]

Perhaps most notably, the program tried to help clients secure housing that met their individual needs and from which they could establish a 'home.' Over four years, they secured vouchers for 39 of the 75 clients – an impressive feat, given the scarcity of housing and the intricacy of the Section 8 application process.

Santa Cruz MOST Project
Final Report, page 87

Other Elements That Worked

Medication Management: Because people with mental illness often don't like the way their medications make them feel or believe it is no longer necessary to take medication when they start to feel better, assistance with and support for medication compliance proved to be essential in most projects.

In Sonoma County's *FACT Program*, for example, clients participating in focus groups about what aspects of the program were most helpful identified "the good relationships and consistent support from staff, the opportunity to build supportive relationships with other program participants, ... and the practical support such as medication management that allowed them to feel more stable and to begin to work on building life skills and working towards their goals. Many clients who had long histories of having psychiatric medications prescribed for them reported never having been taught how to fill or use medi-sets and reported that life skills such as learning how to renew prescriptions greatly increased their likelihood of being consistent with psychiatric medications."[40]

Use of a Center or Clinic: The projects that were based in a center or clinic reported important benefits from having had a location in which clients gathered, received treatment and other services and were able to develop relationships with one another as well as with staff.

The five-day a week, center-based design of [our] program introduced a sense of structure and responsibilities into participants' lives. For some participants, the routine of getting up and being somewhere five days a week was a noteworthy accomplishment and helped prepare them for the idea of getting a job or attending school."

Humboldt County MIOCR Program
Final Report, page 38

Humboldt County's project was located "in a house in a safe neighborhood on a bus line in downtown Eureka." In addition to noting that its kitchen enabled participants to share meals and cooking activities, Humboldt's evaluation report described other benefits. "Having the program contained in one house added to the overall continuity of the services provided and enhanced the collaborative nature of the professional partnership between corrections, mental health treatment

[37] Ventura County, *MART Program,* page 78
[38] Monterey County, Summary, page 2
[39] Monterey County, Final Report, page 14
[40] Sonoma County, *Forensic Assertive Community Treatment (FACT) Program*, Final Report, page 12

professionals, the courts and other community based agencies. The mental health clinicians, probation officer, case manager and substance abuse counselor were able to meet frequently and easily."[41]

When a need was identified for a place for clients to go during the day to participate in structured activities and receive peer support, San Francisco's MIOCRG II *Connections* Program created the Court Accountability Case Management Center (CACMC) to provide activities on a daily basis. These included courses on life skills, substance abuse (in English and Spanish), health and nutrition, food preparation, anger and stress management; individual and group counseling (also in English and in Spanish); social support; and harm reduction.[42]

Santa Cruz County's *MOST* program was co-located with a non-traditional multi-service center operated entirely by mental health consumers. The MOST team utilized this center as an informal, active drop-in site for participants. "At MHCAN, clients found a place where they felt they belonged and could socialize with people with whom they felt safe. Moreover, clients came to consider the *MOST* team as part of their family."[43] For many, this was their first 'family' experience.

Use of the Jail For and With Treatment: Some MIOCRG projects provided extensive in-custody treatment and/or case management; others used the jail primarily for transition/reentry planning. In either and both cases, the projects reported that the interaction of mental health and custody personnel – and the 'big stick' the jail provided – supported community-based interventions, helped further the goals of treatment and were thereby instrumental in reducing mentally ill offenders' post-program returns to custody. "In other words, despite the explicitly stated goal of decreasing criminal justice contacts for mentally ill offenders, the jail was viable and important to treatment. This … 'restorative policing' philosophy recognizes that law enforcement can be an effective tool in treatment."[44]

It was also frequently noted that having mental health staff working in the custody setting positively affected not only mentally ill inmates, but custody staff as well. Sheriff's Deputies assigned to the mental health unit in Alameda County's jail "came to respect and value the presence of mental health staff on the unit…[and said that] behavioral incidents were decreased by the staff's availability. They further noted that mental health treatment could be offered more persistently to resistant patients and that [the inmate/patients] received initial doses of psychiatric medications more quickly."[45]

Assistance with Transportation: Quite a few counties reported that providing transportation for their clients facilitated the transition from jail as well as clients' ability to access treatment in the community.

San Bernardino, for example, said, "The [MIOCRG I *Star Lite* program] developed successful ways of assisting and augmenting client transportation. Staff transported clients at the time of release from the detention center, to first time appointments and to court and probation offices. Monthly bus passes were given out. … From the clients' perspective, the transportation services were a key factor in their overall success. Staff used transportation services not only to move clients from one location to another but as a context to provide clinical services. Case management plans and treatment goals were discussed while staff coached and clinically intervened. … It became evident that transporting clients gave the staff opportunities to establish the critical professional relationships necessary for success in the program."[46]

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41 Humboldt County, *MIOCR Program*, Final Report, page 59
42 San Francisco, *Connections,* page 22
43 Santa Cruz, page 88
44 Marin County, page 37
45 Alameda County, *MIOCRG II*, Summary, page 2
46 San Bernardino County, MIOCRG I Star-Lite Program, Final Report, page 46

Peer Support: Consistent with building ongoing networks for participants, many projects reflected on the value of the relationships clients developed with one another. It was repeatedly noted that clients drew strength from one another and their common experiences. Humboldt, Kern, Santa Barbara, Sonoma, Ventura and a number of other MIOCRG counties reported that supportive interactions among participants and/or peer service providers helped clients stay clean and sober and maintain focus on their treatment plans.

The neat thing about having a peer counselor…is that they have been there…. When a person is having a psychotic episode, it is as real to them as our normal world is to us. The peer counselor can go in using empathy, letting them know she has been where they are.

Marin County Deputy Sheriff
Marin County STAR Program Final Report, page 46

These peer relationships took many forms. Marin County developed a Peer Support Group, led by a peer counselor and used peer service providers. Santa Cruz, as noted above, co-located its project with a peer/consumer operated multi-service center that welcomed anyone with a mental illness. Regardless of how it was accomplished, most projects said that fostering relationships among clients had value, and benefited the clients and the overall project as well.

A Mentally Ill Offender Speaks

Perhaps the words of one mentally ill offender will serve to summarize what worked and what was best about the MIOCRG program. [47]

A 38 year old, female Caucasian, with a primary diagnosis of Bipolar Disorder, PK had been arrested more than 16 times for alcohol-related offenses in the year prior to her entry into Santa Barbara's *Mental Health Treatment Court* program. PK's most current arrest was on charges of being drunk and disorderly and fighting in public. During that arrest, she had kicked out a window of a police car. When first seen by *MHTC* staff, PK was in the jail's safety cell, reserved for clients too impaired or out of control to be placed in the general jail population.

PK participated in, and was the first graduate of, the *Mental Health Treatment Court.* Interviewed at the 48-month follow-up after graduating, PK said:

> ***The eighteen months of Mental Health Treatment Court "went too fast. I liked it so much. It was the best time I ever had in my life. I felt so safe, like nothing could hurt me. I felt more secure. I felt like I was being heard whenever I needed help. When all you've been around is mean people in your life … it was like heaven." She appreciated the collaboration of the different disciplines (probation, the judge, her case manager and others) because, she said, "each gave their own wisdom," whereas, "on your own you need to make all your decisions yourself. It's kinda tough."***
>
> *Santa Barbara, MHTC*
> *Final Report, page 97*

[47] Additional MIOCRG participant case studies can be found in Appendix D

CHAPTER 3: STATEWIDE EVALUATION FINDINGS

The MIOCRG Program funded demonstration projects for the purpose of determining the effectiveness of various approaches to reducing crime among adult offenders with serious mental illness. The Board of Corrections, with consultation from the State Department of Mental Health, and the State Department of Alcohol and Drug Programs, was charged with the responsibility for designing research to evaluate the Program's impact on reducing recidivism. To satisfy this mandate, a local research design was required for the evaluation of each individual project. In addition, each project collected information on a standard set of research variables or common data elements (CDEs). A statewide research design was also developed in which the CDE data for all projects were combined into an aggregated statewide database.

The majority of the local project evaluations incorporated sophisticated research designs. Twenty-seven of the local evaluations employed a true experimental design, wherein eligible cases were randomly assigned to the local MIOCRG Program enhanced treatment (ET) group or treatment as usual (TAU) group. Another three local evaluations consisted of quasi-experimental designs that used a matched, rather than a randomly assigned, comparison group. The remaining five local evaluations relied exclusively on longitudinal assessments of those in the ET group, in which participants' behavior prior to program entry was compared to their behavior subsequent to program entry.[1]

This chapter focuses exclusively on the statewide evaluation, which had two unique advantages: 1) the aggregated data afforded the opportunity to reach wide ranging conclusions having statewide implications, and 2) the larger research sample formed by combining the research samples from the local evaluations greatly increased the statistical power of the investigation, thereby increasing the chances of identifying overall program effects, as well as isolating case history and/or program characteristics that contributed to differential program outcomes.[2]

STATEWIDE RESEARCH SAMPLE

The data for certain projects were excluded from the statewide evaluation. Because the focus of the statewide evaluation was on identifying program effects (i.e., comparing outcomes for those in the ET group with those in the TAU group), the four projects that lacked an external comparison group were excluded.[3] Another four projects were excluded because the research data were not submitted in a format that permitted aggregation with the data from all other projects. In two instances the data could not be reformatted to make aggregation possible, and in the other two the reformatted data were not provided in time to be included in the statewide evaluation. Finally, two additional projects were excluded due to changes in the research design that occurred during the projects, and resultant concerns as to the nature and appropriateness of the final comparison groups.

[1] Some projects involved more than one evaluation. This occurred in projects where distinctly different groups received program services, or when there was an examination of the impact of different types or systems of delivery of program services (when compared to standard services or to other combinations of program services or types of delivery). Thus, among the 30 projects there were a total of 35 distinct local evaluations.

[2] Those interested in reviewing any project-specific studies are urged to contact either the local project manager or the local project evaluator to request a copy of the final project report (*see Appendix F - MIOCRG Contact List).*

[3] In another project, which conducted two distinct evaluations, one of the evaluations lacked an external comparison group. However this project, and thus both evaluations, was excluded from the statewide database due to data format issues.

Table 2 shows the influence of excluding projects in arriving at the final CDE database of 4,741 cases. All but one of the 20 projects in the final database utilized a true experimental design.[4]

Table 2. Formation of Final Statewide Evaluation CDE Database

	Number of Projects Remaining	Number of Cases Remaining		
		Enhanced Treatment (ET)	Treatment As Usual (TAU)	Total Cases
Initial Database	30	4,510	3,608	8,118
Exclude Projects – No External Comparison Group	26	4,164	3,608	7,772
Exclude Projects – Data Format Issues	22	2,821	2,661	5,482
Exclude Projects – Other Research Design Issues	20	2,506	2,269	4,775
Final Data Base[5]	20	2,472	2,269	4,741

The background characteristics of the cases comprising the final database are summarized in Table 3. The average age of those in the research database was approximately 36. Approximately one in ten (10.6%) were currently married. Slightly over half had never been married (54.8%), about one in five (21.6%) were divorced and another 10.6% were separated. With respect to employment, approximately half were unemployed (in the labor pool and seeking work), whereas almost one in five (19.3%) were employed. Another 31.4% were considered not employed, meaning they had other means of support and were not seeking employment.

With respect to the primary clinical diagnosis of those in the database, approximately one-fourth fell into each of the following three categories: delusional (26.5%), bipolar (25.6%), or depressive (29.6%).[6] Another 10.8% of the cases were diagnosed as schizophrenic, and the remaining 7.5% of the cases had a primary diagnosis of substance abuse disorders (1.8%), anxiety disorders (3.0%), psychotic disorders (.6%) or other (2.1%). Thus, the primary diagnosis of over half the cases reflected mood disorders (bipolar or depressive).

Global Assessment of Functioning Scale (GAF) scores were also collected for each person. GAF scores are clinical assessments of overall psychological, social and occupational functioning based on a 100-point scale.[7] Higher scores reflect better overall functioning. The average GAF score at intake of those in the database was 45.6. A GAF score of 40 is indicative of some impairment in reality testing or communication, or major impairment in areas such as judgment, thinking, mood or social or work relations; whereas a GAF score of 50 is considered indicative of serious psychological symptoms or serious impairment in social or occupational functioning.

[4] As mentioned previously, some projects included multiple evaluations. The 20 projects retained in the statewide evaluation account for 21 of the original 35 local evaluations of MIOCRG programs.

[5] An additional 34 ET group cases were excluded from one of the remaining 20 projects, as these cases did not receive enhanced out-of-custody services.

[6] Primary diagnosis was based on the Diagnostic and Statistical Manual of Mental Disorders (4th edition) published by the American Psychiatric Association (1994), and commonly referred to as DSM -IV.

[7] The GAF Scale is Axis V on the DSM-IV Multiaxial Assessment model.

Finally, approximately half of those in the study group reported problems with alcohol at intake (48.5%), and a slightly higher percentage reported drug problems at intake (59.1%).

Table 3. Background Characteristics of Cases in Final Database

Demographics		Enhanced Treatment (ET)[8]	Treatment As Usual (TAU)[9]	Total[10]
Age (Mean)		36.16	36.19	36.17
Male*		56.7%	59.5%	58.0%
Marital Status, Intake	Divorced	21.1%	22.1%	21.6%
	Married	10.1%	11.3%	10.6%
	Never Married	55.1%	54.3%	54.8%
	Separated	11.4%	9.6%	10.6%
	Widowed	2.3%	2.6%	2.5%
Employment Status, Intake	Employed	18.8%	19.9%	19.3%
	Not Employed	30.8%	32.3%	31.4%
	Unemployed	50.4%	47.8%	49.3%
Homeless at Intake**		20.0%	25.3%	22.2%
Clinical Status		Enhanced Treatment (ET)	Treatment As Usual (TAU)	Total
Primary DSM IV Disorder, Intake	Substance Abuse	1.7%	1.9%	1.8%
	Delusional	27.7%	25.2%	26.5%
	Psychotic	.7%	.4%	.6%
	Schizophrenia	10.0%	11.7%	10.8%
	Bipolar	25.8%	25.4%	25.6%
	Depressive	29.4%	29.8%	29.6%
	Anxiety	2.9%	3.2%	3.0%
	Other	1.7%	2.5%	2.1%
GAF, Intake (Mean)		45.87	45.25	45.58
Alcohol Problems		48.1%	49.2%	48.5%
Drug Problems		59.3%	59.0%	59.1%
Criminal History		Enhanced Treatment (ET)	Treatment As Usual (TAU)	Total
Criminal Intensity Score (Mean)		13.44	13.82	13.62

*p<.05 (Chi-Square); **p<.01 (Chi-Square)

Criminal history at intake was measured using a Criminal Intensity Index. The index takes into account the frequency and severity of bookings during each of three 12-month time periods prior to program intake, as well as the severity of the qualifying booking leading to entry into the program. The formula for the index is shown below. As reflected in the formula, more recent bookings receive greater weight in the formula. Similarly, bookings for more serous offenses (felonies) receive greater weight than bookings for lesser offenses (misdemeanors). The maximum value that can be obtained for the index is 42.

$$\text{Criminal Intensity Score} = \sum_{i=1}^{3} t_i s_i n_i + 3_q$$

[8] N = 2,161 to 2,456
[9] N = 1,493 to 2,255
[10] N = 3,654 to 4,711

Booking Recency Factor
t = time since booking
t_1 = 1 = 25-36 months prior to program entry
t_2 = 2 = 13-24 months prior to program entry
t_3 = 3 = 0-12 months prior to program entry

Number of Bookings Factor
n = number of bookings during period
0 = 0
1 = 1 booking
2 = 2 or 3 bookings
3 = 4 or more bookings

Most Serious Booking Factor
s = severity of most serious booking during period
0 = none
1 = misdemeanor
2 = felony

Most Serious Qualifying Booking Factor
q = severity of qualifying booking
0 = none
1 = misdemeanor
2 = felony

As shown in Table 3, statistically significant differences were found between the ET group and the TAU group on two background variables – gender and homelessness. The significant difference on gender is barely significant (p=.053), and is largely an artifact of one project that served females only and for which there were more subjects in the ET group. When this project is excluded, the difference between the two groups is no longer statistically significant (N=4610; Chi-Square = 3.16, p = .08). Similarly, the statistically significant group difference on homelessness appears to be an artifact of one project for which no data on this variable were available for the TAU group. When this project is excluded, the difference in the percent homeless for the two groups no longer reaches statistical significance (N=4118; Chi-Square = 3.45; p = .06).

OVERVIEW OF APPROACH TO DATA COLLECTION

As mentioned previously, each demonstration project collected data for a uniform set of variables called Common Data Elements (CDEs). The variables and variable definitions were developed in a collaborative effort among the local project managers, local project researchers, and the Board of Corrections staff. In addition to providing information such as reported in Table 3 (intake data), the CDE variables provided information about the nature and frequency of the services received by all cases (intervention data), as well as their subsequent criminal conduct, psychological functioning, and conditions of general living (outcome data). Intervention and outcome data were captured in six-month intervals from program entry, and the projects submitted CDE files to the Board on a semi-annual basis throughout the course of the MIOCRG Program. In the vast majority of instances, the CDEs were also used almost exclusively in the local project evaluations. A data dictionary for the CDEs is provided in Appendix E.

Common Data Element Statewide Research Findings

The purpose of the Mentally Ill Offender Crime Reduction Grant (MIOCRG) program was to: 1) reduce the frequency with which the mentally ill encounter the criminal justice system, and 2) reduce the number of repeat incarcerations among the mentally ill.

To assess whether the MIOCRG programs, taken together, accomplished these goals, data were collected for several outcome measures including:

- Bookings for ET versus TAU group members in terms of:

    1. **Any Booking**. The percentage that was booked during their two-year, post-incarceration involvement in the program.
    2. **Mean Bookings**. The mean number of bookings per six-month program participation period during the two-year, post-incarceration involvement in the program.
    3. **Booking Offense**. The seriousness of the offenses that led to the bookings.

- Convictions for ET versus TAU group members in terms of:

  4. **Any Conviction**. The percentage that was convicted during their two-year, post-incarceration involvement in the program.
  5. **Mean Convictions**. The mean number of convictions per six-month program participation period during the two-year, post-incarceration involvement in the program.
  6. **Conviction Offense**. The seriousness of the offenses that led to the convictions.

- Jail incarceration for ET versus TAU group members in terms of:

  7. **Any Jail Time**. The percentage that served jail time during their two-year, post-incarceration involvement in the program.
  8. **Mean Jail Days**. The mean number of jail days per six-month program participation period during the two-year, post-incarceration involvement in the program.

- Substance abuse problems for ET versus TAU inmates in terms of:

  9. **Drug Problem**. The percentage of participants with drug problems at the end of their two-year, post-incarceration involvement in the program.
  10. **Alcohol Problem**. The percentage that reported alcohol problems at the end of their two-year, post-incarceration involvement in program.

- Mental health status for ET versus TAU inmates in terms of:

  11. **GAF Change**. The Percentage of participants who experienced an improvement, no change or a worsening of their Global Assessment of Functioning (GAF)[11] score between intake and their final program assessment.

- Quality of life status for ET versus TAU inmates in terms of:

  12. **Housing Status**. The percentage of homeless at the end of their two-year, post-incarceration involvement in the program.
  13. **Employment Status**. The percentage that lacked employment (of those not supported in some other manner) at the end of their two-year, post-incarceration involvement in the program.
  14. **Economic Self-Sufficiency**. The percentage of six-month periods after incarceration for the two-year post-incarceration involvement in the program that research subjects experienced "economic sufficiency" (i.e., they were self sufficient in that they received enough funds to cover living expenses either from a job or from their family or public assistance, versus those that needed a job to support themselves and were unable to secure one).

Although more specific information will be presented later in this chapter regarding program specifics, interventions and sub-samples, we begin with the overall hypothesis testing for the statewide aggregated ET and TAU samples. The programs that were aggregated were different in important respects. Nevertheless, ET subjects, when compared with the TAU subjects, were: 1) more comprehensively diagnosed and evaluated regarding their mental functioning and therapeutic needs, 2) more quickly and reliably provided with services designed to ameliorate the effects of mental illness, 3) provided with more complete after-jail systems of care designed to ensure adequate treatment and support, and 4) monitored more closely to ensure that additional illegal behavior, mental deterioration, and other areas of concern were quickly addressed.

[11] Global Assessment of Functioning (GAF) Scale of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

The research compared the results for the ET and TAU groups for the 14 outcome measures. The remainder of this chapter presents the findings for these comparisons.

TOTAL GROUP RESULTS

As mentioned previously, the total statewide sample consisted of 4,741 individuals who participated in the 20 local projects that satisfied the criteria for participation in the hypothesis testing (e.g., true or quasi-experimental design, with an adequate comparison group). The ET group and the TAU group included 2,472 and 2,269 mentally ill offenders respectively.

The total group results included the following subgroups: both males and females, individuals from a wide age range (18 to over 70), those with and without a substance abuse problem, both homeless and those with a stable living situation, employed and unemployed individuals, some individuals charged with misdemeanors and others charged with felonies, individuals with various degrees of involvement with criminality, offenders with various kinds of DSM-IV diagnoses and those with different levels of educational achievement. To further complicate matters, the 20 projects differed significantly in their focus, goals and range of interventions.

Given all the uncontrolled variables, the total group hypothesis testing examines the degree to which there is a robust, overarching advantage to the generic MIOCRG strategy emphasizing accurate diagnosis, timely services, close offender monitoring and aftercare interventions after release from jail (as compared to the TAU of mentally ill offenders in place prior to the initiation of the MIOCRG programs).

The total group hypothesis testing has several advantages:

1. The larger sample sizes inherent in aggregating the separate programs makes possible a more sensitive test of possible treatment effects than would be possible with the smaller samples.
2. If positive results are achieved with so many potentially important variables left uncontrolled, one can have confidence that the ET effect is fairly strong and able to transcend the complicating effects of important sub-factors.
3. Positive results would strongly suggest that sub-group analyses would be fruitful in finding program, participant and other factors that contribute significantly to differential program outcomes.
4. Positive findings would speak of the "generalizability" of the results. In other words, the goal of this research was to address a California-wide problem. If the overall approach was proven to be effective, a California-wide application would be a reasonable recommendation.

Later in this chapter, the results for research subgroups will be presented.

Total Group Findings

Table 4 presents the results of the hypothesis testing for the total group for the 14 outcome measures. The "Outcome" column indicates the keyed response associated with the summary statistics presented in the table. For example, for "Any booking," the summary statistics of 53.3% for the ET group versus 56.2% for the TAU group represent the percentages for which the "Any booking" result was "yes" (i.e., the percentage of each sample that had at least one booking).

The "B minus A" column shows the value that results by subtracting the ET percentage with at least one booking from the TAU percentage. A positive result in the "B minus A" column indicates a superior result for the ET group. The "sample sizes" indicate the number of people for whom the keyed response applied. The "test" indicates the statistic used in the hypothesis testing. "CS" refers to Chi-Square, and

"MWU" refers to the Mann-Whitney U. The hypothesis test values are the "p" values that indicate the probability that the observed ET group and TAU group differences are due to chance alone.

Although the treatment effects were small (as might be expected given the uncontrolled variables), there was a consistent tendency for the ET group to outperform the TAU group as indicated by the following:

- Positive results: significant = 10
- Positive results: approaching significance = 2
- Results in the negative direction, not significant = 2

Total = 14

The ET group performed more poorly than the TAU group for only two outcome measures: 1) mean bookings per period (this outcome could have resulted from the increased scrutiny of the behavior of the individuals in the ET group) and 2) percent unemployed. For the remaining 12 outcome measures, the ET group achieved better results than the TAU group. For 10 of the 12, the ET group results were significantly better or approached statistical significance. Achieving this pattern of results by chance would be extremely unlikely, even given the fact that some of the outcome variables are correlated with one another.

The results indicate that, across a varied set of outcome measures, the aggregated MIOCRG programs produced consistently positive results. Although the sizes of the treatment effects are small, they are probably underestimates given the reasons already stated. As will be seen when the subgroup analyses are presented, the treatment effects were larger for various subgroup by outcome-measure combinations.

Table 4. Total Group Results for 14 Outcome Variables for the Two-Year, Post-Incarceration Period

#	OUTCOMES IN PROGRAM	OUTCOME	ENHANCED TREATMENT = A	TREATMENT AS USUAL = B	B MINUS A	SAMPLE SIZE A	SAMPLE SIZE B	Significance
BOOKINGS								
1	Any booking	Yes	53.3%	56.2%	2.9%	1,288	1,234	.048 CS*
2	Mean bookings	Number	0.531	0.498	-0.033	2,418	2,197	.525 MWU
3	Booking offense	Felony	29.3%	32.5%	3.2%	660	663	.032 CS*
CONVICTIONS								
4	Any conviction	Yes	35.3%	38.3%	3.0%	852	841	.036 CS*.
5	Mean convictions	Number	0.285	0.304	0.019	2,415	2,198	.064 MWU
6	Conviction offense	Felony	22.1%	25.9%	3.8%	467	506	.036 CS*
JAIL								
7	Any jail time	Yes	54.4%	57.1%	2.7%	1,312	1,249	.074 CS
8	Mean jail days	Number	13.7	15.2	1.5	2,410	2,189	.036 MWU*
DRUG / ALCOHOL								
9	Drug problem	Yes	44.8%	55.3%	10.5%	730	352	.000 CS**
10	Alcohol problem	Yes	38.2%	49.6%	11.4%	623	314	.000 CS**
MENTAL HEALTH								
11	GAF change	Worsened	20.6%	32.4%	11.8%	358	413	.000 CS**
QUALITY OF LIFE								
12	Housing status	Homeless	7.3%	12.0%	4.7%	126	91	.000 CS**
13	Unemployed	Yes	43.1%	39.0%	-4.1%	747	297	.081 CS
14	Economic Sufficiency Periods	0%	30.1%	53.4%	23.3%	684	813	.000 CS**

*p<.05, **p<.01, CS indicates Chi Square, MWU indicates Mann-Whitney U.

Total Group Results for 14 Outcome Measures

The results discussed below were based upon outcome measures collected on 4,741 research participants during the four six-month periods after their release from jail and during program participation. The total program participation time of two-years is the basis for all the results that are discussed in this section. The specific computation of each outcome measure is discussed below.

Bookings: The ET group outperformed the TAU group for two of the three outcome measures. Significantly fewer ET group individuals were booked. However, for individuals who were booked, the ET group mean number of bookings was slightly higher than for the TAU group. As previously mentioned, the ET group was more closely monitored which might have led to the higher frequency of bookings.

The "offense booked, most serious" had three keyed responses: 1) none, 2) misdemeanor and 3) felony. The results are displayed in the following table.

Table 5. Percentage of ET and TAU Groups with Misdemeanor and Felony Bookings

		ET		TAU	
	Response	**N**	**%**	**N**	**%**
Booking offense	None	1,130	50.1%	946	46.3%
	Misdemeanor	466	20.7%	432	21.2%
	Felony	660	29.3%	663	32.5%

While a higher percentage of the TAU group had both misdemeanor and felony bookings, the bigger difference occurred with felony bookings.

Convictions: For the three outcome measures involving convictions, the ET group outperformed the TAU group. Significantly fewer ET group individuals were convicted (35.3% versus 38.3% for the TAU group; $p = .036$, Chi-Square). The mean number of convictions per period during the four six-month periods after release from jail was .285 for the ET and .304 for the TAU. The difference approaches significance ($p = .064$, Mann-Whitney U).

In Table 6, the results are presented for the more serious convictions including those for violent offenses, property offenses, drug offenses and other felony offences. A higher percentage of the TAU group than the ET group was convicted of each type of offense. The biggest difference between the two groups was in the area of drug convictions where 9.7% of the TAU group was convicted versus 7.8% of the ET group.

Table 7 presents the conviction data for less serious offenses. For all other misdemeanor offenses, the ET group percentage is about the same as for the TAU group. The ET group subjects were convicted more often for violations of probation. This is probably due to the increased supervision by a probation officer and mental health courts that were key components of many of the MIOCRG programs.

Table 6. Percentage of ET and TAU Groups with Various Types of Convictions

		ET		TAU	
	Response	**N**	**%**	**N**	**%**
Conviction Types	Violent offense	115	5.4%	109	5.6%
	Property offense	167	7.9%	174	8.9%
	Drug offense	164	7.8%	189	9.7%
	All other felony offenses	21	1.0%	34	1.7%
	Total	467	22.1%	506	25.9%

Table 7. Percentage of ET and TAU Groups with Misdemeanor and Convictions and Violations of Probation

		ET		TAU	
	Response	**N**	**%**	**N**	**%**
Conviction Types	All other misdemeanors	189	8.9%	171	8.8%
	Violation of probation	123	5.8%	92	4.7%
	Total	312	14.7%	263	13.5%

Jail Time: The Mentally Ill Offender programs tracked the jail time served by research participants during the two-year program participation period (after being released from the incarceration that resulted from the offense that qualified them for the program). First, the percentages of research participants that received any jail time for the ET and TAU groups were compared. More TAU group members served time in jail during the program participation period (57.1%, versus 54.4% for the ET group). This difference approaches statistical significance ($p = .074$, Chi-Square).

The second jail-related outcome measure was the mean jail days across the four six-month, post-incarceration, program periods. The TAU group served significantly more jail days per period than did the ET group (a mean of 15.2 days versus 13.7 days respectively; $p = .036$ Mann-Whitney U).

This difference in mean jail days in the program participation period, while promising, might be an artifact of the differences in the program and TAU samples. Random assignment does not always produce comparable samples. In the case of this outcome measure, the qualifying arrests for the TAU subjects resulted in significantly more jail days for the TAU group. Therefore, it would be reasonable to assume that re-arrest during the program participation period would result in longer sentences.

Substance Abuse: A much higher percentage of the TAU group than the ET group had drug and alcohol problems at the end of the two-year program participation period (for drug problems, 55.3% versus 44.8% respectively; for alcohol problems, 49.6% versus 38.2% respectively).

Mental Health: The Global Assessment of Functioning (GAF) Scale (Axis V from the DSM-IV) was used to gauge the degree of change in the research participants' mental health. The results appear in Table 8. Over 40% of research participants experienced no change in GAF score (42.3% for the ET group and 41.8% of the TAU group). With regard to subjects that experienced a change in GAF, the majority of the ET group improved, and the majority of the TAU group worsened.

Table 8. Percentage of ET and TAU Group with Types of GAF Change from Intake to Final Assessment

		ET		TAU	
	Outcome	**N**	**%**	**N**	**%**
GAF, intake to last entry	Worsened	358	20.6%	413	32.4%
	No change	735	42.3%	533	41.8%
	Improved	645	37.1%	328	25.7%

For the 1,003 ET subjects that experienced a change in GAF score (57.7%), 64.3% exhibited an improvement in their functioning, the functioning of 35.7% worsened (Table 9). The results for the TAU group were markedly different. Of the 741 (58.2%) who experienced a change in GAF score, only 44.3% exhibited an improvement in functioning, while the functioning of 55.7% worsened.

Table 9. For Those ET and TAU Participants with a GAF Change, the Percentage That Improved and Worsened

		ET		TAU	
	Outcome	**N**	**%**	**N**	**%**
For subjects with GAF change	Worsened	358	35.7%	413	55.7%
	Improved	645	64.3%	328	44.3%
	Total	1,003	100.0%	741	100.0%

The fact that over 40% of both the program and comparison group samples did not experience a change in GAF score is an interesting finding. On the one hand, mental illness often proves to be intractable. One would expect a certain percentage of subjects to neither improve nor worsen. On the other hand, most of the 40 plus percent experience **no** change. That degree of reliability in independent pre-post assessments of GAF would be extremely unlikely. Therefore, for the "no change in GAF" subjects, the post-assessment evaluation was probably influenced by the pre-assessment evaluation (i.e., not an independent evaluation). In light of these speculations, we recommend against concluding that mental illness was resistant to change in over 40% of the type of population included in this research.

We do not have similar reservations about the results for those for whom the GAF did change. The ET, when compared to the TAU, produced definitely superior results.

Housing Status: Although a large majority of both the ET and TAU subjects were adequately housed at the end of the program participation period, there was a significant difference between the two groups. Close to 93% (92.7%) of the ET group were housed, versus 88.0% of the TAU group ($p = .000$, Chi-Square). The status of both groups improved from what was true at intake into the program. Initially, 80.0% of the ET group had housing, compared with 74.7% of the TAU group. Therefore, the TAU group actually improved slightly more than the ET group (13.3% versus 12.7%). One of the confounding factors in this research was programs for the mentally ill, in addition to the MIOCRG grant programs funded through the Board of Corrections, that were initiated during the course of this study (e.g., the previously described Proposition 36 and legislation to assist with the homeless mentally ill). In some counties, only TAU subjects were given access to these additional programs.

One problem with this outcome measure is the disparity between the sample sizes for the two groups. While the programs were able to collect housing data for 1,732 ET subjects (70.0% of the original sample of 2,472), they collected housing data for only 759 of the TAU sample (33.5% of the original sample of 2,269). It is probable that the TAU subjects for whom data were available would be those with stable housing.

Employment Status: At the time of intake, there were no significant differences between the ET and TAU groups in terms of employment status. By the end of the program participation period, there were still no significant differences, but the pattern of results approached significance. Table 10 displays the results.

Table 10. Percentage of ET and TAU Group with Types of Employment Status

		ET		TAU	
	Response	**N**	**%**	**N**	**%**
Employment status	Employed	211	12.2%	112	14.7%
	Not seeking employment	774	44.7%	352	46.3%
	Unemployed	747	43.1%	297	39.0%
	Total	1,732	100.0%	761	100.0%

The problem with this outcome measure is the same as indicated for the housing outcome variable. While the programs were able to collect employment data for 1,732 ET subjects (70.0% of the original sample of 2,472), they collected employment data for only 761 of the TAU sample (33.5% of the original sample of 2,269). It is probably that the TAU subjects for whom data were available would be those with stable housing and employment.

Periods with Economic Self-Sufficiency

The two groups differed significantly in the degree to which they experienced economic self-sufficiency during the four six-month program participation periods. For the ET group, 30.1% of the sample experienced no economic self-sufficiency during the entire program participation period versus over 50% for the TAU group (53.4%). Conversely, 32.0% of the ET group experienced economic self-sufficiency throughout the program participation period, as opposed to only 24.2% for the TAU group. The differences in the patterns of economic self-sufficiency between the two groups were highly significant ($p = .000$, Chi-Square).

Summary of the Total Group Findings

The Mentally Ill Offender Crime Reduction Grant programs have been shown to have an overall positive impact in a number of areas. They reduced the tendency to be booked and convicted of a crime. Program participants showed significantly more improvement in mental functioning than their comparison-group counterparts in the final program assessment. More ET participants than TAU individuals had housing at the end of the two-year program participation period, and program participants more consistently achieved economic self-sufficiency.

On the other hand, the significant differences between the ET and TAU outcomes were fairly small. As mentioned previously, this lack of sizable treatment effects was probably due to the number of variables that were not controlled in the overall group analyses, including gender, age and prior criminal history.

To explore this issue, a number of subgroup analyses were conducted. The results are presented in the next section.

SUBGROUP RESULTS

An important finding of previous Board of Corrections grant research is this: no program works equally well for all categories of program participants. For example, Board of Corrections research regarding juvenile offending indicates that program effects should be assessed separately by gender and age categories (due, at least in part, to the differences in patterns of offenses for males versus females, and younger versus older juveniles).

Table 11 presents the pattern of instances where the ET group performed significantly better than the TAU group for selected intake subgroups and selected outcomes. The research sample was partitioned into:

1. The two gender subgroups.
2. Two age subgroups dichotomized between younger than 30 years of age versus 30 or older.
3. Participants with and without substance abuse problems at entry into the research.
4. Participants that had stable housing at program entry versus those that did not.
5. Three "employment at entry" subgroups: a) those employed, b) those seeking employment but not employed, and c) those unemployed but with means of support such as family and/or public assistance.
6. Two subgroups depending upon whether the offense at booking that qualified the individual to participate in the research was a felony or misdemeanor.
7. Participants that had a drug conviction at the time of entry into the program, and those that did not.
8. Three subgroups based upon the Criminal Intensity Score.
9. Four subgroups based upon DSM-IV diagnosis at intake into the research.
10. Two subgroups made up of those individuals with and those without a high school diploma or GED.

The Table 11 columns display the two categories of outcomes: criminal justice and well-being. A circle at the intersection of the outcome-column and subgroup-row indicates that for the subgroup in question, the ET group had significantly better results than the TAU group for that outcome. For example, in the two-year post-incarceration program participation period, a significantly higher percentage of the TAU group was booked.

Based upon the patterns of significant findings, the following intake variables had the biggest impact on whether the MIOCRG programs would be effective in terms of improving criminal justice outcomes:

1. Age
2. The recency and seriousness of pre-program criminal involvement (the Criminal Intensity Score).
3. Whether or not the participant had a drug problem at the time of intake into the program.
4. Being in the "employment not sought" category. This designation refers to individuals who are not seeking employment because they have other means of support such as from spouses, families, public assistance programs, etc.

Almost all ET subgroups achieved better results in term of four of the well being outcomes measures:

1. The Global Assessment of Functioning (GAF) scale
2. Self report of drug problems at the end of the two-year program participation period.
3. Self report of alcohol problems at the end of the two-year program participation period.
4. Having regular housing.

Table 11. Research Participant Variables at Program Entry, Related to Enhanced Treatment Versus Treatment as Usual Significant Outcome Differences

Table11. Research Participant Variables at Program Entry, Related to Enhanced Treatment Versus Treatment as Usual Significant Outcome Differences		All Participants	Gender		Age at Intake				Booking That Led to Program Entry		Criminal Intensity Score			Drug Conviction as Qualifying Offense		DSM-IV Diagnosis at Intake				Substance Abuse Reported at Intake		Employment			Homeless		Education at Intake		
			Male	Female	< 30	30-39	40-49	50 +	Felony	Misdemeanor	High	Medium	Low	Yes	No	Delusional	Schizophrenic	Bipolar	Depressive	Yes	No	Yes	Not sought	Unemployed	Yes	No	> HS	HS/GED	< HS
Well Being Outcomes	Economic Self-Sufficiency			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●
	Employment at Follow-up				●										●									●		●			
	Housing at Follow-up	●		●			●	●	●	●		●	●		●			●	●	●		●		●		●	●		
	Alcohol Problems, Self-Report	●	●	●		●	●		●	●	●	●	●		●	●		●	●	●		●	●	●	●	●		●	●
	Substance Abuse, Self-Report		●	●	●	●	●		●	●	●	●		●	●	●		●	●	●		●		●		●		●	●
	GAF Change	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Criminal Justice Outcomes	Jail, Mean Days	●				●	●				●					●					●		●		●				
	Jail, Any					●					●				●						●		●						●
	Conviction, Most Serious	●		●										●							●		●			●			
	Conviction, Mean Number			●		●	●		●		●			●							●		●						
	Conviction, Any	●		●		●	●		●		●			●						●			●						
	Booking, Most Serious	●					●				●			●					●		●								
	Booking, Mean Number				●		●				●										●		●						
	Booking, Any	●					●				●								●		●		●						

Subgroup Analyses and the Magnitude of Treatment Effects

The previous sections presented the hypothesis-testing results for the total research sample and selected subgroups. The conclusion is that the Mentally Ill Offender Crime Reduction Grant programs, when aggregated, demonstrated significant positive findings in terms of criminal justice and well-being outcome measures. However, for the most part, the treatment effects were small.

A second conclusion is that results differed depending upon the subgroup to which the research participants belonged. For example, the ET outcomes were more consistently superior to the TAU outcomes for older participants.

This section of the report explores the extent to which the magnitude of the treatment effect was related to subgroup membership. The previous table was used as a guide in choosing which subgroups and which outcome measures to include in this investigation. Several issues were considered in making these choices.

1. Exploring all combinations of the ten-subgroup types and 14 outcome measures would make this report much too long.
2. The sample size, although fairly large, made it infeasible to look at more than two subgroups simultaneously (combining three or more subgroups created too many empty or minimally populated cells, making it impossible to draw meaningful conclusions or conduct statistical tests).
3. Of course, if one looks at selective subgroups and outcome measures based upon results such as appear in Table 11, one can capitalize on chance, making the results difficult to interpret. Nevertheless, the consistency of results across various outcome measures strongly suggests that the tentative conclusions are valid. At the very least, the conclusions suggest fruitful areas for future research.

The Common Data Element research had produced a wealth of data. The database includes over 8,000 mentally ill offender participants. Data were collected for over 1,400 variables for each participant. Fully analyzing and reporting on all results that could be gleaned from the database was not possible. We have attempted to address the major hypotheses and to include the highlights. Hopefully, there will be future staff and resources available to "mine" the database for all that it can tell us about effectively dealing with the problem of mentally ill individuals who encounter the criminal justice system.

Because we could not explore all subgroup/outcome combinations, we decided to focus on those that appeared to have the strongest interaction with treatment effects. Those include: age, Criminal Intensity Score, substance/alcohol abuse[12] and employment. Two outcome measures were chosen (one a criminal justice outcome and the other a well-being outcome): any booking in the two-year post-incarceration program participation period, and GAF change from intake to the final GAF assessment.

It would be interesting to investigate the combined effects of more that two subgroup factors (such as age, involvement in crime and substance/alcohol abuse), and there are more sophisticated statistics that one could use to somewhat ameliorate the sample size problem, but those investigations are beyond the scope of this report which is intended to be a summary of basic hypothesis testing and key results. Hopefully this report will point the way to future, more in depth explorations of program impact as a function of subgroup membership.

Risking taking advantage of chance versus stretching the range of discoveries that a dataset might provide is a conflict researchers grapple with. We present the following findings knowing that future corroboration will be required to confirm their validity. Nevertheless, they make intuitive sense, and are sufficiently promising that we felt we would have been remiss to leave them out.

[12] For the remainder of the report the variable "substance abuse" is a constructed variable indicating drug abuse or alcohol abuse or both.

Age/Criminal Intensity and Bookings in the Program Participation Period

Table12 Presents the "Any Booking" outcome results for the age and Criminal Intensity Score subgroups, individually and in combination. In order to avoid small cell samples, age was dichotomized into those research participants under 30 years of age versus those 30 and older. The Criminal Intensity Score was trichotomized into approximately the lower 25%, the middle 50% and the top 25%. The variable "Any Booking," represents the percentage of the sample that received at least one booking during the two-year post-incarceration program participation period.

As has already been presented, a significantly higher percentage of the TAU group had bookings (56.2% of the TAU group were booked versus 53.3% of the ET group). However, as the table shows, the results are different for the various age and Criminal Intensity Score subgroups:

- **Age**. For the under 30 years of age group, a higher percentage of the ET group than the TAU group were booked (non-significant). In contrast, for the 30 years of age and older participants, a significantly higher percentage of the TAU group was booked. The treatment effect is twice as large as for the total sample (a 5.8% difference versus a 2.9% difference).
- **Criminal Intensity**. There was very little difference between the ET group and TAU group for research subjects with low and medium Criminal Intensity Scores. However, for those with high Criminal Intensity Scores, the TAU group had a significantly higher percentage of individuals with bookings (the TAU/ET difference was 8.4%).
- **Age and Criminal Intensity**. When both age and criminal intensity are taken into account, the six subgroups produce an interesting pattern of results (although caution must be exercised in interpreting the pattern given the somewhat small sample sizes). For participants under 30 years of age with low Criminal Intensity Scores, a smaller percentage of the TAU group than ET group was booked (the difference was fairly large at 7.9%, but not significant due to the small sample sizes). In contrast, for participants 30 years of age and older with a high Criminal Intensity Score, the TAU group had a significantly higher percentage booked (a difference of 13.4%).

Table 12. Total Group, Age and Criminal Intensity Subgroups Related to the Outcome Variable: Any Booking = Yes

	ET = A	TAU = B	B Minus A	Sample Size for A	Sample Size for B	Sig.
TOTAL GROUP	53.3%	56.2%	2.9%	1,288	1,234	.048 CS
Under 30 years of age	58.7%	57.5%	-1.2%	398	327	.660 CS
30 plus years of age	51.8%	57.6%	5.8%	884	885	.001 CS
Criminality Intensity Index = Low	42.2%	42.8%	0.6%	237	216	.862 CS
Criminality Intensity Index = Medium	53.5%	54.2%	0.7%	628	565	.731 CS
Criminality Intensity Index = High	63.3%	71.7%	8.4%	349	386	.003 CS
Under 30, Criminality Intensity Index = Low	47.1%	39.2%	-7.9%	73	49	.185 CS
Under 30, Criminality Intensity Index = Medium	59.0%	60.5%	1.5%	197	156	.715 CS
Under 30, Criminality Intensity Index = High	69.4%	66.7%	-2.7%	111	106	.604 CS
30 +, Criminality Intensity Index = Low	40.0%	45.3%	5.3%	161	163	.145 CS
30 +, Criminality Intensity Index = Medium	52.2%	54.4%	2.2%	430	398	.386 CS
30 +, Criminality Intensity Index = High	62.5%	75.9%	13.4%	238	277	.000 CS

Age/Criminal Intensity and GAF Change in the Program Participation Period

Table 13 presents the results for "GAF-change" for the age and Criminal Intensity Score subgroups, individually and in combination. The GAF-change represents the percentage of participants whose GAF score worsened between intake into the program and the final assessment in the two-year post-incarceration program participation period. As reported earlier for the total group, the GAF did not change for 42.3% of the ET group, got better for 37.1% and got worse for 20.6%. For the TAU group, in terms of GAF at intake versus final assessment, the percentages of no change, improved and worsened were 41.8%, 25.7% and 32.4% respectively. The percentage of participants whose GAF worsened in the TAU group was 11.8% higher than for the ET group. The difference in pattern of GAF score changes between the ET and TAU groups was statistically significant.

There was a general tendency for the percentage of individuals with no GAF change to be similar for the ET and TAU groups, and was in the range of 40% to 60% for the various subgroups that were analyzed. Therefore any ET/TAU differences found in the subgroups occurred in terms of the percentage of individuals whose GAF scores improved or worsened.

As was the case for the Any Booking outcome, the 30 years of age and older subgroup had better GAF-change outcomes than did the younger group. Also, the participants with high Criminal Intensity Scores had better outcomes than those with medium and low scores.

The biggest difference between the ET and TAU groups (15.0%) occurred for the 30 and over age group with medium Criminal Intensity Scores.

Table 13. Total Group, Age and Criminal Intensity Subgroups Related to the Outcome Variable: GAF Worsen

	ET = A	TAU = B	B Minus A	Sample Size for A	Sample Size for B	Sig.
TOTAL GROUP	20.6%	32.4%	11.8%	358	414	.000 CS
Under 30 years of age	21.2%	28.1%	6.9%	103	98	.660 CS
30 plus years of age	20.5%	34.2%	13.7%	255	314	.001 CS
Criminality Intensity Index = Low	17.3%	24.5%	7.2%	64	65	.031 CS
Criminality Intensity Index = Medium	19.4%	31.5%	12.1%	171	195	.000 CS
Criminality Intensity Index = High	28.1%	41.3%	13.2%	121	150	.000 CS
Under 30, Criminality Intensity Index = Low	20.0%	23.6%	3.6%	21	17	.744 CS
Under 30, Criminality Intensity Index = Medium	18.3%	22.1%	3.8%	45	38	.027 CS
Under 30, Criminality Intensity Index = High	30.1%	42.9%	12.8%	37	42	.143 CS
30 +, Criminality Intensity Index = Low	16.2%	25.1%	8.9%	43	48	.007 CS
30 +, Criminality Intensity Index = Medium	20.0%	35.0%	15.0%	126	156	.000 CS
30 +, Criminality Intensity Index = High	27.4%	41.2%	13.8%	84	108	.000 CS

Age/Substance Abuse and Bookings in the Program Participation Period

Table 14 presents the results for the subgroup of participants with a substance abuse problem at program intake versus those who did not report substance abuse. It also shows the results when age is taken into account. The outcome measure was Any Booking. For both substance abuse subgroups (those with, versus those with no, substance abuse problem), a higher percentage of the TAU group had bookings than the ET group, although the differences were not significant.

When age is taken into account, for the under 30 years of age subgroup, a higher percentage of the ET group than the TAU group had bookings for both substance abuse groups, although, once again the differences were not significant.

For the 30 years of age and older subgroup, a significantly higher percentage of the TAU group had bookings for both substance abuse groups. The ET-TAU difference was greater for the No Substance Abuse group than for those in the Substance Abuse group (8.7% difference versus 5.2% difference respectively).

Table 14. Age and Substance Abuse Subgroups Related to the Outcome Variable: Any Booking = Yes

	ET = A	TAU = B	B Minus A	Sample Size for A	Sample Size for B	Sig.
No Substance Abuse	47.6%	51.9%	4.3%	312	353	.112 CS
Substance Abuse	55.7%	57.8%	2.1%	893	661	.269 CS
Under 30, No Substance Abuse	55.6%	53.4%	-2.2%	105	97	.704 CS
Under 30, Substance Abuse	60.6%	58.9%	-1.7%	274	168	.652 CS
30 +, No Substance Abuse	44.7%	53.4%	8.7%	207	255	.008 CS
30 +, Substance Abuse	54.8%	60.0%	5.2%	619	478	.025 CS

Age/Substance Abuse and GAF Change in the Program Participation Period

Table 15 presents the results for the age/substance abuse subgroups for the GAF-change outcome measure. Unlike with the Any Bookings outcome, the participants with substance abuse at intake had better results than those with no substance abuse problem. However, once again, better results were achieved with older participants. For the older group with substance abuse problems, 41% of the TAU participants experienced a change for the worse in their GAF score versus only 22.5% of the ET participants.

These results must be interpreted in the context of the fact that a relatively small percentage of participants with no report of substance abuse at intake experienced a worsening GAF score during the program (19.1% of the TAU group with No Substance Abuse versus 36.9% of those in the TAU Substance Abuse group). Therefore, there was significantly less room for improvement for those with no substance abuse problem.

Table 15. Age and Substance Abuse Subgroups Related to the Outcome Variable: GAF Worsen

	ET = A	TAU = B	B Minus A	Sample Size for A	Sample Size for B	Sig.
No Substance Abuse	14.5%	19.1%	4.6%	77	86	.014 CS
Substance Abuse	23.2%	39.6%	16.4%	273	314	.000 CS
Under 30, No Substance	13.1%	16.0%	2.9%	20	21	.773 CS
Under 30, Substance Abuse	25.3%	35.9%	10.6%	83	75	.023 CS
30 +, No Substance Abuse	15.1%	20.4%	5.3%	57	65	.008 CS
30 +, Substance Abuse Report	22.5%	41.2%	18.7%	190	238	.000 CS

Age/Employment and Bookings in the Program Participation Period

For the outcome "employment," participants were divided into three categories: 1) employed, 2) unemployed and needing employment for support (i.e., seeking employment group), and 3) Not Employed, but with a means of support such as family and/or public assistance (i.e., not seeking employment). For the Not Employed subgroup and the outcome measure of Any Bookings, the TAU group had a significantly higher percentage of participants that were booked than did the ET group.

Table 16. Age and Employment Subgroups Related to the Outcome Variable: Any Booking = Yes

	ET = A	TAU = B	B Minus A	Sample Size for A	Sample Size for B	Sig.
Employed	51.3%	55.4%	4.1%	214	174	.272 CS
Not Employed	55.5%	62.2%	6.7%	376	319	.020 CS
Unemployed	52.9%	51.9%	-1.0%	585	387	.689 CS
Under 30, Employed	51.2%	56.6%	5.4%	65	47	.439 CS
Under 30, Not Employed	68.8%	61.0%	-7.8%	86	61	.222 CS
Under 30, Unemployed	59.7%	56.8%	-2.9%	216	121	.501.CS
30 +, Employed	51.9%	56.8%	4.9%	149	125	.272 CS
30 +, Not Employed	52.9%	63.3%	10.4%	290	257	.001 CS
30 +, Unemployed	50.8%	53.9%	3.1%	369	253	.292 CS

The only other significant finding was also for the Not Employed group and 30 years of age and older subgroup (63.3% booked versus 52.9%). In the Not Employed and under 30 years of age group, the ET group had a higher percentage of bookings than the TAU group, once again demonstrating the importance of the age factor in criminal justice research.

Age/Employment and GAF Change in the Program Participation Period

For the outcome measure GAF-change, being Unemployed had a stronger impact on the outcome than did being Not Employed (see Table 17). Only 18.5% of the Unemployed ET group experienced a worsened GAF score compared with 42.5% of the TAU group. This difference was slightly larger when the factor of age was added. For the over 30 years of age, Unemployed ET group, 18.2% of the participants experienced a worsened GAF score as opposed to 45.4% of the comparable TAU group.

Age is a significant factor within the context of employment. For all three employment categories, the ET/TAU differences were significant for older participants. For the under 30 years of age group, there was a significant difference only for the Unemployed subgroup.

Table 17. Age and Employment Subgroups Related to the Outcome Variable: GAF Worsen

	ET = A	TAU = B	B Minus A	Sample Size for A	Sample Size for B	Sig.
Employed	25.7%	38.5%	12.8%	66	72	.012 CS
Not Employed	21.6%	34.6%	13.0%	113	104	.000 CS
Unemployed	18.5%	42.5%	24.0%	167	202	.000 CS
Under 30, Employed	22.6%	35.3%	12.7%	19	18	.182 CS
Under 30, Not Employed	26.7%	32.8%	6.1%	24	21	.660 CS
Under 30, Unemployed	19.4%	36.7%	16.9%	57	54	.000 CS
30 +, Employed	27.2%	40.3%	13.1%	47	54	.024 CS
30 +, Not Employed	20.6%	35.2%	14.6%	89	83	.000 CS
30 +, Unemployed	18.2%	45.4%	27.2%	110	147	.000 CS

Discussion of Subgroup Analyses

For the outcomes of Any Booking and GAF Change, the subgroup factors of age, criminal intensity, substance abuse and employment all had significant impacts on the results. Below is a summary of the findings related to Any Booking.

- The results for older participants (30 years of age and older) were better than the results for younger participants
- The positive treatment effect size increased with the Criminal Intensity Score (e.g., the higher the Criminal Intensity Score, the greater the difference between the ET and TAU results, in favor of the ET group).
- There was an interaction between age and the Criminal Intensity Score so that the largest treatment effect occurred with older participants with high Criminal Intensity Scores.
- Participants with no self-report of substance abuse problems at intake had better outcomes than those with substance abuse problems. This result applied only to older participants.
- For participants under 30 years of age, the percentage of TAU participants that was booked was slightly lower than the ET percentage (irrespective of substance abuse).
- Participants who were “not seeking employment” (e.g., had adequate means of support from family or public assistance) exhibited a bigger treatment effect (i.e., a 6.7% difference between

the percent of ET versus TAU participants booked, in favor of the ET participants). For older participants, the ET advantage increased to 10.4%

The results for the GAF Change outcome were as follows:

- Once again, the larger treatment effects occurred with older participants with high Criminal Intensity Scores. The interaction between age and GAF Change was not as dramatic as for the Any Booking outcome measure. In this case, the biggest ET/TAU treatment effect occurred for older participants with medium Criminal Intensity Scores.
- Unlike for the Any Booking outcome, for GAF Change, the larger treatment effects occurred with participants with substance abuse problems at intake. There was also an interaction with age. Almost twice the percentage of older TAU participants with substance abuse problems experienced a worsening of their GAF score than did similar ET participants (41.2% versus 22.5% respectively).
- Also in contrast to the Any Booking results, for GAF Change, the biggest treatment effect occurred with the Unemployed participants (i.e., those seeking, but not successful in securing employment). More than twice the percentage of older unemployed TAU participants experienced a worsening of their GAF score than did similar ET participants (45.4% versus 18.2% respectively).

These results point out the reality that crime reduction programs for mentally ill offenders do not work equally well for all subgroups. The interventions studied in this research had a bigger impact on older participants with more recent and more serious encounters with the criminal justice system. The programs do not have the same impact on all outcome variables. The biggest improvement in terms of criminal justice outcomes can be expected for those with no substance abuse issues who have means of support other than their own employment. The biggest improvement in mental functioning can be expected with participants who do have substance abuse issues, and who are seeking, but have not yet found, employment.

THE ASSERTIVE COMMUNITY TREATMENT MODEL

Assertive Community Treatment (ACT) is an intensive mental health program model that has been shown in a variety of studies to reduce psychiatric hospital use and increase independent living.[13, 14] However, little research has examined the benefits of applying ACT-enriched programs to the mentally ill *offender*. Although the MIOCRG Program was not designed specifically to assess the ACT model, the MIOCRG projects varied considerably with regard to ACT characteristics, thus making it possible to study the impact of "ACTness" on program outcomes. This chapter describes ACT, as well as the methods and results of the investigation of the model based on the MIOCRG statewide research sample.

Description of ACT

Developed during the 1970s at the Training in Community Living Program in Madison, Wisconsin by Leonard Stein and Mary Ann Test, ACT consists of a multidisciplinary group of mental health professionals and social workers who service their clients as a team rather than as individual providers, and do so for the most part in the community, rather than in the hospital or their offices. Services are typically provided over an extended period of time.

[13] Latimer E. Economic impacts of assertive community treatment: A review of the literature. Canadian Journal of Psychiatry 1999; 44: 443-454.
[14] Bedell JR, Cohen NL, Sullivan A. Case management: The current best practices and the next generation of innovation. Community Health Journal 2000; 36: 179-94.

Test and Stein developed specific criteria that characterize ACT. [15] These attributes, which have been modified only slightly over time, include the following:[16]

- **Multidisciplinary staffing.** ACT enriched programs consist of a group of mental health care professionals, with each individual providing expertise in a specific area of care necessary for the person with Severe Mental Illness (SMI). A typical ACT staff might consist of psychiatrists, nurses, social workers, rehabilitation counselors, and substance abuse counselors.
- **Integration of services.** ACT promotes an integrated approach to health care delivery, wherein each member of the multidisciplinary team of providers is aware of the efforts of the other team members, and the impact of those efforts on the client. By contrast, a common approach to health care delivery has historically been brokerage, in which clients are referred to various sources for services. Thus, while a client may receive services from multiple sources, each source will often be unaware of the role other sources are playing in the life of the client. In other words, brokered care is fragmented (i.e., uncoordinated).
- **Team approach**. A full integration of services implies a team approach to treatment. ACT team members share caseloads and meet frequently to discuss clients, solve client-related problems, and jointly plan treatment and rehabilitation.
- **Low client-staff ratios**. ACT programs seek to ensure one-on-one contact between the client and provider and to provide individualized services. This is optimized when there is a low ratio of clients to staff. The rule of thumb for ACT programs is about 10:1. This contrasts with non-ACT case management programs where the ratio may be as high as 50:1.
- **Location of contact in the community**. Most contacts with clients and others involved in their treatment occur where the clients live, work and interact with others (*in vivo* contacts), rather than in the offices and places of work of the providers (hospital, clinic, etc.).
- **Medication management**. ACT regards the effective use of medication and medication management as of paramount importance.
- **Focus on everyday problems in living**. In addition to placing great emphasis on medication management, ACT personnel also focus on the range of activities and chores that the client confronts daily. Examples include securing housing, making and keeping appointments, cashing checks, shopping, and dealing with landlords.
- **24-hour access**. ACT services are frequently available 24 hours a day, 7 days per week. ACT teams also respond quickly to emergencies, so that minimal time elapses between the onset of the crisis and the appearance of care.
- **Assertive outreach**. ACT takes an aggressive approach to engaging and maintaining relationships with clients in outreach efforts that emphasize relationship building and the provision of tangible social services. Clients who miss appointments are not automatically terminated from ACT programs.
- **Individualized services**. Treatment and services are tailored to the individual needs and preferences of the client, and due to the breadth of community resources available, the team is able to maximize client options.
- **Time-unlimited services**. Clients do not separate from ACT programs once their situation has stabilized, but rather continue to receive ACT assistance on an ongoing basis as needed.

Other common characteristics of ACT programs are the active support, preparation and involvement of the family in the client's treatment plan, and the provision of vocational assistance to help clients find and maintain employment.

[15] Test MA, Stein LI. Practice guidelines for the community treatment of markedly impaired patients. Community Mental Health Journal 1976; 12: 72-82.

[16] Assertive treatment for people with severe mental illness: Critical ingredients and impact on clients. Bond, GR, Indiana University-Purdue University, Indianapolis, IN; Drake RE and Mueser, KT, Dartmouth Medical School, Lebanon, NH; and Latimer E, McGill University, Verdun, Quebec; July 2000.

Act Fidelity

These ACT criteria have become the basis for several psychometrically sound scales of ACT fidelity, thereby making it possible to measure the extent to which mental health care programs are characterized by "ACTness." One such rating scale is the Dartmouth ACT Scale (DACTS).[17] Ratings for all items on the DACTS are made on an anchored 5-point scale, with ratings of 5 representing maximum "ACTness". The items in the DACTS comprise 3 subscales. The Human Resources: Structure & Composition Subscale focuses on a variety of staffing issues, including overall client to staff ratio, the extent to which the provider group functions as a team, continuity of staff, and the client to staff ratio for various disciplines on the team (psychiatry, nursing, etc.). The Organizational Boundaries Subscale addresses issues such as explicitness of admission criteria, extent of responsibility for treatment services, 24/7-access to emergency services, and the provision of time-unlimited services. The Nature of Services Subscale contains items pertaining to such things as *in-vivo* services, assertive client engagement, frequency of client contact, intensity of services, individualized substance abuse treatment and the use of dual-diagnosis treatment models.

Program staff from each MIOCRG project provided a singe rating for each item in the DACTS.[18] The ratings obtained for the 20 MIOCRG projects in the statewide research sample are summarized in Table 18. Results are reported for total DACTS score and total score on each of the three subscales. As will be noted, the scores reflect considerable variation in the degree of "ACTness" among the 20 projects.

Table 18: MIOCRG Project DACTS Scores (N=20)

DACTS Score	Minimum	Maximum	Mean	Standard Deviation
Human Resources	25	45	37.06	5.209
Organizational Boundaries	19	35	27.05	5.365
Nature of Services	22	42	35.35	5.306
Total Score	69	121	99.46	13.447

Treatment effects associated with degree of "ACTness" were examined by assigning the projects into low, medium and high categories based on total DACTS score. Projects with total DACTS scores of 79 or less were assigned to the low category, those with total DACTS scores between 80 and 100 were assigned to the middle category, and the remaining projects were assigned to the high category.

Table 19 summarizes the results obtained for the same outcomes included in Table 11. Cell entries show significant ET/TAU group differences. (Empty cells indicate no significant ET/TAU group differences.) With the exception of Mean Bookings for low ACT programs, all significant differences are in the hypothesized direction (i.e., a higher incidence of the undesirable outcome, such as Any Bookings, for the TAU group). For example, with reference to high ACT programs, the 5.4% difference in the percent of individuals in each group with Any Bookings indicates that 5.4% more of individuals in the TAU group received a booking. Similarly, the difference of 5.0 Mean Jail Days for medium ACT programs indicates that, on average, individuals in the TAU group received 5.0 more jail days than those in the ET group.

While caution must be exercised in interpreting the results in Table 19 (due to the lack of statistical controls for factors other than "ACTness"), the overall pattern of results suggests that the degree of "ACTness" was associated with desired program effects. With regard to criminal justice outcomes, 8 of the 9 statistically significant ET/TAU group differences in the desired direction were found for medium or

[17] Teague GB, Bond GR, Drake RE. Program fidelity in assertive community treatment: Development and use of a measure. American Journal of Orthopsychiatry 1998; 68: 216-32.
[18] Local project staff were encouraged to circulate the DACTS so that the most knowledgeable individual provided the rating for each item.

high ACT programs, and among low ACT programs, one of the two statistically significant group differences was in the opposite than predicted direction (Mean Bookings).

A similar pattern of results was obtained for the outcomes of drug and alcohol use. For both outcomes, no statistically significant group differences were found for low ACT programs, whereas significant differences in the desired direction (i.e., a lower percentage of those in the ET group with drug or alcohol problems) were obtained for medium and high ACT programs.

The same general pattern of results was also obtained for GAF score changes, with statistically significant results in the desired direction obtained for the medium and high ACT programs only (i.e., a lower percentage of ET cases with reduced GAF scores).

Less conclusive findings were obtained for the "Quality of Life" outcomes of Housing (percent homeless during last available reporting period), Employment (percent unemployed during last available reporting period) and Economic Self Sufficiency (percent who never achieved economic self sufficiency during any of the six-month periods comprising the two-year post-incarceration program period). In the case of Housing (Homeless), a significant difference in the desired direction was found for medium ACT programs only. No evidence was found that the degree of "ACTness" was associated with ET/TAU differences in employment in that no significant ET/TAU group differences were found in the percent unemployed for any of the three ACT program categories. And finally, no evidence was found that "Quality of Life" was associated with degree of "ACTness'" in that a significantly smaller percentage of ET cases in each ACT program category had no periods of economic self-sufficiency.

Table 19. The Effect of Adherence to the ACT Model on Outcome Measures

OUTCOME MEASURES	ACT								
	Low			Medium			High		
	Treat (A)	Control (B)	Diff. (B - A)	Treat (A)	Control (B)	Diff. (B - A)	Treat (A)	Control (B)	Diff. (B - A)
Any Bookings							36.4%	38.3%	1.9%
Mean Bookings Per Period	.44	.35	-.09						
Felony Booking	35.6%	40.0%	4.4%				40.2%	42.3%	2.1%
Any Convictions				20.2%	25.1%	4.9%	43.7%	49.1%	5.4%
Mean Convictions Per Period				0.19	0.24	0.05	0.33	0.36	0.03
Felony Conviction									
Any Jail Days				39.4%	46.4%	7.0%			
Mean Jail Days				10.6	15.6	5.0			
GAF Change (Worsen)				11.7%	26.1%	14.4%	34.6%	48.0%	13.4%
Drug Problem				39.1%	54.8%	15.7%	48.0%	56.3%	8.3%
Alcohol Problem				29.8%	41.8%	12.0%	44.3%	55.3%	11.0%
Homeless				9.5%	15.5%	6.0%			
Unemployed									
No Economic Self Sufficiency	50.2%	78.3%	28.1%	27.4%	58.8%	31.4%	13.4%	24.5%	11.1%

As a means of further investigating the relationship between "ACTness" and criminal justice outcomes, summary statistics were computed for each program for many of the criminal justice variables in Table 20. More specifically, summary statistics were computed for each variable for both the ET group and the TAU group. For continuous variables (e.g., Mean Bookings), mean values were computed for the two groups in each program. For dichotomous variables, such as Any Bookings, the values computed were

the proportion (or percentage) of individuals in each group with the outcome (e.g., at least one booking). Within each program, the value for the ET group was then subtracted from the value for the TAU group to arrive at a difference score for the outcome. These difference scores were then correlated with the total DACTS score (total ACT score). Thus, the unit of analysis for these correlations was program (rather than individual within program), and unlike the previous analyses, which were based on assigning each program to a low, medium or high category based on total ACT score, the correlations were based on the full range of Total ACT scores.[19]

The resulting correlations are shown in Table 20. Each correlation provides an index of the degree to which program increases in "ACTness" are associated with program-level TAU versus ET differences for the outcome in question. For example, the significant positive correlation between ACT and difference scores for Any Bookings indicates that, at the program level, as "ACTness" increases, the proportion of TAU versus ET individuals who receive any bookings also increases. Thus, even though the results in Table 20 show a significant mean difference in the proportion (percentage) of TAU and ET individuals who received Any Booking for high ACT programs only, the correlation results indicate a significant program-level relationship between ACT level and differences in TAU versus ET rates for Any Booking.

Further review of Table 20 shows that all correlations are in the desired direction (i.e., indicate a positive relationship between ACT level and increased differences in TAU minus ET rates for each of the criminal justice outcomes). Two of the four correlations are statistically significant (Any Bookings and Any Convictions; $p<.05$) and another two just fail to reach statistical significance (Mean Convictions and Any Jail Days; $p=.06$). Given the small sample sizes, and the associated loss of statistical power, the results are impressive in the degree to which they indicate a consistent and substantial relationship between level of "ACTness" and hypothesized differences in TAU versus ET incidents of criminal conduct at the program level. Further, the results are highly consistent with the results for the criminal justice outcomes reported in Table 19, wherein programs were grouped into low, medium and high categories based on ACT score.

Table 20. Program-Level Correlations Between ACT and TAU/ET Group Differences on Criminal Justice Outcomes

Outcome (TAU minus ET)	Correlation	Sig (one-tailed)	Sample Size[20]
Mean Bookings	0.20	0.19	21
Mean Convictions	0.35	0.06	21
Mean Jail Days	0.18	0.22	20
Any Bookings	0.47	0.02	21
Any Convictions	0.48	0.01	21
Any Jail Days	0.36	0.06	20

[19] A disadvantage of the correlation analyses was the significant reduction in statistical power associated with using program as the unit of analysis (N=21).

[20] For purposes of this analysis, the one project that conducted two local evaluations (with different treatment and comparison groups) was treated as two distinct projects.

CHAPTER 4: CONCLUSION

COST EFFECTIVENESS

In addition to studying their quantitative and qualitative outcomes, many of the MIOCRG programs also investigated the cost benefits and/or cost effectiveness of their efforts. More than a dozen counties conducted utility studies as part of their project evaluations. However, because almost every county had a unique approach to this analysis, results are not readily comparable. There was no one formula or strategy for determining cost benefit, nor were there simple, consistent findings.

Increased Cost For Enhanced Treatment

The most general finding was that enhanced treatment resulted in increased costs. In some jurisdictions and/or some projects, the increased treatment costs were more than offset by reduced criminal justice costs. Other projects found the two balanced each other, i.e., the savings in criminal justice expenditures equaled or nearly equaled the increased costs of providing additional treatment. Still other projects found that the net effect was an overall increase in costs to the county. For example, Stanislaus County noted that while there were no significant differences in total cost between that County's FACT group and its standard treatment group, there were also no significant differences in mental health costs. Stanislaus' evaluators concluded, "The fact that improvements in some of the mental health variables were observed while the average cost of the three years of treatment did not exceed the baseline year is a positive finding."[1]

In the 12-month period before the program an average participant cost an estimated $28,479 in arrest, court and custody costs. While in the program and in the six months after completion, the cost to the County dropped to $4,824 per participant, a cost avoidance of $23,654 per participant or a total of over $1.4 million for all participants. The average cost per participant was $20,654. When this is deducted from the accrued benefits, there is a net benefit of $3,484 per participant, generating a ratio of $1.17 of benefit per dollar of cost.

Yolo County Project Nova
Final Report, page xxviii

In San Mateo County, an expenditure of roughly $17,000 in additional treatment services (interventions) resulted in a reduction of nearly $9,000 in criminal justice costs. "For every two dollars spent on services, you can expect to see a one dollar reduction in criminal justice costs. While this return on investment is not of the magnitude that one would hope to see, it should not be considered in isolation from the other goods that may have been produced but not measured by the economic outcome variables of this project."

San Mateo County, Options Project
Final Report, page 25

The average treatment cost for participants in the MHTC was higher and average emergency services costs lower than were costs for participants in TAU. Participants in the MHTC averaged five fewer jail days overall than did participants in the TAU, thus offenders in the MHTC saved on average $231 in jail costs relative to offenders in the TAU. "There did not appear to be significant cost savings. … There was considerable range in jail costs across participants and the increased cost of treatment was not offset, on average, by the decreased cost of emergency services or jail days. Thus the program provided more cost-shifting than cost-savings in the short run."

Santa Barbara Mental Health Treatment Court
with Intensive Case Management
Final Report, Page 60

[1] Stanislaus County, *Forensic Assertive Community Treatment (FACT) Program* Final Report, page 31

Taken together the total annual per participant costs of MCSTAR were $49,616 for the ET group and $36,328 for the TAU group, a $13,288 difference. However, since the TAU group consistently experienced a higher incidence of jail bookings, more bookings with felony charges, a higher probability of convictions, more with violence offenses and about 187 more jail days than the ET group, "it appears that positive outcomes were demonstrated through the intervention efforts with the net costs of additional $836 monthly or $10,027 annually derived from the MCSTAR program."

Monterey County Supervised Treatment After Release (MCSTAR) Program Final Report, pages 61-62

"Mental health services provided by Butte County Behavioral Health are a constant for the target population, regardless of whether clients are involved in the criminal justice system. System-wide costs, however, were shown to be somewhat mitigated by the intensive ET interventions, as law enforcement and criminal justice expenses for the five ET clients studied for the cost analysis dropped dramatically during the year following program participation. Average client costs went from $9,482.85 to $8,838.04. Of this, Behavioral Health costs were $5,225 in period one and $7,861 in period three, while Criminal Justice//Law Enforcement costs went from $4,257 to $976. Based on this nearly 75% reduction for law enforcement and criminal justice costs, [Butte projected] substantial savings even in light of an increase in intervention phase expenditures."

Butte County FORENSIC RESOURCE TEAM (FOREST) Final Report, pages iv and 86

Limitations of Cost Benefit Analysis

There was general agreement across jurisdictions and projects that the cost benefit analysis was limited by the relatively short term of the MIOCRG evaluation. Most projects noted that the positive effects and fiscal benefits of the MIOCRG programs would be longer lasting and increasingly evident as mentally ill offenders remained crime-free and stabilized in the community. Ventura County, for instance, said while it could not show demonstrable cost savings, the MART program's positive results would be "...worth the expense. Many clients in the treatment group had their lives dramatically changed by their experiences in the program and the community benefits directly from their improvement."[2]

While Placer County found the cost impact on the justice system was slightly favorable, on the whole, the PCCARES program cost more than it saved. "However, the cost benefit analysis did not include the potential long range benefits of improved mental health, physical health, employment, housing, self sufficiency, stabilization on medications (reducing hospitalizations and potential recidivism), and family or other support relationships. These make the value of the program larger than its fiscal expenditures.

Placer County Continuum of Care to Avoid Re-Arrest and Enter Society (PCCARES) Final Report, pages 2, 37 and 38

Although Sacramento County, like others, did not analyze "savings associated with general healthcare, medical emergency care, community services (e.g., shelters for homeless), crime laboratory services, victim and witness services and the cost of diversion programs, … even without these items taken into account, there was over $9,500 saved per client over the course of the project or approximately $2,400 per client per year. The bulk of this savings was associated with the criminal justice side ($1,500 of the $2,400)."

Sacramento County, Project Redirection, Final Report page 62

[2] Ventura County, *Multi-Agency Referral and Treatment (MART) Program* Final Report, page 95

Blended Funding

A third impressive finding of the MIOCRG cost effectiveness studies was counties' experience that silos came down as funding streams were merged. Counties reported learning to think in terms of the costs of dealing effectively with mentally ill offenders – not the Behavioral Health Department costs or the Alcohol and Other Drug Department costs or the Sheriff's Department costs or Probation Department costs, but the overall county costs.

CARES led to overall cost savings totaling a little over $29,000. These savings resulted mainly from fewer jail and hospital inpatient days. Crisis intervention costs were reduced by about one-half. Agreeing that its program created "cost-shifting with a long term benefit, rather than immediate cost savings," Tuolumne County said, mental health (with increased case management) and jail (with a full-time classification officer) incur more costs but over time, the courts save."

Tuolumne County Crime Abatement Rehabilitation/Recovery Enhancement (CARES) Program Final Report, page 1-2

"The FACT program and its associated costs increased the quality of life for program participants (less time in jail and in psychiatric hospitalization), while requiring [fewer] county resources overall. The increased cost of providing Assertive Community Treatment to this population resulted in dramatically lower criminal justice system and hospital costs for the county."

Sonoma County, Forensic Assertive Community Treatment (FACT) Program Final Report, page 17

Other Findings

For several jurisdictions, cost benefits were not found. San Bernardino County, for example, reported no cost savings from either its STAR-LITE or SPAN Programs. In STAR-LITE, the cost of jail days was greater for program participants than for comparison group members and for SPAN the costs within the two groups – enhanced treatment and treatment as usual – were said to have been "very similar."

While San Francisco reported a positive finding for its MIOCRG II, jail-focused *Connections Program*, it was not able to demonstrate similar cost efficiencies for its high-risk project targeting mentally ill offenders likely to be committed to prison. Of *Connections*, San Francisco said, "The evaluation clearly demonstrates that these expenditures resulted in reduced jail days for participants, which translates directly into cost savings. In fact, *Connections* appeared to reverse an upward trajectory of encounters with the criminal justice system for participants. Considering that a jail bed in California costs $19,700 per year, and it costs more than $25,000 to house a [state] prisoner for one year (The Little Hoover Commission, 1998), any jail days saved represents a positive contribution to overall cost savings." [3]

In contrast, in its MIOCRG I Forensic Support Services (FSS) Program, San Francisco said that the treatment as usual – Jail Aftercare Services (JAS) – had equivalent criminal justice costs to its enhanced treatment (FSS), while FSS was more costly in terms of mental health treatment provided to its participants. The relatively abundant services provided to FSS clients were reported to have had little utility in reducing clients' criminal justice costs. Although FSS clients were less likely than JAS clients to have a prison commitment in the post-period, San Francisco said, "the costs of averting a prison commitment were quite large. It required approximately three million dollars in mental health expenditures to avert 11 prison commitments in FSS clients over 18 months, or about $270,000 per prison commitment averted. Thus it does not appear that FSS was a cost-effective intervention for reducing State prison commitments."[4]

[3] Harder + Company Community Research, Evaluation of the *Connections Program*, Impact of a Jail Alternative Program for Mentally Ill Offenders, page 82

[4] UC San Francisco, Final Program Report, *Mentally Ill Offender Crime Reduction Grant Program*, pages 40-41

CONSIDERATIONS FOR FUTURE REPLICATION

The MIOCRG program produced a wealth of information about the challenges and opportunities inherent in seeking to reduce recidivism and enhance stabilized functioning in the community for mentally ill offenders. This report has discussed many of the achievements of the counties engaged in the MIOCRG effort, some of the operational and programmatic challenges with which they were faced and the environmental and fiscal considerations within which they designed and conducted their demonstration projects.

In addition to capturing the history and outcomes of the MIOCRG program, this report is also intended to provide a base of best practices on which future programs might be built. As counties, in California and elsewhere, consider either replicating MIOCRG efforts or embarking upon similar kinds of projects dealing with mentally ill offenders, attention should be paid to the lessons learned in the MIOCRG program.

The program's state and local research shows that the key principles of effective programs include, but are not necessarily limited to:

- Use of the Assertive Community Treatment (ACT) model, as a conceptual platform;
- Multidisciplinary, collaborative design and operation involving mental health and justice system agencies, as well as other public and private community based entities;
- Intensive case management and flexible, enhanced services and supervision;
- Involvement of the courts; and
- Support for socialization and life-skills development in such areas as housing, transportation, managing medications, securing benefits, managing finances and seeking vocational training and/or employment.

Those interested in replicating one or more MIOCRG programs would be well served to examine not only this document, but also the evaluation report(s) of the project(s) of interest to understand the nuances and differences in the ways each was operated and to understand the details of each project's implementation and findings. Readers are additionally encouraged to contact the project managers and/or related staff of the various projects,[5] to hear about the mass of programmatic details, complexities and challenges involved in their projects directly from those at the local level who were intimately involved.

Mental Health Services Act (Proposition 63)

With the passage of Proposition 63, the Mental Health Services Act (MHSA), in November 2004, California voters have created a unique funding potential for counties to plan and design their own versions of the MIOCR concept for implementation. The proposition creates a more stabilized funding source than was available under the MIOCRG program. Given the fact that the MHSA's goals include 1) defining mental illness as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care; 2) reducing the long-term adverse impact resulting from untreated serious mental illness; 3) expanding successful, innovative service programs including culturally and linguistically competent approaches for underserved populations; 4) providing funds to adequately meet the need of all who can be identified and enrolled; and 5) ensuring that funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices with oversight to ensure accountability,[6] it is likely that efforts such as those demonstrated with MIOCR grant funding could garner support. While, as of the publication of this report, the implementation details of Proposition 63 have not been fully determined, the MHSA holds the potential for greater service delivery to those with mental illness in California, including mentally ill offenders.

[5] Project managers' contact information is provided in Appendix G
[6] California Department of Mental Health, Letter to Interested MHSA Stakeholder, November 16, 2004

LESSONS LEARNED

The Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program has shown that the formidable challenges facing those who suffer a mental illness, particularly those who are caught up in the cycle of reoffending and returning to jail primarily because of their illness, are not insurmountable. Across its 26 counties and 30 local projects, the MIOCRG Program demonstrated a host of innovations, interventions and strategies that, individually and collectively, provide promising directions for future programming and exciting avenues for further research.

More than 8,000 adult offenders were involved in the MIOCRG Program. For many of them, the program provided services, support, treatment and supervision that reduced the number of times they returned to jail, the number of days they spent in jail if/when they were returned and the seriousness of the offenses for which they were returned. Additionally, many program participants accomplished significant improvements in life functioning and quality of life indicators. These participants had fewer drug and alcohol problems after being in a MIOCRG program, improved substantially in Global Assessment of Functioning (GAF) scores and had achieved greater economic self-sufficiency than did those in the treatment as usual groups with whom they were compared.[7] With assistance, support and encouragement from the dedicated staff working in the MIOCRG projects, clients learned to comply with medication regimens, stay sober, return to school, find jobs, manage their money, and, in some cases, live independently and/or reunite with their families. By improving the quality of life for offenders with mental illness, the MIOCRG Program reduced many participants' involvement in the criminal justice and acute-care hospitalization systems and provided an opportunity – the first for some – to maintain crime-and-drug-free lives in the community.

Additionally, and at least as significantly, the MIOCRG Program has enabled counties to build strong multi-agency collaborations in which disparate agencies work together in new and effective ways. Mental health and public safety agencies have learned a great deal about each other's functioning, strengths, limitations and cultures. Departments of Mental Health, Behavioral Health, and Alcohol and Other Drugs now work more effectively with their counterparts in Police, Sheriff's and Probation Departments, and both are better known to and acquainted with the workings of the courts. In return, many Superior Court judges in California have a new appreciation for law enforcement, corrections and mental health agencies' ongoing efforts to work effectively with mentally ill and dually diagnosed offenders.

The Legislature's foresight and investment in the MIOCRG Program has paid meaningful dividends. Thousands of individuals and hundreds of communities have benefited directly from the demonstration projects. Mental health and criminal justice agencies have learned to work together to maximize funding and fill service gaps. Clear evidence has been generated that Assertive Community Treatment (ACT) can be an effective platform for dealing with mentally ill offenders. Mental Health Courts have been shown to present a viable multi-agency approach to comprehensive supervision, services and support for treatment. Assessment and wraparound, targeted, flexible services to address the needs identified through assessment have been found to be the most successful core of most, if not all, program models. Counties across California now have evidence-based experience in mitigating the costs and impact of mentally ill offenders on California's jails. A rich store of data has been developed for future exploration. The MIOCRG program has achieved its primary goal of enhancing understanding about effective strategies for successfully intervening with mentally ill offenders to help them live and participate in the community rather than cycling in and out of jail. These achievements benefit all Californians.

[7] See Chapter 3, Statewide Evaluation Findings, pages 8-11

APPENDICES

A. Enabling Legislation and Definition of Mentally Ill Offender

B. Executive Steering Committees for MIOCRG I and MIOCRG II

C. Summaries of County Projects

D. Additional Details of Statewide Research – Logistic Regression and Other Specifics

E. Common Data Elements

F. Program Contacts

APPENDIX A
ENABLING LEGISLATION AND DEFINITION OF MENTALLY ILL OFFENDER

Enabling Legislation

CHAPTER 501, STATUTES OF 1998

BILL NUMBER: SB 1485 CHAPTERED

CHAPTER 501
FILED WITH SECRETARY OF STATE SEPTEMBER 15, 1998
APPROVED BY GOVERNOR SEPTEMBER 15, 1998
PASSED THE SENATE AUGUST 30, 1998
PASSED THE ASSEMBLY AUGUST 27, 1998
AMENDED IN ASSEMBLY AUGUST 21, 1998
AMENDED IN ASSEMBLY JULY 8, 1998
AMENDED IN SENATE MAY 5, 1998
AMENDED IN SENATE APRIL 1, 1998

INTRODUCED BY Senator Rosenthal
(Principal coauthor: Senator Rainey)
(Coauthor: Senator McPherson)
(Coauthors: Assembly Members Hertzberg, Migden, Papan, Strom-Martin, Sweeney, and Thomson)

FEBRUARY 4, 1998

An act to add and repeal Article 4 (commencing with Section 6045) of Chapter 5 of Title 7 of Part 3 of the Penal Code, relating to mentally ill criminal offenders.

LEGISLATIVE COUNSEL'S DIGEST

SB 1485, Rosenthal. Mentally ill offender crime reduction grants.

Under existing law, it is the duty of the Board of Corrections to make a study of the entire subject of crime, with particular reference to conditions in the State of California, including causes of crime, possible methods of prevention of crime, methods of detection of crime, and apprehension of criminals, methods of prosecution of persons accused of crime, and the entire subject of penology, including standards and training for correctional personnel, and to report its findings, its conclusions and recommendations to the Governor and the Legislature as required.

This bill would require, until January 1, 2005, the Board of Corrections to administer and award mentally ill offender crime reduction grants on a competitive basis to counties that expand or establish a continuum of swift, certain, and graduated responses to reduce crime and criminal justice costs related to mentally ill offenders.

The bill would require the board, in consultation with the State Department of Mental Health and the State Department of Alcohol and Drug Programs, to create an evaluation design for the grant program that will assess the effectiveness of the program in reducing crime, the number of early releases due to jail overcrowding, and local criminal justice costs, and would require the board to submit annual reports to the Legislature based on the evaluation design. The bill would require funding for the program to be provided, upon appropriation by the Legislature, in the annual Budget Act.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) County jail inmate populations nearly doubled between 1984 and 1996, from 43,000 to 72,000. Court-ordered population caps have affected 25 counties and represent 70 percent of the average daily population in county jails. As a result of these caps and a lack of bed space, more than 275,000 inmates had their jail time eliminated or reduced in 1997.

(b) An estimated 7 to 15 percent of county jail inmates are seriously mentally ill. Although an estimated forty million dollars ($40,000,000) per year is spent by counties on mental health treatment within the institution, and that figure is rising rapidly, there are few treatment and intervention resources available to prevent recidivism after mentally ill offenders are released into the community. This leads to a cycle of rearrest and reincarceration, contributing to jail overcrowding and early releases, and often culminates in state prison commitments.

(c) The Pacific Research Institute estimates that annual criminal justice and law enforcement expenditures for persons with serious mental illnesses were between one billion two hundred million dollars ($1,200,000,000) and one billion eight hundred million dollars ($1,800,000,000) in 1993-94. The state cost in 1996-97 to incarcerate and provide mental health treatment to a seriously mentally ill state prisoner is between twenty-one thousand nine hundred seventy-eight dollars ($21,978) and thirty thousand six hundred ninety-eight dollars ($30,698) per year. Estimates of the state prison population with mental illness ranges from 8 to 20 percent.

(d) According to a 1993 study by state mental health directors, the average estimated cost to provide comprehensive mental health treatment to a severely mentally ill person is seven thousand dollars ($7,000) per year, of which the state and county cost is four thousand dollars ($4,000) per year. The 1996 cost for integrated mental health services for persons most difficult to treat averages between fifteen thousand dollars ($15,000) and twenty thousand dollars ($20,000) per year, of which the state and county costs are between nine thousand dollars ($9,000) and twelve thousand dollars ($12,000) per person.

(e) A 1997 study by the State Department of Mental Health of 3,000 seriously mentally ill persons found that less than 2 percent of the persons receiving regular treatment were arrested in the previous six months, indicating that crimes and offenses are caused by those not receiving treatment. Another study of 85 persons with serious mental illness in the Los Angeles County Jail found that only three of the persons were under conservatorship at the time of their arrest, and only two had ever received intensive treatment. Another study of 500 mentally ill persons charged with crimes in San Francisco found that 94 percent were not receiving mental health treatment at the time the crimes were committed.

(f) Research indicates that a continuum of responses for mentally ill offenders that includes prevention, intervention, and incarceration can reduce crime, jail overcrowding, and criminal justice costs.

(g) Therefore, it is the intent of the Legislature that grants shall be provided to counties that develop and implement a comprehensive, cost-effective plan to reduce the rate of crime and offenses committed by persons with serious mental illness, as well as reduce jail overcrowding and local criminal justice costs related to
mentally ill offenders.

SEC. 2. Article 4 (commencing with Section 6045) is added to Chapter 5 of Title 7 of Part 3 of the Penal Code, to read:

Article 4. Mentally Ill Offender Crime Reduction Grants

6045. The Board of Corrections shall administer and award mentally ill offender crime reduction grants on a competitive basis to counties that expand or establish a continuum of swift, certain, and graduated responses to reduce crime and criminal justice costs related to mentally ill offenders, as defined in paragraph (1) of subdivision (b) and subdivision (c) of Section 5600.3 of the Welfare and Institutions Code.

6045.2. (a) To be eligible for a grant, each county shall establish a strategy committee that shall include, at a minimum, the sheriff or director of the county department of corrections in a county where the sheriff is not in charge of administering the county jail system, who shall chair the committee,

representatives from other local law enforcement agencies, the chief probation officer, the county mental health director, a superior court judge, a client of a mental health treatment facility, and representatives from organizations that can provide, or have provided, treatment or stability, including income, housing, and caretaking, for persons with mental illnesses.

(b) The committee shall develop a comprehensive plan for providing a cost-effective continuum of graduated responses, including prevention, intervention, and incarceration, for mentally ill offenders. Strategies for prevention and intervention shall include, but are not limited to, both of the following:

(1) Mental health or substance abuse treatment for mentally ill offenders who have been released from law enforcement custody.

(2) The establishment of long-term stability for mentally ill offenders who have been released from law enforcement custody, including a stable source of income, a safe and decent residence, and a conservator or caretaker.

(c) The plan shall include the identification of specific outcome and performance measures and a plan for annual reporting that will allow the Board of Corrections to evaluate, at a minimum, the effectiveness of the strategies in reducing:

(1) Crime and offenses committed by mentally ill offenders.

(2) Criminal justice costs related to mentally ill offenders.

6045.4. The Board of Corrections, in consultation with the State Department of Mental Health, and the State Department of Alcohol and Drug Programs, shall award grants that provide funding for four years. Funding shall be used to supplement, rather than supplant, funding for existing programs and shall not be used to facilitate the early release of prisoners or alternatives to incarceration. No grant shall be awarded unless the applicant makes available resources in an amount equal to at least 25 percent of the amount of the grant. Resources may include in-kind contributions from participating agencies. In awarding grants, priority shall be given to those proposals which include additional funding that exceeds 25 percent of the amount of the grant.

6045.6. The Board of Corrections, in consultation with the State Department of Mental Health and the State Department of Alcohol and Drug Programs, shall establish minimum standards, funding schedules, and procedures for awarding grants, which shall take into consideration, but not be limited to, all of the following:

(a) Percentage of the jail population with severe mental illness.

(b) Demonstrated ability to administer the program.

(c) Demonstrated ability to develop effective responses to provide treatment and stability for persons with severe mental illness.

(d) Demonstrated history of maximizing federal, state, local, and private funding sources.

(e) Likelihood that the program will continue to operate after state grant funding ends.

6045.8. The Board of Corrections, in consultation with the State Department of Mental Health and the State Department of Alcohol and Drug Programs, shall create an evaluation design for mentally ill offender crime reduction grants that will assess the effectiveness of the program in reducing crime, the number of early releases due to jail overcrowding, and local criminal justice costs. Commencing on June 30, 2000, and annually thereafter, the board shall submit a report to the Legislature based on the evaluation design, with a final report due on December 31, 2004.

6045.9. This article shall remain in effect only until January 1, 2005, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2005, deletes or extends that date.

6046. Funding for mentally ill offender crime reduction grants shall be provided, upon appropriation by the Legislature, in the annual Budget Act. It is the intent of the Legislature to appropriate twenty-five million dollars ($25,000,000) for the purposes of Mentally Ill Offender Crime Reduction Grants in the 1999-2000 fiscal year, subject to the availability of funds. Up to 5 percent of the amount appropriated in the budget may be available for the board to administer this program, including technical assistance to counties and the development of an evaluation component.

Definition of Mentally Ill Offender

WELFARE AND INSTITUTIONS CODE SECTION 5600.3
Subdivision b):
(1) Adults and older adults who have a serious mental disorder.
(2) For the purposes of this part "serious mental disorder" means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.
(3) Members of this target population shall meet all of the following criteria:
(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).
(B) (i) As a result of the mental disorder the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.
(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.
(C) As a result of a mental functional impairment and circumstances the person is likely to become so disabled as to require public assistance, services, or entitlements.
(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:
(A) Homeless persons who are mentally ill.
(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.
(C) Persons arrested or convicted of crimes.
(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

Subdivision(c):
Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

APPENDIX B
EXECUTIVE STEERING COMMITTEES
MIOCRG I & MIOCRG II

MIOCRG I EXECUTIVE STEERING COMMITTEE

BOC Members

Harry Nabors, Chairperson
Jerry Krans, Co-Chairperson
Susan Saxe-Clifford, Ph.D.
Daniel Ballin

California State Association of Counties Representative

Supervisor John Flynn, Ventura County

California State Sheriffs Association (CSSA) Representatives

Sheriff Bill Kolender, San Diego County
Captain Norm Hurst, San Bernardino County, CSSA Detentions and Corrections Subcommittee

State Department of Mental Health Representative

Gary Pettigrew, Deputy Director

State Department of Alcohol and Drug Programs Representative

Susan Nisenbaum, Deputy Director

California Mental Health Directors Association Representative

John Anderson, MFCC, Deputy Director, Humboldt County Mental Health Department

MIOCRG II EXECUTIVE STEERING COMMITTEE

BOC Members

Chief Taylor Moorehead, Los Angeles County (Chairperson)
Sheriff Lou Blanas, Sacramento County (Co-Chairperson)

California State Association of Counties Representative

Supervisor John Flynn, Ventura County

California State Sheriffs Association (CSSA) Representatives

Sheriff Keith Royal, Nevada County
Chief Norm Hurst, San Bernardino County, CSSA Detentions and Corrections Subcommittee

Chief Probation Officers of California

Chief Melton Losoya, Yolo County

State Department of Mental Health Representative

Tom Wilson

State Department of Alcohol and Drug Programs Representative

Patricia Hill

California Mental Health Directors Association Representative

John Anderson, MFCC, Deputy Director, Humboldt County Mental Health Department

APPENDIX C
SUMMARIES OF COUNTY PROJECTS

ALAMEDA COUNTY
CHANGES

Type of Program: In and after custody – Jail and Center based – Dual diagnosis
Key Strategies: Assertive and intensive case management; transition services; outpatient services; strong probation involvement; center contracted to residential and outpatient service provider

Target Population: Seriously and persistently mentally ill inmates of Santa Rita Jail; likely to be released locally; not arrested for serious felonies or parole revocation; dually diagnosed
Study Population: Enhanced Treatment 98; Treatment as Usual 72

Summary Description:
Alameda County's MIOCR effort had three components. The first was an in-custody service that evaluated all seriously and persistently mentally ill people admitted to the Alameda County Jail at Santa Rita who were likely to be discharged locally. This component delivered outpatient therapy and medication to the identified inmates and assessed them for suitability for the *Changes* outpatient program. The second component, called *Changes*, provided outpatient treatment for dually diagnosed (mentally ill and substance abusing) offenders in jail and in the community. The third element provided short-term (60 days) case management services to all inmates who were served by the in-custody portion of the grant, whether or not they participated in the *Changes* component, to assist in their transition to the community and help them use available services such as financial, housing and/or psychiatric services. The *Changes* component was the part of Alameda County's three-pronged effort that involved randomized selection and evaluation.

Goals and Approach:
Alameda County's overall goal was to reduce recidivism among mentally ill offenders. *Changes* and the other elements of service (in-custody evaluation and short term case management to facilitate transition) offered intensive services beginning while the clients were in the jail in order to increase the program's chances of engaging them in treatment and thereby to decrease their substance abuse behaviors, increase their compliance with mental health treatment and improve their quality of life. Alameda County believed that accomplishing those goals would lead to reduced jail recidivism.

The *Changes* program component, delivered outpatient dual diagnosis treatment in an Assertive Case Management and Intensive Case Management model, using a harm reduction approach. Site reviews by the program's evaluator and invited experts indicated that the program had "high fidelity to the SAMHSA evidence-based practice called Integrated Dual Diagnosis Treatment."[1]

The *Changes* program was a collaboration involving a number of agencies, including Alameda County Behavioral Health Care Services, the Sheriff's Department, the Probation Department and Telecare Corporation, a provider with extensive experience in both residential and outpatient psychiatric care in Alameda County. Behavioral Health Care Services contracted with Telecare to operate the site and provide services for the *Changes* program. Additionally, the Probation Department assigned a probation officer to the *Changes* site. This officer supervised and worked with *Changes* clients, most, if not all of whom had been ordered to probation after completion of their jail terms.

Local Perspective of What Worked:
While there was a "long list of valuable features of the MIOCR Grant in Alameda County,"[2] the County pointed to things that worked especially effectively, including having full-time mental health staff posted to the mental health unit in the jail, psychiatric staff helping to coordinate discharge planning, treating

[1] Alameda County Mentally Ill Offender Crime Reduction Grant – MIOCRG II, Summary, page 1
[2] op. cit., page 2

dually diagnosed mentally ill offenders and assisting program participants with obtaining benefits once they were released to the community. Behavioral Health Care Services found that the MIOCR In-Custody Service's intensive efforts to obtain benefits for inmates, a process initiated while the client was still in custody, resulted in securing benefits for a much higher percentage (approximately 70%) of clients than expected.

Alameda County reported that having mental health staff working in the jail unit helped to reduce the number and kinds of behavioral incidents and created the ability to offer mental health treatment more persistently to resistant patients. Moreover, their presence made it possible for inmates in the mental health unit to receive initial doses of psychiatric medications more quickly.

The *Changes* Program found the probation officer's presence very helpful. The officer interpreted the legal process for the program and facilitated communication with the courts and legal system. Moreover, being on-site at the program's center allowed the officer to learn about the clients' mental illnesses; made her more available, thus decreasing the need for revocation because the client failed to appear for appointments; and allowed her to use her authority to encourage the clients' participation in mental health treatment.[3]

Future of the Program:
Alameda County's MIOCR-funded services were discontinued at the end of the grant period due to severe budget constraints facing the County. There is the strong intention to reinstitute those services if / when money becomes available.

[3] ibid.

BUTTE COUNTY
FORENSIC RESOURCE TEAM (FOREST) PROGRAM

Type of Program: In and after custody – Mental Health Court -- Community based
Key Strategies: Wraparound with multi-disciplinary teams; case management; alcohol and substance abuse treatment; money management; employment counseling; benefits support; strong probation involvement

Target Population: Inmates with major mental health diagnoses and dual diagnosis; offense history acceptable to the Butte County District Attorney; exclusions for history of violence including domestic violence, serious felony history and previous felony history (prior strikes); willing and able to pursue treatment
Study population: Enhanced Treatment 50; Treatment as Usual 43

Summary Description:
Butte County's Forensic Resource Team (FOREST) Program was an integrated approach to provide a comprehensive, collaborative and cost effective wraparound continuum of care for seriously mentally ill and dually diagnosed offenders in Butte County. FOREST included a mental health court presided over by a judge considered to be part of the treatment team who adjudicated mentally ill offenders.

Goals and Approach:
The FOREST Program's goals were to provide a comprehensive wraparound continuum of care; to increase substance abuse treatment options, including in-home detoxification and residential treatment; to implement necessary and appropriate system changes to support collaborative community responses to the needs of mentally ill offenders; to increase housing options for mentally ill and dually diagnosed offenders; and to implement a MIOCR Mental Health Court.[1] FOREST adapted the Integrated Service Agency and Program of Assertive Treatment (PACT) approach that relies on multidisciplinary teams as a central component of effective treatment. FOREST provided participants a comprehensive plan, wide ranging community-based support and quick response to their needs.

FOREST employed five inter-related major interventions, the first of which was early contact and screening in jail by a team including a probation officer, a Behavioral Health clinician and a sheriff's deputy. Discharge planning and inter-departmental communication about treatment and follow up occurred in this phase as well. FOREST's second major element was its MIOCR Mental Health Court, in which offenders were adjudicated and which reviewed offenders' progress toward treatment goals on a weekly basis. Third, a Forensic Coordinator was responsible for linking the Court to all elements of the project, and, fourth, FOREST enhanced services to mentally ill offenders, including clinical treatment and case management. Finally, a housing / employment specialist developed community-based resources and placed clients in educational, vocational and employment training programs to help them find employment. Clients received customized services based on a case plan driven by their specific needs. Case plans were crafted by the treatment team and overseen by a case manager. Services included clinical counseling, alcohol and substance abuse treatment, money management education, employment counseling, entitlement program consultations and referrals (sometimes mandated) to self-help and support groups.

FOREST reported that its participants experienced statistically significant improvements in functioning and symptomatology, that a lower percentage of program participants were booked into jail following graduation from the program and a lower percentage were convicted of a post-program offense as compared to the treatment as usual group. Systemwide costs were said to have been "somewhat mitigated" by the intensive FOREST interventions, as law enforcement and criminal justice expenses

[1] Gary Bess Associates, Butte County FORENSIC RESOURCE TEAM (FOREST) Final Program Report, page ii

dropped dramatically for the five participants studied during the 12-month period following program participation.[2] Over the life of the program, 24 participants graduated, after having spent approximately 12 months in FOREST's enhanced services.

Local Perspective of What Worked:
According to the eight SWOT (Strength, Weakness, Opportunities and Threats) assessments conducted during the FOREST study, the multi-agency collaborative approach was considered a particularly effective feature of the project. Butte noted that problem resolution across departments was easier and quicker to achieve and that the "team achieves what individual agencies can't."[3]

The mental health courtroom was said to feel like a safe place, not adversarial among agencies, and the presiding judge was described as the "lynchpin" for the multi-disciplinary team approach as well as of the mental health court, "assimilating FOREST staff knowledge and therapeutic recommendations into the ... court proceedings."[4]

Butte also acknowledged the commitment and enthusiasm of staff, residential treatment, the program's van transportation, flexibility of programming, the development of a supportive culture among clients that helped them in job searches and staying clean and the ongoing support of the Board of Corrections among additional things that were particularly effective.

Future of the Program:
Due primarily to funding considerations, the FOREST Program ended June 30, 2004 at the conclusion of the grant.

[2] op. cit., pages iii - iv
[3] op. cit., page 73
[4] op. cit., page 88

HUMBOLDT COUNTY
MORE INTENSIVE OPTIONS & CREATIVE RESPONSES (MIOCR) PROGRAM

Type of Program: In and after custody – Center based
Key Strategies: Multi-disciplinary teams; MIOCR Program court for Status Review Hearings; strong probation involvement after release from jail

Target Population:
Inmates with major mental health diagnoses; no excluded offenses; probation jurisdiction mandatory, post-sentencing; willing and able to pursue treatment
Study population: Enhanced Treatment 68; Treatment as Usual 73

Summary Description:
Humboldt County's *More Intensive Options and Creative Responses (MIOCR) Program* was a center-based, multi-disciplinary team approach to providing intensive, individualized and coordinated services to randomly selected, less- or non-violent adult offenders identified as having a serious mental health diagnosis. Most (93%) also had co-occurring substance abuse disorder. Each inmate's involvement with the program began during the custody period and included extensive assessment; mental health and substance abuse in-custody counseling; discharge planning; structured transition from jail to the community; intensive probation supervision and support; bi-monthly Status Review Hearings before the MIOCR Program Court; and community located counseling, treatment, medication maintenance and socialization services, for a total treatment period of one year.

Goals and Approach:
The MIOCR Program was constructed to address "three goal sectors"[1] – the public safety goal sector, which focused on reducing recidivism through the community protective use of intensive probation services; the accountability goal sector, which sought to promote the offender's acceptance of responsibility for the harm s/he had caused and acceptance of the need to work to repair the damage; and the treatment goal sector, which involved building offender competence in specified life domains where there were identified needs, such as mental health, housing, social supports, education, etc. The MIOCR Program adopted a multi-disciplinary team approach providing individualized services, along with an overlay of a structured environment. The program focused on collaboration among agencies to construct and implement individually tailored, strength-based case plans.

As to the outcomes, while there were no statistically significant differences between the Pilot Service/Enhanced Treatment and the Standard Service/Treatment As Usual groups in jail bookings, convictions and/or jail days, the evaluation did find that a smaller proportion of Pilot group participants spent time in jail after the program (41% vs. 49%) and a larger proportion of Pilot clients had no criminal justice activity after the program (56% vs. 49%). The study found the MIOCR Program most effective in reducing subsequent jail bookings and bed days for younger (under median age 34) clients who received a range of services. Well over half of the younger Pilot participants (64%) had no criminal justice activity after the program as compared to 46% of the younger Standard participants. Younger male Pilot participants averaged 15.3 days in jail after the program while younger male Standard Services participants spent an average of 70.5 days.

Local Perspective of What Worked:
Humboldt County's MIOCR Program was a therapeutic model that maintained accountability while reinforcing a supportive atmosphere. What worked for Humboldt in implementing that intention was the MIOCR Program's use of multi-disciplinary, interagency teams for treatment, its platform of case management and services coupled with intensive probation supervision, its location of the program in a

[1] Center for Applied Social Analysis & Education, Humboldt State University, Department of Sociology, Final Project Report: Humboldt County's Mentally Ill Offender Crime Reduction Program, June 30, 2004, page 24

center where participants were involved in activities each day, and its Status Review Hearings through the MIOCR Court.

Individuals in the MIOCR Program received a variety of services related to their individual case plans and were involved in peer therapy and art therapy as well as regular social activities. Educational groups were oriented around anger management, substance abuse treatment, parenting skills, job readiness, violence prevention, life skills and relapse prevention techniques. The monthly MIOCR newsletter provided advice on recovery, updates on activities and feature stories as well as participants' artwork, stories from alumni, and graduation photos highlighting their successes and talents.

Case studies show that, from helping them secure housing to driving them to the doctor to taking them to the Arcata Marsh to walk and eat blackberries, the program's intensive level of services and activities – and the positive relationships between clients and staff – contributed to an environment conducive to treatment.

In summarizing 'what worked,' Humboldt County identified relationship building between staff and participants, relationship building among participants, relationships with other programs in the community, the inter-agency approach to service delivery and the program's strengths-based approach as the primary factors of success. Among the program's shortcomings, Humboldt noted the absence of a structured aftercare plan, inflexibility in program requirements (i.e., the five day a week, four + hours a day involvement), the lack of access to 24/7 crisis services in the program and not regularly including family members in program activities or support groups.

Future of the Program:
Due primarily to funding considerations, the MIOCR Program ended at the conclusion of the grant.

KERN COUNTY
JAIL ALTERNATIVES, INFORMATION, AND LINKAGE (JAILINK)
MIOCRG I

Type of Program: Post booking / post arraignment – community based
Key Strategies: Intensive case management; specialized, multidisciplinary team; treatment as a condition of probation; linkage with community mental health services

Target Population: Misdemeanants and [eventually] felons who were "seriously and persistently" mentally ill to the extent that functional impairments related to their mental illness placed them at risk of harm or homelessness; were U.S. citizens; had pled guilty at arraignment, pre-trial or day of trial; were not identified as violent or treatment resistant
Study Population: Enhanced Treatment 289; Treatment as Usual 279

Summary Description:
Kern County's MIOCR I program, Jail Alternatives, Information and Linkage (JAILink), was a specialized team that provided intensive case management and probation services for mentally ill offenders from the time of their arraignment until they could be placed in an appropriate full-service treatment team. JAILink focused on identifying suitable alternatives to incarceration, improving planning for jail release, finding emergency housing and aftercare, providing probation supervision for misdemeanor and felony clients, providing immediate access to services and improving information sharing systems.

Goals and Approach:
JAILink sought to reduce the incidence of recidivism by mentally ill offenders in Kern County, particularly in the metropolitan Bakersfield community. A secondary goal was to eliminate the duplication of services to those people between or among agencies. To accomplish these goals, members of the JAILink team provided a variety of services for their clients including: psycho-social assessments; psychiatric evaluations and medication follow up; emergency food and shelter; probation supervision; limited transportation to appointments; assistance in applying for General Assistance and Social Security Insurance benefits; assistance in complying with court orders' referrals to outpatient and residential substance abuse treatment linkage to full service mental health teams for ongoing treatment; monitoring of progress in treatment; and linkage to other community services as needed. JAILink intended to transfer clients to full-service mental health teams within three months; however, some clients were transferred within weeks and some needed continued JAILink treatment and received services for more than four years.

Mentally ill offenders entered the program after recommendation from JAILink probation officers to the presiding judge. If the judge agreed that the individual was eligible and suitable, s/he ordered the defendant placed on JAILink probation and added specific probation orders requiring the client to cooperate with the JAILink team in developing and following an individual treatment plan. For those who were subsequently found ineligible and/or those who refused to participate, requests for probation modification were sent back to the court asking that the JAILink probation orders be deleted. JAILink probation officers typically saw felony clients three to four times per month and misdemeanants at least once a month (more frequently if needed). The probation officers received frequent updates on clients and responded to client needs identified by the JAILink case managers. A JAILink probation officer supervised Proposition 36 clients involved with the program for the duration of their probation.

Local Perspective of What Worked:
Kern County identified a number of key components of JAILink that 'worked' particularly effectively. First among these was the fact that field staff members participated in the initial program planning. This is credited with ensuring that the program design had 'real world' applicability and feasibility. Program

managers also noted that it was important to educate the courts and other agencies about JAILink because increased awareness in courts and jails improved the quality and quantity of referrals and increased the likelihood that judges would issue probation orders that included JAILink.

According to JAILink case managers, several factors contributed to success with clients, including:

- Offering help as quickly as possible
- Case manager/probation officer teamwork
- Ensuring that clients had a safe place to go
- Fostering a trusting relationship between client and case manager
- Providing clients with encouragement and support, even when they failed
- Maintaining ongoing collaboration between JAILink and other agencies' case managers to assist clients

An important objective for the JAILink team was stabilizing clients on medications. This was reported to have been facilitated by consistent monitoring (e.g., once a week). Arranging housing through providers who were willing to take criminal offenders was also reported to be effective as it allowed JAILink case managers to be notified immediately when their clients were having problems so the team could respond before difficulties escalated. Having a probation officer on the team was said to have increased clients' accountability and the case manager/probation officer team model was credited with greatly increasing awareness of mental health issues among probation officers as well as enhancing mental health personnel's understanding of the criminal justice system.

Future of the Program:

While JAILink itself ended at the end of the MIOCR grant, many of its most effective elements – as well as the multi-agency team – have been transitioned into a support team for a newly created Mental Health Court. The Mental Health Court support team is primarily a treatment team rather than a linkage provider. In this new program, mentally ill felons will receive substance abuse and mental health services for three to five years.

KERN COUNTY
RURAL RECOVERY TREATMENT PROGRAM (RRTP)
MIOCRG II

Type of Program: At arraignment or after jail – Dual diagnosis – Sober living residence and community based services
Key Strategies: Housing in sober living environment; intensive outpatient day treatment at mental health clinic; aftercare at clinic nearest client's home

Target Population: Males with at least one criminal offenses (excluding violent felonies) and a mental illness accompanied by chemical abuse and/or addiction; current residents of East Kern County or had resided in Kern County during the three years prior to enrollment in the program; agreed to participate
Study Population: Enhanced Treatment 46

Summary Description:
Kern County's MIOCR II, Rural Recovery Treatment Program (RRTP) was a dual diagnosis program for mentally ill male felons with co-occurring substance abuse issues. RRTP provided housing in a sober living environment coupled with intensive outpatient treatment for the mental illness.

Goals and Approach:
The RRTP sought to reduce rearrest and incarceration among dually diagnosed men in east Kern County. Clients in the RRTP were engaged for four to six months in an intensive dual diagnosis program with both residential and day treatment components. Clients were admitted to the program's sober living residence in California City upon release from county jail, or at arraignment. Each day, they were transported to a community mental health clinic where they participated in an intensive day treatment program that included a series of groups as well as individual counseling and medication support. Following graduation, some clients completed up to four months of aftercare at the clinic nearest their home.

RRTP was based on a belief that it was important to educate clients in order to lay a foundation for them to better conduct and manage their lives. Clients were exposed to a variety of new strategies and tools they could utilize in their daily lives outside the program. Most especially, clients learned new social skills and how to work cooperatively in a group.

Local Perspective of What Worked:
Staff members found beneficial the MIOCR grant requirement that the program not be used as an alternative to sentencing. This helped to ensure that clients were voluntarily taking part in the program and, presumably, were more prepared and willing to work with the treatment team. Because the program offered components consistent with requirements for level 4 Proposition 36 probationers, many RRTP referrals came from local Proposition 36 probation officers.
The Program's staff members also reported that treatment flexibility was important as it allowed the team to tailor individual treatment plans for each client's specific problems and issues.

Elements of the sober living facility / residence were attributed with helping the program achieve its goals. The fact that the clinic and the residence were near one another allowed for quick transfer of clients between sites. Moreover, the residence was approximately 500 yards from the nearest private residence, which is believed to have helped diminish concerns about having such a program in the community. Clients reported valuing the camaraderie and clean, comfortable environment the residence provided. There were no major problems in the residence and clients were said to have enjoyed a standard of living that was higher than what they had before (or would have after) participation in the program.

Positive interactions between clients and staff members was Kern County's major answer to the question, 'what worked?' Staff members observed that the quality of their relationships with clients had a large impact on the clients' treatment, noting that clients talked more openly and honestly with staff members they trusted and responded positively to the time and effort staff put into helping them manage their impulsive behaviors. Staff reported that the trusting and supportive relationships appeared to foster a greater willingness for clients to seek additional needed services and treatment and to work towards recovery.

It was additionally important to the program that the evaluator's data manager worked closely with one of the RRTP case managers to create an Access database for entering and transmitting program-specific information. When combined with data from other sources, this database facilitated more efficient data reporting for each of the BOC's six-month reporting periods.

Future of the Program:

The RRTP closed at the end of the grant period due to the fact that no subcontractor could be found to manage the sober living residence in California City's rural location at a cost the County could afford. The day treatment program component has been eliminated as well because all members of the RRTP treatment team have left the immediate area and the County does not have the resources to replace them.

Treatment for about half of former program clients is continuing in the form of individual outpatient care and medication support in the former RRTP contractor's east Kern County mental health clinics. Not all of the eligible offenders are required to participate in this aftercare; however, clients who are involved in Proposition 36 are required to complete 90 days of aftercare treatment and do so in these clinics. Others are participating voluntarily.

LOS ANGELES COUNTY
COMMUNITY REINTEGRATION OF MENTALLY ILL OFFENDERS (CROMIO)
MIOCRG I

Type of Program: In and after custody – Community based – High Risk
Key Strategies: Combination of ACT and intensive case management through multi-disciplinary staff; family and support system involvement; strong probation involvement

Target Population: Jail inmates with a current felony arrest, two prior arrests; homeless or at risk of homelessness; a co-occurring diagnosis of substance abuse/ dependency; agreed to participate. Exclusions: history of serious violence / violence prone at the time of screening; on conservatorship
Study population: Enhanced Treatment 133; Treatment as Usual 134

Summary Description:
The Community Reintegration of Mentally Ill Offenders (CROMIO) Program, Los Angeles County's MIOCR I effort, was an intensive case management approach, utilizing many elements of the Assertive Community Treatment (ACT) model, that provided a continuum of services which began while the client was in jail and continued upon his/her release into the community. In the community, case managers provided needed services directly and/or linked clients with those services, in the critical areas of mental health care including medication; substance abuse treatment; housing; obtaining and maintaining benefits and entitlements; transportation; education; socialization; rehabilitation; and employment.

Goals and Approach:
CROMIO's ultimate goal was to reduce jail and especially prison recidivism for those offenders for whom the majority of arrests were related to their mental illness. The program focused on assertive outreach to engage clients while they were in jail and then provided very intensive services when they were released to the community, seeing most clients at least once a week and some almost every day, especially when just released from jail or the hospital. The treatment staff was comprised of social workers, substance abuse counselors, community workers, probation officers, deputy sheriffs and a psychiatrist and sought to involve not only service providers but also the client's support system, including his/her family members as appropriate.

CROMIO's researchers devised a rating instrument describing the spectrum of mentally ill offenders by the psychiatric and personality factors that contribute to their pattern of arrests. At one end was the chronically mentally ill offender and at the other end, the habitual offender. They posited that mental health treatment would reduce the recidivism rate for those who were arrested primarily because of their mental illness, while those at the habitual offender end of the spectrum would be less affected by successful mental health treatment and more likely to respond to behavioral controls like probation, mandatory drug testing and close supervision.

Local Perspective of What Worked:
CROMIO's major hypothesis that fewer subjects in the Enhanced Treatment group would end up in prison during the post release period was strongly supported. Almost twice as many mentally ill offenders from the Treatment as Usual group as from the Enhanced Treatment group went to prison. The County attributes this success to both the program's intensive treatment and the fact that program staff's representatives, including probation officers, advocated in court for CROMIO's clients, telling the court exactly what services were being provided and thereby providing the court a viable alternative to sending the person to prison.

Los Angeles County also reported that, "probation was one of and at times the most important aspect of the program."[1] The evaluators noted numerous testimonials from clients that their positive interactions with probation officers had impacted their propensity for criminal behavior and made them want to become more stable and law abiding.[2]

"To some degree, the fact that the clients were on probation seemed to increase treatment compliance, at least enough and to the point where medication and other treatments could begin to have an effect. We have called this apparent positive effect of having competent and caring probation officers 'compassionate coercion'…"

One of the most effective elements of the CROMIO program was reported to be its concerted effort to get SSI benefits for its clients. SSI benefits were said to have enabled clients to find housing and/or to enter residential treatment programs and, as a result, seemed to be directly correlated to the facts that psychosocial functioning improved for the treatment group over time, they were less often homeless or homeless for less time and they were significantly less likely to go to prison than those without SSI. In fact, of the 88 participants who obtained Social Security Disability benefits, only 7% were sentenced to prison, whereas of those without SSI, 34% were sentenced to prison.[3]

Future of the Program:
While the CROMIO program per se ended at the conclusion of the grant, CROMIO staff began working in a new ACT program that targets similar clients, including those with incarceration and substance abuse histories. This new program is located in the same site/space that CROMIO inhabited, and already has two former CROMIO staff acting as liaisons to the jail, so CROMIO will be continuing in a significant, if more informal, way.

[1] Los Angeles County, CROMIO Final Report, page 75
[2] ibid.
[3] op. cit., page 59

LOS ANGELES COUNTY
FORWARD MOMENTUM
MIOCRG II

Type of Program: In and after custody – Gender Specific (females)
Key Strategies: Specialized treatment while in jail; enhanced discharge planning; post release linkage to mental health agencies, substance abuse programs and other services; probation involvement

Target Population: Female inmates ages 18 – 50 who were pregnant, mothers or primary care givers for child under 18; at least one prior adult arrest; history of symptoms and current diagnosis of severe and persistent mental illness and history of substance abuse indicating current abuse or dependence, or significant risk for relapse; homeless or lacking stable residence at time of enrollment, or being at risk for homelessness or unstable housing upon release
Study population: Three-levels of Enhanced Treatment 92; Treatment as Usual: 43

Summary Description:
Los Angeles County's MIOCR II program, FORward MOMentum was a joint project of the Los Angeles Counties Sheriff's Department, Department of Mental Health, and Probation Department. The program was designed to reduce criminal recidivism in incarcerated mothers with co-occurring disorders. Initially, the project was designed with four, randomly assigned groups providing three levels of enhanced treatment and one treatment-as-usual group. The four groups were: 1) Intensive Jail Treatment – only in-custody treatment, 2) Intensive Community Treatment – only post-release treatment, 3) Combined – Intensive Jail and Intensive Community Treatments, and 4) Treatment as Usual – non-program rendered treatments in the jail and in the community. However, difficulty enrolling participants who met the initial selection criterion of a four-week minimum anticipated jail stay necessary to provide at least 21 days of specialized treatment while incarcerated forced the project to eliminate two of the four groups –Intensive Jail Treatment and Combined. The last year of the study was conducted using two treatment groups (Intensive Community Treatment and Treatment as Usual) in order to eliminate the required length of incarceration.

Goals and Approach:
FORward MOMentum was designed to develop integrated treatment and intervention approaches. Its goals included: reducing criminal recidivism; providing mental health treatment and services in jail and in the community after release to ensure psychiatric stability; providing interventions to assist participants in achieving and maintaining sobriety from drugs and alcohol; and assisting in developing skills and resources to help participants live independently in the community in stable conditions, thereby reducing homelessness.

The program sought to achieve these goals by providing in-custody, discharge and post-release services to program participants. In-custody treatment was a hybrid of psychosocial rehabilitation, cognitive-behavioral and harm reduction approaches. The post-release treatment approach was primarily intensive case management with components of the Assertive Community Treatment (ACT) model. Services were provided by a treatment team consisting of a primary case manager, a patient's financial services worker, a substance abuse counselor and a probation officer, and were designed to prevent relapse, reduce re-arrests and maintain psychiatric stability.

Local Perspective of What Worked:

Los Angeles reported that continuous, integrated care, starting while the participant was incarcerated, and continuing after release, 'worked' in reducing criminal recidivism, preventing relapse into substance abuse, reducing homelessness, and facilitating psychiatric stability. The most intensive level of treatment – the combination of in-custody and post-release services – was said to have resulted in fewer re-arrests than other levels of enhanced treatment and treatment as usual.

Additionally, FORward MOMentum's researchers noted that participants who received the combination of in-custody and post-release services had a lower proportion of reported problems associated with drug use than did those receiving treatment as usual. Participants in the enhanced treatment groups had fewer inpatient psychiatric hospital days and more engagement in residential treatment such as dual recovery programs, indicating that intensive treatment, particularly jail- and community-based, does effectively increase psychiatric stability.

LA emphasized the importance of in-custody treatment combined with post-release services for enhancing treatment engagement and reducing recidivism, saying, "…providing intensive services in jail would not only 'prime' participants for post-release treatment, but also provide positive experiences with treatment staff to enhance treatment engagement and adherence post-release."[1] In reporting that all its enhanced treatment groups had significantly fewer days in jail upon rearrest than those women receiving treatment as usual, the County said, "once rearrested, program participants on formal probation had the benefit of the FORward MOMentum probation officer and case manager working collaboratively and proactively to find alternatives to lengthy jail sentences, such as residential or outpatient drug treatment, thus their fewer days in jail may [have been], at least in part, attributable to effective and timely release planning by program staff."[2]

Future of the Program:

Services provided by MIOCR II ended on June 30, 2004. All participants who previously received treatment by the grant's staff were linked to a variety of community agencies such as mental health clinics, integrated service providers, and residential treatment centers. Although currently there are no plans to continue this program in this exact format, the grant underscores the need for continuous, integrated treatment in jail and in the community post-release to ensure successful re-integration and reduce the likelihood of recidivism.

[1] Los Angeles County, Final Program Report, FORward MOMentum: Reducing Criminal Recidivism in Dually Diagnosed Incarcerated Mothers, page 55

[2] op. cit., page 57

MARIN COUNTY
SUPPORT & TREATMENT AFTER RELEASE PROGRAM (STAR)

Type of Program: After custody – community based
Key Strategies: ACT; multi-disciplinary team; intensive case management; medication support; probation officer on treatment team; daily team meetings; peer support

Target Population: Mentally ill offenders in Marin County; diagnosed with a DSM Axis I disorder; arrested for a felony or misdemeanor after the start of the study; residents of Marin County, Medi-Cal eligible; agreed to participate; excluded if charged with serious, violent offense; if found not guilty by reason of insanity or incompetent to stand trial; if primary diagnosis was substance abuse disorder
Study population: Study results reported only for those who completed at least 1 full year of services – Enhanced Treatment 34; TAU 16

Summary Description:
Marin County has a long history of collaboration between the Sheriff's Department and Marin County Community Mental Health to provide mental health services to inmates in the county jail as well as in the community. Additionally, the County has an interagency Behavioral Health Criminal Justice Committee (BHCJC), whose goal is to inform policy development and foster interagency collaboration, and a Forensic Multidisciplinary Team (FMDT), which meets monthly to help law enforcement develop individualized action plans for responding to mentally ill or dually-diagnosed individuals within their jurisdictions. Operating in this context, the STAR program sought to provide enhanced case management and services in the ACT model to mentally ill offenders.

Goals and Approach:
The STAR team consisted of a mental health practitioner/case manager, clinical supervisor, mental health liaison police officer, probation officer, peer service provider, nurse, psychiatrist and STAR administrator. The team worked with participants to develop individualized treatment plans to address the program's major goals. These goals were to reduce crime committed by participants; reduce their incarceration rates and length of stay if/when they were returned to jail; reduce psychiatric hospitalizations and psychiatric emergency contacts and improve global assessment of functioning (GAF) scores; reduce substance abuse; and improve participants' quality of life.

The team's mental health practitioner/case manager had primary responsibility for identifying, obtaining and coordinating community services appropriate for the client. In addition to mental health services, these often included substance abuse and health care services as well as securing benefits or entitlements. Psychiatric, medical and medication services were available through the nurse or psychiatrist. The probation officer worked with the courts and the participants to establish conditions of probation that encouraged participation in mental health services. Off-hour emergency services were obtained through hospital emergency rooms and services for special needs (e.g., eating disorders, sexual disorders) were contracted out.

Participants in the STAR program, as well as the treatment as usual group, were followed from the time they were enrolled in the study until the end of the project. The County's evaluation study focused only on those individuals who received services for at least one full year.[1]

It found that participants had fewer jail days during treatment and a decrease in the number of felony convictions than did members of the comparison group. STAR clients did not show significantly greater

[1] Prins, Williams & Associates, LLC, Marin County STAR Program: Final Report, page 15

reductions in the number of incarcerations and court cases than those in the comparison group, nor did they show statistically significant improvements on substance abuse outcomes as measured by the ASI. They did, however, show statistically significant reductions in clinician judgments of alcohol and drug related problems. STAR clients did not have fewer psychiatric hospitalization days or fewer psychiatric emergency contacts than mentally ill offenders receiving standard treatment, but they were reported to have shown greater improvements in overall functioning than the did members of the comparison group.[2]

Local Perspective Of What Worked:

Marin County reported that the factors considered most important to the successful implementation of STAR were prior collaboration among the stakeholders, the personal qualities of the project coordinators and a shared vision of the goals of STAR. The two variables that were said to have been most crucial to the actual operation of STAR were the delivery of flexible services by a committed and caring staff and the use of jail as part of treatment.[3] The County quotes program coordinator, police officer and psychologist Joel Fay as saying, "An arrest is just an arrest. An arrest with a treatment plan moves people in the right direction."[4]

STAR participants were reported to have had twice as many probation contacts as did members of the comparison group. This finding was said to "suggest that differences in outcome may be due to the presence of probation or law enforcement on the STAR team. In other words, it is possible that one of the most important features of the STAR program is regular probation contact."[5]

The importance of a peer service provider was also emphasized in this project. In addition to providing direct services for STAR consumers, the STAR peer counselor helped police officers in the field deal with mentally ill individuals.

Future of the Program:

A modified STAR program continues to serve clients and includes a newly established mental health court as well as an employment specialist and a case manager with expertise in substance abuse.

[2] op. cit., pages 24 - 26
[3] op. cit., page 34
[4] op. cit., page 37
[5] op. cit., page 31

MENDOCINO COUNTY
THE SOLUTIONS PROGRAM

Type of Program: Post-arraignment – Mental Health Court – community based
Key Strategies: Comprehensive, multi-disciplinary services; detailed assessment; case management; strong probation involvement

Target Population: Mentally ill offenders with or without co-occurring disorders; those charged with a serious or violent felony or sexual predation are excluded
Study Population: Enhanced Treatment 17; Treatment as Usual 35

Summary Description:
In cooperation with the Mendocino County Superior Court, the Departments of Mental Health, Probation, Social Services and Public Health's Division of Alcohol and Other Drugs Program, the District Attorney and the Public Defender, the Mendocino County Sheriff's Office implemented a 'therapeutic court' program called SOLUTIONS for mentally ill offenders. The cornerstones of the Solutions Program were the court – the Mentally Ill Offender Therapeutic Court (MIOTC) – and related professional assessment and treatment of mentally ill offenders. SOLUTIONS' multi-disciplinary team collaborated with the MIOTC Judge to develop and oversee individual case management plans for individuals under the supervision of the MIOTC and to link them to needed services in the community.

Goals and Approach:
The primary goal of the SOLUTIONS Program was to reduce recidivism among mentally ill offenders and associated criminal justice costs by offering suitable and eligible offenders the option of participating in a specialized, therapeutic court. SOLUTIONS, also known as the Mentally Ill Offenders Court Program, involved assessment, oversight, case management and enhanced support services. For each offender eligible for the MIOTC, the SOLUTIONS Mental Health Clinicians prepared detailed assessments and the Alcohol and Other Drug Program (AODP) Substance Abuse Therapist completed an Addiction Severity Index assessment. Probation Case Managers also evaluated each referral for criminality and, after entry, for core life needs such as income and shelter. These members of the Treatment Team and the Therapeutic Courts Coordinator met weekly to assure individual needs were addressed and to draft weekly progress reports for the judge.

In order to prevent recidivism, the program sought to ensure the availability of and linkage to an array of supportive services in the community to which a case manager could refer his or her clients. Those supportive services included**:** medications management; crisis management; family counseling; marriage counseling; housing advocacy; general assistance, Veterans' benefits, Medi-Cal and Supplementary Security Income benefits; access to the California Department of Vocational Rehabilitation; and food, clothing and transportation vouchers.

The SOLUTIONS Program also sought to ensure public safety and conserve peace officer time by developing a compassionate and informed cadre of law enforcement, hospital, pre-hospital, mental health, AOD, Fire District, and other service providers who could correctly identify and effectively manage mentally ill offenders in the field. To this end, among other efforts, the Sheriff's Department developed and provided STC certified training classes, including a "Suicide Prevention/Mental Illness/Depression" class, later renamed "Mental Health Issues in the Jail," and a POST certified "Critical Focus" class for field officers.

An additional goal was to improve identification and management of mentally ill offenders by expanding and enhancing automated information system linkages within and between agencies, while ensuring full participant confidentiality. A web-based data collection system was installed that links the Therapeutic Courts Administration (Superior Court) with the countywide criminal justice JALAN database and AODP's

database. This has enhanced communication and information sharing as well as facilitating identification and offender management.

Local Perspective of What Worked:
There was consistent agreement reported among program partners that 'what worked' was, first and foremost, the MIOTC's interagency collaboration and intensive case management. The collaborative team was credited with serving the multiple needs of clients who had too many issues for any one agency alone to be entirely successful. Chief Probation Officer Robert McAlister said, "...the importance and accomplishments of this program are seen in the intense case management that occurred with a segment of our population that slips between anti-social/mental health driven behavior and criminal activities for which they can be prosecuted. These clients have always been on our probation caseloads, but [in the SOLUTIONS Program] we were able to place them in a more intensive case management milieu and to concentrate on assistance, rather than punishment."[1] Mendocino County concluded that the intensive and collaborative case management allowed "essential services [to be] provided to a very needy, underserved population in a coordinated comprehensive manner."[2]

Making our systems more responsive to the needs of the client rather than making the client respond to our static systems improves effectiveness.

Future of the Program:
The SOLUTIONS Program was discontinued at the end of the grant due to fiscal constraints; however, elements of the program are continuing. The Mental Health Department and the Public Health Department's Division of Alcohol and Other Drugs Program have signed a Memorandum of Understanding to work together to meet the needs of dually-diagnosed individuals and are providing a Dual Diagnosis Group on a weekly basis. Court-ordered referrals for mental health services continue to be received by the Mental Health Department's Forensics Unit for evaluation and placement and clients with Medi-Cal served by the SOLUTIONS Program who wanted to continue counseling services are being seen by the Mental Health Department's Forensics Unit and/or AODP's Outpatient Treatment Program.

[1] Mendocino County, The SOLUTIONS Program Summary, page 2
[2] ibid.

MONTEREY COUNTY
SUPERVISED TREATMENT AFTER RELEASE (MCSTAR)

Type of Program: Primarily post custody – community based
Key Strategies: FACT team; Mental Health Court; individualized treatment plans; cognitive skill building classes; supervised and supported housing; probation officer on treatment team

Target Population: Inmates with severe and persistent mental illness (schizophrenia, bipolar or other psychotic disorders) as primary presenting problem; could have personality disorder and/or substance abuse dependence as secondary problems; history of two or more arrests; resident of Monterey County; willing to plead guilty and, at sentencing for the qualifying arrest, agree to participate in the program
Study population: Enhanced Treatment 31; Treatment as Usual 31

Summary Description:
The Monterey County Supervised Treatment After Release (MCSTAR) Program was a comprehensive effort to use community resources in conjunction with intensive programming developed by Behavioral Health specifically for the mentally ill offender population. The key elements of MCSTAR were: in-custody assessment and treatment services; a Mental Health Court; an Forensic Assertive Community Treatment (FACT) Team with a 1:10 staff to client ratio and a probation officer on the team; a cognitive skills training program; and supervised and supportive community housing in designated Board and Care and other MCSTAR housing, provided by contract agencies. Clients were also provided individualized treatment addressing issues of dual diagnosis, anger management, communication skills, medication education, leisure skills, stress management and lifestyle building. The curriculum was augmented by counseling groups such as the Success Group and 12 Step Groups, DRA, AA and NA. Each participant had a schedule that was monitored by the probation officer, and each participant reported to the Judge of the Mental Health Court weekly to bi-monthly depending on his/her progress and standing in the Program.

Goals and Approach:
The goals of MCSTAR, were to:

- Increase participants' knowledge and acceptance of mental illness,
- Increase medication compliance,
- Reduce repeat arrests,
- Increase cognitive skills,
- Increase clients' ability to live independently,
- Increase their willingness to accept recovery and
- Increase clients' ability to accept success as possible.

To accomplish those goals, Monterey County created a FACT Team that included a probation officer, an in-jail social worker, a field social worker, an aide (consumer), a psychiatrist (who worked with the program 8 hrs/wk), a team supervisor and a housing specialist. The Team met three to five times weekly and talked several times during most days about the needs and progress of individual clients. The FACT Team also met with the Mental Health Court Team – comprised of a District Attorney, Public Defender, Private Attorneys, and the Mental Health Court Judge – weekly prior to the Mental Health Court calendar.

MCSTAR's philosophical approach was to encourage responsibility. Participants were expected to attend the required classes and groups, work to learn the material presented and participate in court in order to help them accomplish cognitive restructuring which would support their independent living and crime free behavior during and after completion of the program. The FACT Team utilized unique sanctions to increase compliance, including requiring clients to write 'Thinking Reports' and essays, attend more 12

Step Groups, meet with staff individually more frequently and/or spend the weekend in jail. Staff saw their role as providing encouragement as part of a harm reduction approach. They supported clients' progress toward recovery by providing awards at the completion of Cognitive Skills class and at other points during the program and conducting a graduation at the Program's end.

Local Perspective of What Worked:
Staff of the MCSTAR Program reported that the most effective program elements were: a structured schedule including the 12-Step Groups; the cognitive skill building classes; the firm and caring staff; and a Judge who was fair, perceptive and willing to set appropriate limits. The County additionally reported that providing housing in treatment furlough beds, augmented board and care beds, supportive housing beds, single room occupancy units, and rent subsidies where clients could live together was an important factor in their stabilizing and supporting one another. Focusing on medication compliance and helping participants accept their illness was considered additionally effective for MCSTAR, as was helping clients who were without benefits obtain them. Participants were reported to have been generally appreciative of the Program and its staff, despite the Program's having been very difficult for them. It was clear, according to the County's process evaluation, that most participants had never been involved in anything like MCSTAR before.[1]

Future of the Program:
Although the MCSTAR Program per se ended at the end of the MIOCR grant, key components have been transferred into a new program called Creating New Choices. Creating New Choices incorporates the Mental Health Court and will be staffed by the former MCSTAR Probation Officer as well as all the other staff from the grant, with the exception of the data person. While its program will be very similar to that of MCSTAR, Creating New Choices will accept people not currently in jail. The County is hoping to find additional grant funds to expand services to more clients and to develop specific components for women and mono-lingual Hispanic clients.

[1] Monterey County, MCSTAR Program Summary, page 2

ORANGE COUNTY
IMMEDIATE MENTAL HEALTH PROCESSING
ASSESSMENT & COORDINATION OF TREATMENT (IMPACT)

Type of Program: After custody – Intensive case management – Community based
Key Strategies: Multidisciplinary collaboration; linkage to services; strong probation involvement in one of two separate studies of intensive case management (one with and the other without enhanced probation supervision services)

Target Population: Offenders diagnosed with a major mental illness, not sentenced to state prison; an Orange County resident; not charged with murder, arson or sexual crimes such as rape or child molestation; for Study I, sentenced to probation with at least one year remaining on probation; for Study II, not sentenced to probation
Study populations:
Study I: Enhanced Treatment 201; Treatment as Usual 206
Study II: Enhanced Treatment 211; Treatment as Usual 194

Summary Description:
The IMPACT project provided intensive case management services to mentally ill offenders in two study models – one, called Study I, teamed mental health case managers with a specialized probation unit dedicated solely to the supervision of mentally ill clients. The other, Study II, provided enhanced case management services to offenders not sentenced to probation and therefore not supervised by a probation officer.

Goals and Approach:
The primary goal of the IMPACT program was to help keep mentally ill offenders (MIOs) from returning to jail. The project focused on intensive case management as the mechanism for stabilizing mentally ill offenders, reducing their future criminality and limiting their recidivism and did so in two separate but related studies. In Study I, a case management unit (five case managers and two therapists) dedicated solely to MIOs and a probation unit (four deputy probation officers) dedicated solely to MIOs worked together to support project clients after release from jail. IMPACT probation officers and case managers met monthly to discuss client needs and determine how best to deliver services; they contacted one another regularly to ensure quality services and head off emerging problems. The two units utilized various ancillary services, including special linkages to outpatient behavioral health and substance abuse treatment services, transportation, housing, assistance with securing SSI and advocacy with judges, treatment clinics, housing centers and so on when the need arose. Probation officers' caseloads were limited to 25 – 30 active clients. In Study II, the MIO case management unit and the same ancillary services as in Study I (without the probation unit) supported the non-probation treatment group after these offenders' release from jail.

Local Perspective of What Worked:
Orange County's first major conclusion was about what didn't work. The County's said, "Although this project focused on MIOs and linked a case management unit with a specialized probation unit, its findings parallel those in previous randomized trials … that case management does little to reduce jailing of the mentally ill."[1] IMPACT's local research found no statistically significant changes in the number of jail bookings, the time between bookings or the time in jail for participants receiving intensive case management – with or without enhanced probation supervision – as compared to those receiving treatment as usual.

[1] Public Statistics Institute, Case Management and Jail Recidivism of Mentally Ill Offenders: The IMPACT Demonstration Project, Irvine CA, Abstract.

Nonetheless, the County reported other positive outcomes of the IMPACT Program. These included the fact that clients formed positive relationships with case managers and probation officers, which was considered important given that many of the clients had difficulty forming relationships. Moreover, clients were informed about resources available to them. Many clients were helped with residential services, sources of income, transportation, and so on, which the County believed reduced stress and improved clients' quality of life. It was noted that probation treatment clients were more likely than comparison group clients to obtain psychotropic medications and receive services from treatment clinics, so there was some treatment effect arising from the pairing of the case managers with specially trained probation officers. The County emphasized that, prior to the IMPACT project, there was little precedent for the Health Care Agency and the Probation Department to collaborate on behalf of mentally ill clients. Most significantly, IMPACT's collaboration was reported to be congenial, helpful and a stepping stone for other collaborative projects between the two agencies.

Future of the Program:

While the IMPACT program has ended, local law enforcement agencies, the Health Care Agency, the Probation Department, and individual advocates are continuing to address the issue of offenders who suffer from mental illness. Institutional Health Services, a division of the Health Care Agency, has funded a clinical position to help MIOs. This position will augment a team of multidisciplinary mental health professionals in the Program of Assertive Community Treatment (PACT), administered by Adult Mental Health Services as a specialized treatment program for clients who are service and treatment resistant and therefore have a chronic history of cycling through jails and/or hospitals. Additionally, a new program, The Connection Center, has been proposed as a possible treatment and disposition alternative for police officers. The projected site for this Center will be the 'Great Park' (site of the former El Toro Marine Corp Airbase) in an area designated for use by the Sheriff's Department. Finally, a majority of the IMPACT clients who were still actively involved with probation were assigned to two former IMPACT deputy probation officers. These two deputies also serve as consultants to their colleagues, recommending options for referrals to treatment programs and advising other deputies on ways to effectively supervise clients who are mentally ill. A third former IMPACT probation officer has been assigned to a new Dual Diagnosis Court to supervise clients who have co-existing diagnoses of mental illness and substance abuse.

PLACER COUNTY
PLACER COUNTY CONTINUUM TO AVOID RE-ARREST AND ENTER SOCIETY (PC CCARES)

Type of Program: In and after custody – Mental Health Court
Key Strategies: In-custody assessment; mental health court (post adjudication treatment alternatives to incarceration); multi-disciplinary teams; intensive case management; residential treatment component; strong probation involvement

Target Population: Mentally ill criminal offenders, including those with co-occurring, substance abuse disorders who had a criminal record and had spent at least one day in the Placer County Jail in the three year period before the program began (July 2000) or during the intervention period; primary exclusion was for conviction of serious violent offenses
Study population: Enhanced Treatment 152; Treatment as Usual 165

Summary Description:
PC CCARES provided a continuum of care that included: in-custody assessment and stabilization; a multidisciplinary team comprised of members from the District Attorney's office, the Public Defender's office, the Sheriff's Department, and the Division of Mental Health to evaluate and triage people booked into the Placer County Jail and referred to Mental Health Court; a Mental Health Court calendar with post adjudication sentencing incorporating treatment alternatives to custody; an intensive, residential, forensic inpatient program; targeted probation supervision; outpatient services and aftercare.

Goals and Approach:
Placer County sought to reduce recidivism among mentally ill jail inmates and to enhance those individuals' functioning in the community through the PC CCARES Program. The in-custody interventions the program provided were assessment of participant needs, provision of medications and crisis intervention. These services were generally available to both PC CCARES clients and clients in the treatment as usual (TAU) group.

All eligible offenders were referred to mental health court and all received some level of probation supervision. However, PC CCARES clients were subject to more intensive probation supervision, were provided more intensive treatment and were more closely case-managed by mental health staff than TAU clients after release from jail. The residential treatment program developed for PC CCARES, Cedar House, was focused on the dual-diagnosis issue and was more client-centered than the pre-existing Manzanita House to which TAU clients were assigned if residential treatment was called for. A dedicated probation officer provided supervision to participants at Cedar House, whereas several probation officers provided supervision to TAU participants assigned to Manzanita.

Placer County did not find or report any statistically significantly improved outcomes for PC CCARES Program participants as compared to TAU participants, either in the criminal justice or mental health domains. However, there was reported improvement in functioning, as measured by GAINS scores for those in PC CCARES.

Local Perspective of What Worked:
Placer County attributed the development of a continuum of interventions and services with helping to forge strong collaborative relationships among partner agencies. Both the continuum and the fact that agencies learned to work well collaboratively were credited with enabling PC CCARES' personnel to make better-informed decisions for mentally ill offenders, and to track client progress.

Having a multi-disciplinary team member as part of the in-custody treatment continuum was credited with helping with evaluations and recommendations to the mental health court. That court, with a dedicated judge, mental health services liaison, public defender and deputy district attorney, was described as "an invaluable contribution to better outcomes for mentally ill offenders."[1] The court calendar devoted specifically to mentally ill offenders was said to be "an important cornerstone for the project," as well as an indicator of Placer County's commitment to the mentally ill offender population in the County. [2]

PC CCARES' Project Manager noted that having a forensic-specific program in a residential setting enabled clients to make better transitions from custody, acquire housing and employment, and become more stabilized on medications before transition to out-client services. Having staff available 24/7 at the residential program was additionally said to be helpful to clients who had transitioned out of the residential program, but needed someone familiar with their history to talk to and explore options with.

Another element that 'worked' for Placer County was placing forensic mental health clients in a specific dual diagnosis residential program, rather than in residential programs in which populations were mixed. And finally, the County noted that having the on-site support of Probation for the residential program, and support from the Sheriff when clients were non-compliant, made a big difference in project staff's ability to work with the mentally ill offender population in the PC CCARES study.

Future of the Program:
The PC CCARES Program was discontinued at the end of the MIOCR grant due to financial constraints. However, Placer County is continuing to operate its mental health court.

[1] Placer County Continuum to Avoid Re-arrest and Enter Society Program Summary, page 1
[2] Placer County Continuum of Care to Avoid Re-Arrest and Enter Society Final Evaluation Report, page 30

RIVERSIDE COUNTY
IN-CUSTODY HOUSING, PRE-RELEASE PLANNING AND ALTERNATIVE SENTENCING PROGRAMS

Type of Program: In and out of custody – Specialized jail housing and post custody diversion
Key Strategies: Dedicated 80-bed housing unit in jail, mental health training for jail staff, after custody day treatment as condition of probation for dually diagnosed offenders, community based housing assistance, strong probation involvement

Target Population: In-custody: Mentally ill offenders booked into and housed at the Robert Presley Detention Center (RPDC) or transferred to RPDC within 24 hours of booking; post-custody: dually diagnosed offenders booked into and housed at RPDC or transferred there for housing within 24 hours of initial booking
Study population: Enhanced Treatment in-custody: 304; Enhanced Treatment post-custody: 83*; Treatment as Usual: 289

Summary Description:
The in-custody component of Riverside County's project was a specialized inmate housing unit with pre-release discharge planning. The Sheriff's Department dedicated an 80-bed housing unit at the Robert Presley Detention Center (RPDC) to mentally ill offenders. The unit was staffed around the clock by correctional deputies who had been trained for this assignment in a specially developed, 24-hour training course in the supervision and handling of mentally ill offenders.

The non-custody component, the Alternative Sentencing Program, provided comprehensive day treatment to dually diagnosed mentally ill offenders in lieu of state prison or county jail sentences. The Alternative Sentencing Program was a collaboration among the County's mental health, probation and sheriff's departments, detention health services and the courts, to provide comprehensive mental health treatment and support, coupled with strict terms of probation and intensified probation officer supervision.

Goals and Approach:
Riverside County's goals were multiple. Through the specialized housing unit, the County sought to increase and streamline services, provide 24-hour coverage, and provide better access to mentally ill inmates by jail medical and mental health staff. The housing unit supported those goals and further helped to decrease the use of safety cells, both in frequency of use and in average duration of stay, for mentally ill inmates. Because it provided better access to mental health and medical staff and closer supervision by trained custody staff, the unit facilitated interventions before a mentally ill offender decompensated to the point of needing placement in a safety cell.

The in-custody component of Riverside County's project was also focused on reducing recidivism, and thereby jail crowding and costs, by providing discharge plans for the aftercare of mentally ill offenders. Mental health workers identified the specific needs of randomly selected inmates housed in the specialized unit and began working on individualized discharge plans prior to selected inmates' release from custody. An inmate's discharge or aftercare plan might included referrals to specific community based programs, follow-up treatment, initial prescription medication, assistance with filling out applications and paperwork for benefits, and sheltered living vouchers if necessary. To ensure compliance with discharge plans, inmates released from jail on formal probation were closely monitored by one of the program's two dedicated deputy probation officers.

The primary goal of the post-custody part of Riverside County's project was to divert mentally ill offenders from the criminal justice system, and thereby reduce jail crowding, by giving the courts an

alternative to incarceration. To accomplish this goal, Riverside used a part of its MIOCR grant to double the capacity of a pre-existing Alternative Sentencing Program using a day treatment format. This expansion of the Alternative Sentencing Program added the staff and resources to not only administer comprehensive therapy and counseling, but also provide linkage to community based support and services, and help obtaining public assistance and housing assistance as necessary. Two probation officers were dedicated to the program. Offenders' terms of probation required that they report and take part in day treatment activities every day. Failure to comply with the rules and regulations or failure to complete any portion of the program could result in revocation of the participant's probation and a return to custody. This gave the program the "teeth" it needed to be successful.

Local Perspective of What Worked:
The specialized housing unit increased the number of dedicated jail beds for mentally ill offenders from 8 to 80, and helped ensure timely service delivery and helped expedite correctional staff's rapid referrals to mental health and/or medical personnel. The unit also provided safer, sheltered housing where mentally ill offenders were less likely to be victimized by other inmates and it allowed for 24-hour coverage by the specially trained deputies who recognized and were able to deal with issues unique to mentally ill offenders. Further, the specialized housing unit helped reduce the use of safety cells and the costs associated with psychiatrists' services for inmates housed in safety cells.

Providing day treatment services was considered successful. A particularly effective element of the Alternative Sentencing (day treatment) Program was the use of probation orders and the supervision and support of the program's probation officers. While there were cases of participants who failed to complete the program, staff felt the authority that came from the conditions of probation and the presence of the probation officers had a positive impact on many participants and were contributing factors to their successful graduation from the program.

Future of the Program:
The jail housing unit and the training and use of specialized correctional deputies are continuing. Unfortunately, fiscal limitations have forced the mental health department to significantly reduce the level of discharge planning it can provide and rendered the probation department unable to provide intensive supervision of small caseloads of mentally ill offenders. The Alternative Sentencing Program cannot operate even at the level it did prior to the MIOCR Grant. For it to continue, new funding sources will be needed.

SACRAMENTO COUNTY
PROJECT REDIRECTION

Type of Program: After custody – dual diagnosis
Key Strategies: Intensive case management; Assertive Community Treatment ACT); integrated substance abuse and mental health treatment; housing; transition services; strong probation involvement

Target Population: Seriously and persistently mentally ill inmates of the Sacramento County Jail with either 3 admissions to Jail Psychiatric Services (JPS) or 3 arrests in the previous 3 years; not on current parole; no history of specified serious, violent felonies; not receiving mental health services through AB 34 / AB 2034.
Study Population: Enhanced Treatment 100; Treatment as Usual 100

Summary Description:
Sacramento County's Project Redirection (PR) focused on intensive case management in combination with integrated mental health and substance abuse treatment and access to immediate, stabilizing housing. The program began in jail with identification of potentially eligible inmates and random assignment of those who agreed to participate. Once an offender was randomized into the program, he or she (57% of the study population was female) was released from jail and transported to either the program's 12-bed facility or other identified housing, which provided safe, drug and alcohol free environments. The 12-bed facility/center was contracted to a provider expert in housing and entitlement issues, case management and residential treatment for individuals with co-occurring disorders.

Goals and Approach:
The primary goal of Project Redirection was to reduce involvement in the criminal justice and mental health systems by jail inmates with co-occurring disorders. The program's major elements were integrated mental health and alcohol and drug treatment, emergency and stabilizing housing and intensive case management and service coordination. The County's approach was a combination of the Assertive Community Treatment (ACT) model and Dr. Kenneth Minkoff's Comprehensive, Continuous, Integrated System of Care (CCISC) model for organizing services to individuals with co-occurring disorders. CCISC recommends that "co-occurring disorders be treated as primary and primary diagnosis-specific treatment be integrated into the treatment plan."[1]

Housing staff and treatment staff worked closely to coordinate treatment services, ancillary services and transportation pursuant to the individualized treatment plan developed with the active collaboration of all members of the program team and the offender. Services included dual diagnosis groups held multiple times a week at the program's site, external recovery groups such as Alcoholics Anonymous or Narcotics Anonymous, weekly contacts with line staff, monthly or more frequent psychiatric appointments and supervision as well as advocacy by the program's probation officer.

Local Perspective of What Worked:
The three core components – housing, integrated mental health and substance abuse treatment and intensive case management were said to have worked well, with the interdependence of the three reported to have been essential to the overall functioning of the program. The County credits PR's transition to a team case management service delivery model with enhancing the program's effectiveness and points to daily team meetings with all treatment staff, including the probation officer, with mitigating the stresses of working with the challenging PR population. The meetings were said to have focused on coordinating services and identifying emerging issues before they became crises.[2]

[1] Sacramento County, Final Program Report, Mentally Ill Offender Crime Reduction Grant – PROJECT REDIRECTION, page 15
[2] op. cit., page 60

Sacramento County reported that Project Redirection (PR) clients spent significantly less time in jail for the qualifying arrest than treatment as usual (TAU) clients. In addition, PR clients were more likely to be placed on formal probation than TAU clients. The County suggests that a possible reason for this was that judges were so favorably impressed with the PR program they allowed a shorter jail stay and assigned formal probation with the PR probation officer to PR offenders. The value of having a probation officer working with the PR treatment team, was further supported by the findings that PR clients were reported to have had fewer arrests, spent fewer days in jail, were less likely to be charged with a misdemeanor and were less likely to be convicted of either felonies or misdemeanors than TAU clients.

The collaboration with probation presented a unique and challenging partnership, and one during which the Division of Mental Health learned a great deal. ... The probation officer became vital in navigating the criminal justice system, but complete inclusion as a team member was never fully actualized.

The housing component of the PR program was described as critical on several levels. It provided a safe and welcoming environment for people accustomed to the disorder, chaos and harshness of the streets; it was a clean and sober place to return to if needed; it functioned as a crisis stabilization facility; and most importantly, it offered a transition from jail so that individuals did not have to return to the environment in which s/he had offended or become homeless.[3]

Sacramento County noted that, even using its most conservative estimates, Project Redirection saved over $9,500 per client over the course of the project, or approximately $2,400 per client per year. The majority of these savings – $1,500 of the $2,400 – were reported to have come from criminal justice, as distinguished from mental health, cost avoidance.

Future of the Program:
Sacramento County has continued to fund Project Redirection, although at a reduced level. However, the program will not admit new clients until new revenues can be found.

[3] op. cit., pages 60 - 61

SAN BERNARDINO COUNTY
SAN BERNARDINO PARTNERS AFTERCARE NETWORK (SPAN)
MIOCRG I

Type of Program: Primarily after custody – Short-term intensive – clinic based
Key Strategies: Short-term case management; discharge planning; supported housing; linkage; medication support; transportation assistance; augmented outpatient services

Target Population: Adult mentally ill and dually-diagnosed offenders; current resident of San Bernardino County; current illness or a history indicating that mental illness was manageable with outpatient services; client able to pursue voluntary treatment; client medically stable and able to live safely in the community; excluded for criminal charges of serious violence or sex crimes
Study population: Enhanced Treatment 636; Treatment as Usual 642 including STAR-Lite, the quasi-experimental designed companion program.

Summary Description:
The SPAN program provided short-term case management / mental health services for inmates who suffered from pervasive mental disorders or were dually diagnosed with both mental disorders and substance abuse disorders. The program operated out of a clinic housed next to the county jail, staffed by a team of mental health, medical, drug and alcohol and social worker personnel. Working under the assumption that mentally ill and dually-diagnosed inmates were re-incarcerated due to a lack of mental health and community support, SPAN sought to provide assistance from the time of release from jail to support successfully reentry to the community.

Prior to release from the West Valley Detention Center or the Glen Helen Rehabilitation Center, each client was screened, assessed and had a treatment plan negotiated. Upon release, the SPAN clinic assisted the client by providing needed services, in a case management model, for a period of up to three months after which time cases were closed if staff determined that the client had transitioned safely into the community and was linked with the necessary support services. Cases were reopened when a client required additional mental health services or if the client was rearrested.

Goals and Approach:
The primary goal of SPAN was to provide mental health services intended to reduce additional incarceration and/or recidivism of mentally ill and dually-diagnosed inmates. To accomplish this, SPAN provided an array of services and interventions including:

- placement in sober living homes, room and board homes, homeless shelter homes, board and cares and/or augmented board and cares;
- linkage to community and social services;
- a two-week supply of medications;
- assistance with establishing Social Security and Medi-Cal benefits;
- referral to vocational programs;
- short term psychotherapy; and
- drug and alcohol counseling.

Additionally, clients were offered transportation assistance to their housing and/or for first time appointments with probation offices, mental health clinics, DMV offices, Social Security offices and medical appointments. Those who needed them were provided bus passes and/or assistance in filing paperwork to receive disability bus passes.

San Bernardino reported that its study's basic hypothesis, that jail recidivism would be reduced as a result of clinical services, was not supported. The County posited the reason could have been that, instead of serving the persistently mentally ill, the program actually served substance abusers who were highly resistant to changing their drug related life styles. The SPAN evaluation concluded that short-term case management, augmented by additional Department of Behavioral Health services, had no remarkable impact on outcomes.[1]

Local Perspective of What Worked:
San Bernardino County reported that the shortcomings of the SPAN program were offset by many positive and highly successful elements involving direct services, therapeutic outcome and the target population. The County noted that, for the persistently mentally ill clients who participated in the program, the outcome measures showed good success.

Moreover, the transportation services provided by SPAN were described as "very successful," not only in moving clients from one location to another, but also as a context to provide clinical services. Transporting clients gave staff opportunities to establish the critical professional relationships necessary for benefiting from the program.

Those clients who had significant and rewarding family relationships were said to have done better and responded to treatment services in ways participants without clear family support did not. San Bernardino noted, "Clients who had a parent, spouse or significant other who was supportive tended to do better in the program. Family was especially critical for establishing and maintaining sobriety.

Future of the Program:
Due to funding and other considerations, the SPAN program closed its doors on June 30, 2003.

[1] San Bernardino County Department of Behavioral Health and Sheriff's Department SPAN Program Final Report, page 47

SAN BERNARDINO COUNTY
SUPERVISED TREATMENT AFTER RELEASE – LESS INTENSIVE TREATMENT ENVIRONMENT (STAR-LITE)
MIOCRG I

Type of Program: In and primarily after custody – dual diagnosis – clinic based
Key Strategies: Longer term (6 – 12 months) case management services Court ordered as condition of probation; discharge planning; supported housing: linkage; transportation assistance; medication assistance; augmented outpatient services; probation involvement

Target Population: Jail inmates who suffered from pervasive mental disorders or mental disorders and substance abuse (co-occurring disorders); referred by court personnel in the Victorville, San Bernardino and Redlands Superior Courts; likely to be released to San Bernardino County; mental illness manageable with outpatient services; client medically stable and able to live safely in the community; excluded for criminal charges of serious violence or sex crimes
Study population: Enhanced Treatment 115; Treatment as Usual 137

Summary Description:
Operated in conjunction with SPAN, San Bernardino County's other MIOCR I program, STAR-LITE[1] was also housed at the SPAN clinic next to the West Valley Detention Center. STAR-LITE, built on the assumption that clients needed assistance to keep them working toward stability, provided six to 12 months of ongoing services after release and worked in close conjunction with the Court. The program's clients were under the jurisdiction of, and regularly monitored by, the Superior Court.

Like the short-term SPAN program, STAR-LITE provided assistance to released inmates through placement services, linkage to community mental health and social services, two weeks supply of medications, assistance with establishing Social Security and Medi-Cal benefits, short-term psychotherapy, medical services and substance abuse and alcohol counseling. Staff provided interface with probation and court services, referrals for vocational or employment assistance and help with family support.

Goals and Approach:
STAR-LITE's primary goal was to provide mental health services to reduce incarceration and recidivism of mentally ill and co-occurring disordered inmates. Clients' participation in the program and their use of services were continuously reported to the Superior Court. Clients were offered transportation assistance upon release and to first-time appointments with probation officers, mental health clinics, and various other agencies. Working within Superior Court mandates, ongoing case management included regularly scheduled court hearings in which their progress was reviewed for participation and compliance. Successful cases culminated in an official graduation; those who were unwilling or unable to follow through with their negotiated treatment plan could be terminated or even rearrested.

San Bernardino found that STAR-LITE, like SPAN, did not reduce recidivism. Although recidivism decreased in the first six months after completion of the program, it increased over time. On the positive side, however, the County reported that utilizing the Court to mandate services did accomplish improved client compliance with treatment, including using medications. Seventy-two percent of STAR-LITE clients

[1] STAR-LITE was modeled after a pre-existing San Bernardino County Department of Behavioral Health program called STAR (Supervised Treatment After Release), which worked with lower functioning clients who required more intensive services. STAR-LITE clients were higher functioning and required less professional assistance while in board and care placements, hence the 'LITE' part of its name ("less intensive treatment environment."

were reported to have followed through with treatment services, a much higher success rate than that of clients not mandated to pursue treatment (29%).[2]

Local Perspective of What Worked:
What worked in STAR-LITE was in some respects similar to and in others unique from what the County felt worked in SPAN. Again transportation services were seen as "a key factor" in clients overall success, as the program developed successful ways to assist and augment client transportation.[3]

The ability to find appropriate mental health and substance abuse placements for those clients who were committed to the program and wanted assistance was considered a major accomplishment. Staff were reported to have been highly successful in finding board and care homes, homeless shelters and various types of substance abuse programs for STAR-LITE persistently mentally ill clients who followed through with treatment.[4] Staff did note that the needs of the population far outstripped the resources available to them.

The presence of the Court and Probation was considered very important in motivating those clients who were on felony probation. It should be noted that probation participation was not a formal part of STAR-LITE, even though most participants were on probation. Clients who saw mental health services as an alternative to prison commonly responded favorably to the program and followed through with the treatment plan. Jail returns were significantly reduced for offenders in STAR-LITE; however, there was no statistically significant reduction in average jail days served thus it appeared that the contact provided by STAR-LITE allowed fewer returns to jail but did not reduce the number of days in jail for those who returned. [5]

Future of the Program:
Due to funding and other considerations, the STAR-LITE program, like SPAN, ceased operating on June 30, 2003.

[2] San Bernardino County Department of Behavioral Health and Sheriff's Department STAR-LITE Program Final Report, page 44
[3] op. cit., page 45
[4] ibid.
[5] op. cit. 45 - 46

SAN BERNARDINO COUNTY
THE PASSAGES PROGRAM
MIOCRG II

Type of Program: In custody and after – dual diagnosis
Key Strategies: Specialized day treatment; intensive mental health therapy and substance abuse treatment; intensive post-release case management; supported housing; court oversight; probation involvement

Target Population: Male, dually diagnosed mentally ill offenders with primary diagnosis of mental illness and secondary diagnosis of substance abuse disorders
Study population: Enhanced Treatment 68; Treatment as Usual 60

Summary Description:
The Passages Program was a jail-and-community-based intensive treatment program designed to provide a continuum of care to dually diagnosed mentally ill offenders with a primary diagnosis of mental illness and a secondary diagnosis of substance abuse. This program treated offenders from incarceration through release and community reintegration and stabilization using an array of intensive services provided by a collaborative team of professionals from the Department of Behavioral Health and the Sheriff's Department. Additionally, two designated Probation Officers, assigned from the Probation Department, provided immediate response and monitoring of offenders after release from jail to ensure compliance with the terms of probation. The Courts provided judicial oversight and review of participants in the Passages Program.

Goals and Approach:
The three major goals of the Passages Program were to significantly improve the community functioning of project participants, to reduce recidivism (in terms of both reincarceration rates and detention bed days), and to reduce adjudication and jail costs by using community treatment alternatives wherever safe and appropriate in lieu of jail. The program addressed these goals through the program's coordinated pre- and post-custody continuum of care.

Efforts to improve participants' community functioning, which the program hoped would lead to reductions in recidivism, began with the 90 day-to-one-year intensive treatment and recovery services provided in a day treatment format during incarceration. Elements of intensive day treatment included: occupational therapy (life skills, community groups and prevocational training); anger management; dual diagnosis, relapse prevention and step-study groups; discharge planning groups co-led by the Program's assigned Probation Officers; process-oriented individual therapy and family therapy; and medication and symptom management. These intensive, in-custody interventions were designed to serve as a foundation for participants' understanding of their mental illnesses and substance addictions in order to enable them to avoid repeating their patterns of incarceration.

All Passages Program participants received intensive case management services at and after release to assist them with the reintegration into the community. The services provided included exposure to vocational skills intended to aid participants in finding jobs instead of having to rely on public assistance. Upon release, those participants who needed housing were placed in a transitional home or board and care facility, depending on the participant's level of functioning. Having housing available to those participants who would otherwise be homeless removed a major obstacle, allowing them to concentrate on their treatment in the community instead of their need for housing. The program's Probation Officers collaborated with Passages' treatment staff to find treatment alternatives, instead of revoking probation, when substance relapse or medication non-compliance occurred with participants. Whenever possible, treatment facilities such as Cedar House and Gibson House were used in lieu of probation violations or revocations.

Local Perspective of What Worked:

The Passages Program pointed to its initial intensive in-custody treatment component as an aspect that 'worked' particularly well. Participants said it "aided in their following a treatment regime," and "gave them an understanding of their mental illness and substance addiction which upon release aided them in dealing with relapse triggers and medication compliance issues."[1]

Transitional housing upon release from custody was also credited with playing an important role in the Passages Program. Noting that there were many participants who would have been homeless upon release, the program reported that transitional housing gave participants time to reintegrate in the community without the worry of finding housing.

As a part of its vocational effort, the Passages Program initiated a pilot dog-training program in which a participant provided 12-weeks of obedience training to a dog from the local animal shelter with the goal of having the animal adopted by a family in the community. Passages participants gained vocational skills in addition to increased self-esteem and a more positive self-image. Moreover, the dog became part of day-to-day dorm life, so inmates other than the trainer benefited as well. Passages Program participants successfully trained two dogs and had them adopted into the community. The first became a pet therapy dog and is currently being trained as a crisis response dog. The pilot dog training effort has transitioned into a full time program at the Glen Helen Rehabilitation Center.

Future of the Program:

Due to budget constraints, the Passages Program was discontinued at the end of the grant. However, based on the County's experience with the Passages Program, a mental health component will be added, when staffing is available, to the previously existing In-Roads Program at the Glen Helen Rehabilitation Center, enabling it to provide both mental health and substance abuse treatment.

[1] San Bernardino County Mentally Ill Offender Crime Reduction (MIOCR) Demonstration Grant Summary – Passages, page 2

SAN DIEGO COUNTY
CONNECTIONS PROGRAM

Type of Program: Primarily after custody -- Community based
Key Strategies: Intensive case management using ACT; multi-disciplinary teams; pre-release treatment planning; linkage to community-based interventions; family involvement; strong probation involvement after release from jail

Target Population: Jail inmates with major mental health diagnoses; ordered to probation; exclusions included being on active State Parole and/or Federal Probation or Parole; having an INS hold, active felony warrants and/or holds from other jurisdictions; history of excessive violence; needing supervision by another program such as sex offender or gang unit; not a county resident or permitted to reside out of county
Study population: Enhanced Treatment 225; Treatment as Usual 224

Summary Description:
San Diego County's Connections Program used the principles of Assertive Community Treatment (ACT) and provided intensive case management by multi-disciplinary teams (MDT) – called service coordinating teams – comprised of a social worker, deputy probation officer (DPO) and correctional deputy probation officer (CDPO). The staff to client ratio was 1:10 and staff were available 24 hours a day; each team had a caseload maximum of 30 clients at a time. Staff's focus was to provide pre-release / transition planning and to broker and/or provide linkage to services for their clients in the community. Although they encountered several obstacles, staff made ongoing efforts to mitigate systemic difficulties that stood between their clients and the services they required.

Services were begun while the client was still in custody and continued for up to a year after release. The intensity of service was designed to decrease as the client became more stable and was linked to community resources. Services were driven by individual service plans, which were designed with the involvement of both the client and the client's family and/or significant others. Key elements of Connections' services could include a payee program to assist clients in managing finances, early intervention by the Psychiatric Emergency Response Team (PERT), case management focusing on long-term stability and substance abuse monitoring and intervention.

Goals and Approach:
The goal of Connections was to use service teams to help mentally ill offenders integrate successfully into the community in ways that would render them less likely to recidivate after program participation. To accomplish this, Connections provided continuous and coordinated mental health treatment and intensive case management services, crisis intervention and education about, as well as linkage to, resources in the community.

Because they were the lynchpin of the model, attention was paid to making the coordinating teams as effective as possible. Members of the five service coordination teams were provided thorough and ongoing training on subjects including the probation system, mental illness and co-occurring disorders. Staff development activities, such as monthly meetings, retreats and supervision meetings were used to help strengthen the teams' cohesiveness.

The County reported that findings from both their process and impact evaluations indicated that the program achieved its outcomes and met its intended goals. Connections clients felt they achieved a higher quality of life after program participation, with sufficient income to meet their basic needs such as housing, food and clothing. They reported using less alcohol and other substances and exhibited a higher level of functioning. The program also said it demonstrated the ability to reduce the recidivism

rate of participants. Connections clients had significantly fewer bookings, convictions and days spent in jail both during program participation and in the six-month follow-up period than did clients receiving treatment as usual.[1]

Local Perspective of What Worked:

San Diego County noted that Connections' use of multi-disciplinary teams was key to the program's effectiveness. The County said, "Although bringing together professionals from two distinct fields required a significant amount of training and attention, it was one of the strongest aspects of the project."[2] Both the partnering and the training that enabled it were identified among Connections' most successful features.

The melding of the enforcement/compliance role of Probation with the treatment role of the Social Worker provided a balance and means to address the multiple needs of the clients.

Intensive case management was also credited with having worked particularly well. The County reported that, "by providing intensive, consistent and directed support, Connections created a continuum of care that this population does not usually receive. The case management involved creating a client-centered case plan, going to the client, getting to know the client and his/her community, being consistent, anticipating set-backs and providing advocacy when needed."[3]

San Diego further noted that partnering with the community was an important element of the project. Noting that it was necessary to educate providers and the community to see mentally ill offenders as citizens and not criminals, and that there was "an undeniable shortage of resources," Connections nonetheless reported having created trust with service providers to facilitate access for its clients.

Future of the Program:

Connections as designed and implemented for the MIOCR grant no longer exists due to fiscal constraints facing the County. Both Probation and the Sheriff's Department remain committed to providing specialized services to the mentally ill offender population and both are continuing some of the service elements developed for Connections.

[1] San Diego County's Connections Program board of Corrections Final Report, page 110
[2] ibid.
[3] op. cit., page 111

SAN FRANCISCO COUNTY
MENTALLY ILL OFFENDERS CRIME REDUCTION GRANT
MIOCRG I

Type of Program: In and after custody – Community and clinic based – High Risk
Key Strategies: Intensive case management via modified ACT and Citywide Case Management model; multi-disciplinary team; medication and money management; probation involvement

Target Population: Mentally ill jail inmates at risk for being committed to prison; serious Axis I and/or II disorders or a history of prescription of psychiatric medications for those disorders; held on felony charge; two prior local bookings since 1993; SF resident; not currently participating in Citywide Case Management programs; agreed to participate in study; excluded for charges of serious, violent offenses; prior conviction of murder or rape; currently on a 5150 hold; or not mentally competent to be arraigned
Study population: Enhanced Treatment 93; Treatment as Usual 113

Summary Description:
San Francisco's MIOCRG I program compared an enhanced treatment intervention – Forensic Support Services (FSS) – with treatment as usual, delivered through an existing program, Jail Aftercare Services (JAS). FSS was a 4-year, multi-agency collaborative project through the University of California San Francisco's Citywide Case Management Program to provide intensive case management to mentally ill offenders who had committed felonies and was an adaptation of the ACT intervention model with the Citywide Case Management model. Both FSS and JAS were initiated during incarceration; however, only FSS provided out-of-custody services after release from jail.

Goals and Approach:
The goal of the demonstration project was to provide a cost effective intervention to mentally ill offenders in the San Francisco County Jail that would reduce offenders' involvement with the criminal justice system and provide treatment for their mental illness in the community mental health system. FSS delivered services in a modified ACT model, using a multidisciplinary team to case management and service delivery. Although many services were provided at a clinic site, team members routinely met with clients in their living milieu. In addition to traditional individual and group counseling, case management, medication and money management and substance abuse treatment, the team provided a range of socialization, skill building, recreation and pre-vocational opportunities. Throughout their enrollment in the programs, clients were able to access a case manager 24 hours a day. In the event of incarceration, hospitalization or acute events, case managers met with staff at the institution immediately to ensure continuity of care. FSS was designed to provide services to clients for as long as they wished to use them.

FSS was structured around four phases – 1) client engagement; 2) treatment initiation, 3) intensive treatment, 4) graduated independence / aftercare. Participants moved through phases according to their ability to manage symptoms and comply with their treatment plans rather than according to a pre-determined timetable. Clients were always welcome to reenter a more intense treatment phase according to their needs.

FSS clients were assigned to the Adult Probation Department's Intensive Supervision Unit (ISU). Probation Officers were on-site at the FSS offices and were experienced in working with mentally ill probationers. ISU Probation Officers had smaller caseloads than non-ISU officers, to allow for more frequent contact with assigned clients.

While parolees were not included in the randomized study, they were mandated into FSS. Mentally ill parolees received services from the parole outpatient mental health program. Services generally involved one or two visits per month with a counselor. Parole officers monitored the behavior of parolees; missed appointments, medication non-compliance, or positive drug screens were initially considered parole violations that returned the parolee to prison. FSS negotiated with the parole program to loosen the requirements so clients could have up to 3 or 4 positive drug scans before being violated.

Local Perspective of What Worked:
As a result of the increased visibility of both JAS and FSS in the courts, it is now an expectation that a mental health provider will be present in court for mentally ill offenders. The program's efforts to raise awareness of mental health issues resulted in the creation of a Behavioral Health Court, in which a judge, assistant public defender, assistant district attorney and mental health staff work together to generate and oversee treatment plans for mentally ill offenders.

While the overarching hypothesis that FSS would be a more effective and cost-effective intervention than JAS was not supported, significantly fewer FSS than JAS participants received prison commitments and the program reported that FSS was more effective in achieving client stabilization and socialization.[1]

San Francisco further noted that FSS shifted the relationships between parole and probation officers and their mentally ill clients from antagonistic to more trusting and collaborative. As a result, the project said, officers worked through non-compliance issues with their clients rather than automatically violating them and clients were more likely to keep appointments with officers because they were less fearful of being returned to jail or prison.[2]

Future of the Program:
Although FSS ended at the conclusion of the grant, the "most successful elements of FSS and JAS were said to have been incorporated into a new Behavioral Health Court, providing systematized collaboration between criminal justice personnel and mental health programs.[3]

[1] UC San Francisco, Department of Psychiatry, Treatment Outcome Research Group, Final Program Report, Mentally Ill Offender Crime Reduction Grant Program, page 33
[2] ibid.
[3] op. cit., page 45

SAN FRANCISCO COUNTY CONNECTIONS PROGRAM MIOCRG II

Type of Program: Pre-trial diversion – Community based
Key Strategies: Intensive case management; ACT model; linkage; medication support; housing support; employment training; benefits advocacy; day treatment

Target Population: Mentally ill offenders in jail for felonies or misdemeanors, not yet convicted; Axis I, II, or III disorders; excluded for domestic violence charges, current felony charges for violent crimes, weapons charges, sex crimes charges or arson charges or posing safety risk to others
Study population: Enhanced Treatment 138; no comparison group

Summary Description:
Connections was a pre-trial diversion program that provided comprehensive mental health case management, housing, benefits counseling and other support services to mentally ill offenders in lieu of incarceration. The program was administered by the San Francisco Sheriff's Department, which subcontracted for services with community agencies. Connections' multi-agency collaboration involved the Sheriff's Department, the courts, community-based advocates for the incarcerated, the Department of Public Health, psychiatrists, mental health case workers and community-based mental health service professionals. Organizations specializing in housing, benefits and entitlements and employment training were also partners.

Goals and Approach:
Connections sought to enable its clients to successfully complete their court case(s); obtain benefits and entitlements; get linked to community-based health and social services; and successfully complete a treatment plan co-developed by the Connections case manager and the client, which included immediate interventions to help clients reach the stability necessary to access mainstream services. Connections also sought to positively affect organizational relationships between criminal justice and mental health systems. The innovative structure of the Connections program sought to create linkages across traditional barriers to service, using the existing Sheriff's release programs as its foundation. The project's systems-level goals were "to break down distinctions between 'mental health people' and 'criminal justice people' and to permit mentally ill offenders to be positively accepted as mental health clients in the community mental health system."[1]

The program's two 'gatekeeper' agencies were the Center on Juvenile and Criminal Justice (CJCJ) and the San Francisco Pretrial Diversion Project (PTD). These agencies were responsible for initiating client contact, determining eligibility, developing the treatment plan with the client and providing the criminal justice case supervision as required by the court. The mental health component of Connections provided diagnosis, mental health case management, linkage of clients to community-based mental health services, medication support and social / emotional support to stabilize clients and assist them in learning to access community services even after completing their Connections treatment plan.

To address housing issues, Connections acquired a master lease for 30 rooms in a downtown residence and used these rooms as temporary housing for clients, with case managers on-site to provide support services. Lutheran Social Services was contracted to deal with benefits advocacy, money management

[1] Harder + Company Community Research, Evaluation of the Connections Program: Impact of a Jail Alternative Program for Mentally Ill Offenders, pages 5 - 6

and representative payee services. Community Vocational Enterprises, a local organization focused on innovative employment training, placement and support for people with psychiatric disorders, offered incentive-based training to Connections clients referred to them by CJCJ or PTD. When a need was identified for a place for clients to go during the day to participate in structured activities and receive peer support, the program created the Court Accountability Case Management Center (CACMC) to provide such activities on a daily basis as courses on life skills, substance abuse, health and nutrition, food preparation, anger and stress management; individual and group counseling (in English and Spanish); social support; and harm reduction.

Local Perspective of What Worked:
San Francisco reported, "...trend data clearly showed that the provision of mental health services, case management, and the other services provided by Connections did have an effect on recidivism." The number of times clients were booked into jail, the number of days they spent in jail and the number of clients with one or more convictions all declined after starting the Connections program.[2]

Noted as particularly effective were the Program's collaborations and the interagency communication and coordination processes. The mechanisms put in place to ensure the efficiency and effectiveness of the multidisciplinary collaboration was called Connections' "key success factor."[3] The Court Accountability Case Management Center was highlighted as an extremely successful example of how the Connections collaboration was able to identify client needs and create a way to address those needs that simultaneously met court expectations.

The program was also proud that 84% of clients surveyed said being in Connections made them feel somebody cared about them. This was attributed to the high-quality connections with program staff and was described as key to the program's success.

Future of the Program:
The Connections Program was discontinued in June 2003 due to state budget cuts. However, clients are said to be still receiving many of the services they got from Connections through the newly established Behavioral Health Court.

[2] op. cit., pages 8 and 67
[3] op cit., pages 11 and 81-82

SAN JOAQUIN COUNTY
MENTAL HEALTH COURT PROJECT/ACTION TEAM

Type of Program: In and primarily after custody – community based
Key Strategies: Mental Health Court; ACT; assertive case management; multi-disciplinary team; individual, group and substance abuse counseling; housing support; crisis intervention; transportation; medication support; day treatment socialization support; planning for housing; peer groups

Target Population: Non-violent mentally ill offenders, age 18 or older, facing misdemeanor or felony charges in the County criminal justice system; a primary major mental illness diagnosis (Axis I) which produces significant impairment in life functioning; high risk for recidivism due to mental health conditions; resident of San Joaquin County; willing to participate
Study population: Enhanced Treatment 120; TAU 60

Summary Description:
The San Joaquin County Mental Health Court Project/ACTion Team combined a mental health court with Assertive Community Treatment (ACT) model services delivered by a multi-disciplinary team using assertive case management. Offenders were referred to the project at the time of booking when the Correctional Mental Health Care staff reviewed offenders' records to determine if there was a history of mental health contacts. Sometimes at the request of the court, this review also was done prior to disposition of the case. In addition, referrals came from others in the community who wished to have an individual in jail evaluated for services. Eligible individuals were randomly assigned to either the enhanced treatment (ACT services) or treatment-as-usual (Mental Health case management services) group. Offenders assigned to the enhanced treatment group were considered ACTion Team Members and were offered case management, substance abuse treatment, sponsorship, education, vocational training, family and parent education, and cultural and spiritual growth groups and other services. Financial planning and budgeting were also included in individual treatment plans.

Goals and Approach:
The overall goal of this project was to develop a comprehensive, collaborative and integrated plan for implementing a swift, certain and graduated response for reducing crime and criminal justice costs related to mentally ill offenders. More specifically, the Mental Health Court Project focused on prompt and effective mental health assessments, court oversight, and Assertive Community Treatment (ACT). The goal of the ACTion Team was to empower each offender to maintain mental stability and improve quality of life without re-offending.

The Mental Health Court involved a specific Superior Court Judge who adjudicated cases of eligible participants and reviewed individual cases with the multidisciplinary team in chambers preceding an offender's appearance before the judge. As clients experienced difficulties in community adjustment, they were summoned back to the judge for review. Special attention was focused on altering and modifying sentences and community treatment in response to the client's actions. When necessary this involved jail time. As an incentive for the mentally ill offender to participant in treatment, it was agreed that offenders could, on a case-by-case basis, possibly have their charges dropped at the end of the eighteen-month program period.

A key component of the project was the close working relationship among mental health and justice system personnel and community organizations. The ACTion Team included specialists in housing, education and eligibility. The ACTion Team was Medi-Cal certified and billed Medi-Cal for treatment and related services. The Team successfully sought reimbursement from SSI claims and client payment plans for services rendered. An added component was a Day Reporting Program that included individual and group counseling with emphasis on substance abuse issues.

Local Perspective Of What Worked:

A continuum of services was key to the success of this project. Beginning in the jail with initial client contact, individual treatment options were designed with a long term goal of reducing crime and cutting future criminal justice costs.

Clients were referred to the San Joaquin County Mental Health Court, where a specific Judge oversaw mentally ill offenders' cases throughout the period of treatment and involvement in the project. Working with the Judge, a multidisciplinary team met in chambers and members were always present in the courtroom. Partnerships in the courtroom laid the foundation for an effective collaboration in the community to encourage an individual client's success.

Treatment provided by the ACTion Team via assertive case management provided 24-hour client support. Various forms of community outreach including housing liaison and placement plus the use of a revolving fund account for such items as rental and utility security deposits contributed to the successful transitioning of clients from institutional living to self-supporting living arrangements in the community.

Interviews conducted with program participants, program graduates and Mental Health Court Project administrators and providers yielded the finding that clients were enthusiastic about the positive changes that had occurred in their lives thanks to the program. One client reported eating regularly now, as well as being able to take consistent showers. He also no longer worried about the "police being after him." Another client worked with her ACTion Team case manager to reach sobriety and regain visitation rights to her daughter.

Providers noted the successful collaboration between participating agencies and departments (including the District Attorney and Public Defender's offices), serving treatment clients in the community, assisting clients with medication compliance, as well as the Court's willingness in providing feedback directly to clients (whether positive or negative) as the project's greatest strengths. They also said the dedication and commitment of the ACTion Team Case Managers helped ensure that clients attended required court appearances, maintained appointments (i.e. SSI), and developed a sense of stability in the community.

Future of the Program:

While the San Joaquin County Mental Health Court Project has been considered successful, diminishing funds threaten this program. The Court is interested in maintaining the project and components of the multi-disciplinary team are supportive; however, as grant funding ended, people were reassigned. A federal grant has been applied for to maintain the project. In the meantime, San Joaquin County Mental Health has awarded the Human Resources Project, the CBO responsible for the ACTion Team component, a $36,000 contract to continue treatment services and to keep treatment options open until the outcome of the grant is known. Proposition 36 funds for those qualified are also being used. In addition, the County has begun to discuss using funds from the recently passed Mental Health Initiative (Proposition 63 on the November 2004 ballot). However, these funds will not be available until Spring 2005.

SAN MATEO COUNTY
THE OPTIONS PROJECT

Type of Program: Primarily after custody -- Community based
Key Strategies: Intensive case management with a focus on co-occurring disorders; ACT model; multi-disciplinary team; supportive housing; court involvement; strong probation involvement

Target Population: Jail inmates with serious and chronic mental illness; residents of San Mateo County; not charged with a heinous crime
Study population: Enhanced Treatment 37; Treatment as Usual 36

Summary Description:
The Options Project provided intensive case management in the Assertive Community Treatment (ACT) model, using a multi-disciplinary team and creative strategies for engagement. Partners in the Options Project – Mental Health, Probation, Correctional Mental Health and the Sheriff's Department – jointly provided close monitoring and collaborative interaction with clients. The case managers, probation officers and staff psychiatrist held weekly meetings for treatment planning and to coordinate client care, and case managers were issued County cars and cell phones to facilitate transportation and communication. Program oversight and ongoing coordination were provided by monthly MIOCRG Steering Committee meetings that yielded management-level support and guidance for programmatic policy and process and served to quickly solve problems as they arose.

Goals and Approach:
The primary goal of the Options Project was to reduce recidivism among mentally ill offenders by engaging them in intensive community case management combined with intensive probation supervision. Additional goals included reducing overcrowding in San Mateo County's jails and reducing criminal justice costs. To address these goals, Options provided a range of services including but not limited to help with benefit acquisition and money management and placement in community housing or residential treatment for dual diagnosis/substance abusing clients. The Project contracted for 10 shelter beds to provide transitional housing for clients returning to the community from jail and also used beds in existing mental health and substance abuse treatment programs as needed. Additionally, the project offered consumer-run monthly support groups, which included guest speakers on educational topics chosen by clients/consumers, as well as additional social activities designed to inspire peer bonding and mutual support.

Innovative bi-monthly case review meetings were implemented in which clients presented progress reports to a formal panel comprised of the case management supervisor, case managers, the probation supervisor, probation officers and forensic mental health staff. This self-review process was designed to replace courtroom appearances in front of a judge and to build in accountability and support for clients.

Local Perspective of What Worked:
The Options Project reported that its "intensive case management in collaboration with intensive probation/court supervision" clearly demonstrated its efficacy by producing a "reduction in incarceration days, reduction in court costs as well as improved quality of life for Options clients."[1]

Additionally, the project's interagency cooperation and collaboration was noted as particularly effective in accomplishing the intended outcomes and helping to build credibility for Options' services with the judiciary. One of the County's judges was reported to have been not only "effusive in his praise of the

[1] San Mateo County Mental Health Service, A Summary of the Options Project, page 2

program," but also convinced to introduce the idea of a mental health court for San Mateo County as a result of his experience with Options.[2]

Future of the Program:
The Options Project was discontinued at the end of the grant period due to fiscal constraints facing the County. However, San Mateo County continues to research potential resources that would support the future continuation of the most successful aspects of the project.

[2] ibid.

SANTA BARBARA COUNTY
MENTAL HEALTH TREATMENT COURT WITH INTENSIVE CASE MANAGEMENT

Type of Program: Diversion, either pre-plea or post-adjudication – Community-based
Key Strategies: Mental Health Treatment Court; case management in ACT model; intensive care teams; housing support; vocational horticulture training; substance abuse treatment; strong court involvement

Target Population: Adult charged with non-violent felony or misdemeanor with at least one prior booking; diagnosed with serious mental illness; resident of Santa Barbara County; agreed to participate; exclusions – for pre-plea participants – no prior offenses that involved serious acts of violence; for post-conviction participants – could have past violence if the MHTC team members determined the person no longer posed a threat of danger to others
Study population: Enhanced Treatment 137; Treatment as Usual 98

Summary Description:
Santa Barbara County's MIOCR grant was used to develop two mental health treatment courts (MHTC) – one in Santa Barbara and one in Santa Maria. The MHTCs provided non-adversarial criminal processing in conjunction with either pre-plea or post-adjudication diversion to mental health services that used an assertive community treatment (ACT) approach to case management. In so far as both MHTC and ACT models had shown promise for helping mentally ill offenders, Santa Barbara elected to test combining the two, and further to determine if the combined approach would be more beneficial to offenders with mental illness than their existing approach. The primary differences between the enhanced treatment and treatment as usual (TAU) were the adversarial vs. non-adversarial criminal processing, the intensity of case management, opportunities for housing, specialized vocational training and the availability of treatment groups to help with substance abuse and community integration.

Goals and Approach:
The goals of the MHTC with Intensive Case Management were to reduce criminal activity, improve functioning, improve life satisfaction, reduce psychological distress and reduce alcohol and drug problems for mentally ill offenders in Santa Barbara's criminal justice system. To address those goals, the program incorporated procedures adapted from the drug court model of non-adversarial criminal processing and intensive court supervision. A treatment team that met before each court session made decisions regarding eligible participants. Offenders were scheduled for weekly or bi-weekly court supervision.

Participants were assigned a case manager within an intensive care team. Following the ACT model, case managers had frequent contact with their clients and helped them with practical needs, such as assistance in obtaining resources including transportation to meetings, as well as their psychological concerns. In addition to intensive case management, participants in the MHTC attended Substance Abuse Maintenance Management (SAMM) and Community Reentry groups conducted by the Intensive Support team. Further, participants had access to housing, a horticulture vocational training program and group interventions for substance abuse treatment and community integration. Participants received the intensive treatment for 18 months, after which, if necessary, they were referred to long-term county services.

Participation in the MHTC was voluntary and could be terminated by the client at any time. Premature termination from the program resulted in the client being faced with the same legal charges s/he had on entry to the program. For pre-plea offenders, graduation from the program resulted in their charges being dropped, while post-conviction offenders received reductions of their terms of probation.

Local Perspective Of What Worked:

A key finding of the Santa Barbara MHTC study was that, for the majority of offenders – 80% – the program was reported to have resulted in a significant reduction in jail days, improvement in psychosocial functioning and life satisfaction, as well as reductions in psychological distress and drug and alcohol use. The County said its findings suggested that the types of treatment provided did in fact help participants reduce their substance abuse, develop independent living skills and enjoy a higher quality of life.[1] Santa Barbara also noted that for about 20% of the offenders in the study (10% who ended up going to prison and another 10% who used over 50% of all post-treatment jail days) neither form of treatment – the MHTC or TAU – was sufficient to prevent them from being incarcerated for longer periods of time than had been the case prior to program entry. The County posited, "Those who were not helped actually appeared to be getting worse over time. The needs of these clients may not be well met by this type of outpatient program, suggesting the need for other types of more intensive programming for some individuals."[2]

This program had impact at both individual and community levels. … Participants were able to access and utilize services with a treatment focus that covered broad-based skills for living in the community. It was the community-level changes, however, and the development of system-wide staff training and service integration across mental health and criminal justice systems that encouraged offenders to engage in treatment and allowed them to remain in the program despite occasional relapses and recidivism.

The use of case managers who understood participants' specific needs and were willing to help them with their complex psychosocial, medical, vocational and legal problems was considered a major factor in participants using needed interventions and remaining stable in the community.

Future of the Program:

The Mental Health Treatment Court in Santa Barbara has reduced its service capacity but intends to return to full operation as soon as funding is secured to do so; the Mental Health Treatment Court in Santa Maria is continuing.

[1] Merith Cosden et al, Gevritz Graduate School of Education, UC Santa Barbara, Evaluation of the Santa Barbara County Mental Health Treatment Court With Intensive Case Management, pages 65-66

[2] op. cit., page 71

SANTA CLARA COUNTY
PROVIDING ASSISTANCE WITH LINKAGE TO SERVICES (PALS) PROGRAM

Type of Program: Primarily after custody -- Community based
Key Strategies: Short-term (60 day) linkage, case management immediately upon release from custody, medication support, substance abuse treatment, housing support

Target Population: Seriously mentally ill jail inmates, fully sentenced, about to be released to Santa Clara County; excluded for: out of county warrants, being prison-bound, being released to 24-hour care, under conservatorship, assessed as a threat to program staff, not willing to abide by program rules, referred to Intensive Alternatives Program, and/or unable to give informed consent due to organic brain syndrome, active psychotic condition, developmental disability or other intellectual limitation preventing understanding the consequences of participating
Study population: Enhanced Treatment 106; Treatment as Usual 100

Summary Description:
Providing Assistance with Linkage to Services – The PALS Program – used a small team of service providers for short-term (60 days) case management and linkage to key support services, counseling and transportation for mentally ill offenders immediately after custody. PALS was reported to be the only program in Santa Clara County that provided seriously mentally ill inmates assistance and support upon release from jail.

Goals and Approach:
The PALS Program was designed to be a cost effective alternative to more expensive, more intensive case management. One of the program's underlying principles was that, "Without effective linkage to services, a high percentage of mentally ill offenders do not follow their discharge plan and 'fall through the cracks,' becoming lost to further assistance." The main hypothesis PALS tested was that short-term, hands-on support and linkage to services would promote more effective engagement in follow-up services resulting in decreased recidivism and decreased use of emergency and unplanned psychiatric services.[1]

PALS Program staff developed clients' individual treatment plan while the participants were still in custody and then met clients 'at the door of the jail' when they were released. Staff transported these clients to get their psychotropic medications, reconnect to their previous housing or get involved in a local shelter, get clothing if needed, register with local law enforcement agencies and report to probation.

During the 60-day program period, staff provided weekly counseling, daily phone call contacts, crisis intervention when appropriate (e.g., transporting clients to receive psychiatric stabilization at local emergency psychiatric facilities, etc.) and 24/7 availability. Staff also worked with other entities to connect clients to: substance abuse treatment services, required classes for the court system such as domestic violence, parenting and DUI, service team and psychiatric evaluation, ongoing housing and local support groups. Moreover, they helped clients 'stay on track' with follow-up court dates and probation appointments, and assisted in obtaining and/or continuing SSI and other entitlements.

Local Perspective Of What Worked:
The County noted that, while the Program's 60-day case management and linkage support had a limited ability to have enduring impact, The PALS Program did demonstrate short-term effects in the 60 day and

[1] Reiser Healthcae Consulting, Final Program Report, The Santa Clara County PALS Program: A Systematic Approach to Providing Assistance with Linkage to Services

six month follow-up periods post release from custody. PALS Program participation was said to have increased the likelihood that clients would receive significantly more intensive or frequent case management services, vocational services, transportation services, treatment plan development services and contact with mental health courts/legal personnel. "... At both six months and one year follow-up, clients in The PALS Program reported significantly more positive experiences in terms of support, counseling and linkage to services than the treatment as usual group."[2]

Clients were said to have felt that 'what worked' was The PALS Program staff and its services. In particular, clients were reported to have endorsed the helpfulness of the program in terms of staff support, provision of transportation, linkages to mental health and psychiatric services, assistance with housing and appointment reminders.[3]

The County concluded that, while the 60-day short-term support and linkage approach continues to be promising, the target population needs more enduring long-term assistance for the interventions to have a significant impact on behavior and lifestyle. A more extended period of support may be required, the County said, to maintain seriously mentally ill offenders in services.[4]

Future of the Program:
The PALS Program is ongoing.

[2] op. cit., page 68
[3] op. cit., page 54
[4] op. cit., page 70

SANTA CRUZ COUNTY
MAINTAINING ONGOING STABILITY THROUGH TREATMENT (MOST) PROGRAM

Type of Program: Post custody – Community-based with a center
Key Strategies: ACT coupled with probation authority; multi-disciplinary teams; case management; strong probation involvement

Target Population: Out of custody adults diagnosed by the County Mental Health Services Agency as seriously mentally ill, with at least two arrests in the three years prior to the grant; on mental health probation caseload
Study population: Enhanced Treatment 76; Treatment as Usual 77

Summary Description:
The MOST Program provided intensive case management and support in an Assertive Community Treatment (ACT) model enhanced by the addition of probation authority as demonstrated in the State Department of Mental Health's Conditional Release Program (CONREP). In keeping with the ACT construct, MOST used a multi-disciplinary team that included both professional and paraprofessional members, focused on individual strengths instead of pathology, sought to build primary relationships between clients and case managers or care coordinators, developed a treatment plan tailored to individuals' needs and linked clients to a variety of community resources.

Goals and Approach:
The MOST team carried caseloads averaging between 12 – 15 clients. Team members met and worked with clients at places of the clients' choosing as well as at the team's offices, which were co-located with a non-traditional multi-service center operated entirely by mental health consumers. The MOST team utilized this center as an informal, active drop-in site for participants.

The frequency of contact and provision of services to MOST clients varied according to perceived and reported need. In the most acute circumstances, staff members would make contact twice a day, seven days a week. Nursing and psychiatric interventions were made available on a daily basis when indicated.

The entire MOST team met four days each week to review clients' status, prioritize interventions and triage emergencies. As each client was identified, team members collaborated to develop a treatment plan addressing both the strengths and weaknesses the client was exhibiting and noted planned interventions. Team meetings also were the forum wherein interventions were planned and primary interveners were designated.

The MOST team placed a high priority on working initially on clients' dual issues of benefits and housing. All clients not receiving benefits upon entering MOST were assisted in applying for SSI / Medi-Cal and any other income assistance entitlements available. Once the client had a steady source of income, then applications to various treatment facilities and/or housing programs, such as the HUD Section 8 program, were initiated.

Additionally, clients' individualized treatment plans addressed dental and medical problems, training and educational needs, substance abuse treatment and volunteer/leisure time activity. The MOST team said it linked a majority of clients with meaningful, interesting, and community-oriented activities such as volunteer work and educational/vocational opportunities. About one-third helped at a local food bank, where they received groceries or an hourly stipend for their work. About one-quarter of clients explored educational and vocational training options. Those pursuing such goals were linked to available community resources in an effort to assess skills and readiness for school and/or work. MOST team members then helped facilitate clients' entry into school or a vocational center, often working with

Disabled Student Services, and helped clients address their social or functional impairments in these new settings.

Local Perspective Of What Worked:

Collaboration among MOST team members was identified as an especially effective element of the program because, among other advantages, it allowed the team to quickly determine and respond to issues related to their clients. The team atmosphere of shared goals and responsibilities was said to have contributed to better staff cohesiveness and morale, thereby not only providing a positive environment for team members and clients, but also yielding a benefit for supervisors and management.

Santa Cruz also reported that the use of the informal 'clubhouse' model of client engagement led to improved relationships with MOST clients, many of whom were initially suspicious of, and resistant to, efforts to engage them. For many, this was their first 'family' experience.

The project noted that, by the end of the grant period, nearly all MOST clients had SSI / Medi-Cal and all had received some sort of income assistance. With stable income, clients could apply for permanent housing; in fact, more than half of the caseload received HUD Section 8 vouchers, entitling them to access Federal housing and requiring that they spend no more than 30% of their income for housing costs. In addition, a 'flex fund,' established to assist clients with security deposits and initial rent payments, became a budget-learning tool for many clients, who were paying back their first-ever loans. Eventually the flex fund was also used for the purchase of consumer goods, most often computers. Santa Cruz also noted that the vast majority of loans were repaid, most in a timely fashion.

The project's attention to clients' overall physical health was noted as effective. By program's end, the County said, the majority of clients' health had improved and most had demonstrated a dramatic decrease in their use/abuse of substances.

Future of the Program:

While MOST was not entirely replicated at the end of the grant period, several components were continued by means of reformulating a pre-existing team into an ACT team, which serves seriously mentally ill probationers, with Medi-Cal or Short-Doyle funding, who are in danger of being hospitalized or re-incarcerated.

SOLANO COUNTY
MENTAL HEALTH COURT PROJECT

Type of Program: Primarily after custody – Mental Health Court – community and center- based
Key Strategies: 3-6 months intensive community treatment followed by 6-12 month aftercare; intensive case management; collaboration with community providers; drop-in center; crisis residential treatment targeted to mentally ill and dually diagnosed habitual offenders; transitional aftercare

Target Population: Adults booked into the Solano County Jail who had a serious mental illness that significantly impaired their functioning; agreed to participate; excluded if not a County resident, serious felony charges pending, on parole or had multiple violations of probation and a pending state prison sentence and/or prior criminal history of serious felony
Study population: For whom there was at least 6 months of data - Enhanced Treatment 44; Treatment as Usual 26

Summary Description:
Solano County's Mentally Ill Offender project had four major components – a Mental Health Court; Transitional Community Treatment consisting of outpatient treatment and intensive case management for 3 to 6 months; a short-term Adult Residential Treatment component specifically targeted to mentally ill and dually diagnosed offenders used for crisis intervention; and Aftercare Services, for 6 to 12 months, to transition program graduates to mainstream treatment services.

Goals and Approach:
The mission of the project was to determine whether enhanced mental health services would curb the frequency of recidivism among participants who were both chronically mentally ill and chronic offenders. Its major goal was to establish a comprehensive continuum of care for mentally ill offenders that would enhance public safety, reduce the number and severity of offenses committed by mentally ill individuals, and improve the quality of life of offenders with mental illness. The County used an enhanced services model to address these goals, consisting of a court supervised intensive, structured and individualized community treatment program.

The guiding principles of the Mental Health Court included:
- *The involvement of consumer and family members …*
- *Access to appropriate and flexible mental health services …*
- *The jail is a community institution, and the mentally ill inmate is a community concern.*
- *Creative use of existing resources can encourage and inspire … needed changes without the massive infusion of new resources.*
- *Cross training of law enforcement, mental health, and corrections personnel is crucial.*

The Mental Health Court and Mental Health Team provided the overarching framework within which the other three treatment components took place. The Mental Health Court's goal was "to place participants in treatment programs and link them with appropriate services so that, when their participation was concluded, they would continue to make use of resources that would assist them to function normally and not return to the criminal justice system." [1] The Court ordered treatment to meet the individual's needs and circumstances and monitored the participants' use of these services. Participants who were successful moved from intensive services to more independent, self-sufficient living situations and completed probation successfully.

[1] Resource Development Associates, Solano County Sheriff's Office Mentally Ill Offender Crime Reduction Grant Demonstration Program Evaluation Report, page 7

The Transitional Community Treatment (TCT) component, provided by Telecare, used a team approach similar to the ACT model, and facilitated clients' dropping in to the Telecare TCT office for assistance. This provided clients access to daytime drop-in services and round the clock access to treatment providers by telephone. The Telecare TCT office provided participants with a nurturing and structured environment where clients could establish supportive relationships with one another. The Crisis Residential treatment component – Community House – additionally met short-term housing and crisis resolution needs of the client population.

Local Perspective Of What Worked:

Solano County reported that the Mental Health Court project created an environment blending accountability and positive, therapeutic support to which participants reacted positively. The project was said to have removed system barriers and allowed the different agencies working on a particular case to focus the discussion and advocacy on the best interests of the individual participant. As a result, the project demonstrated a positive effect in reducing inpatient psychiatric hospitalizations and decreasing jail days served. It was also said to have been successful in improving client well being.[2]

The Telecare TCT was considered a strong partner in the collaboration. Telecare was credited with establishing strong connections to the participants, getting to know them well and providing good recommendations to the Court.[3]

The County noted, as a significant accomplishment, that 12 individuals were assisted with applying for and receiving Supplemental Security Income. Of these, 5 were enrolled who never previously had benefits and 7 had coverage reinstated.

The Mental Health Court itself was seen as a very successful element of the project. The Judge was praised for his thoughtfulness and concern for every client in the program. Team meetings were felt to be productive and to focus on program clients in a thoughtful and respectful fashion that contributed to their willingness to commit to the program.[4]

Future of the Program:

The Solano County Mental Health Court was discontinued due to fiscal constraints, officially ending November 30, 2003.

[2] op. cit., pages 2-3
[3] op. cit., page 40
[4] ibid.

SONOMA COUNTY
FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT) PROGRAM

Type of Program: In custody, community and center based program.
Key Strategies: ACT; intensive case management; creation of a Mental Health Court calendar in order to enroll clients and monitor cases; probation officer on treatment team; medication support; housing support; dual diagnosis/dual recovery approach; money management; required groups

Target Population: Inmates booked into Sonoma County Jail; priority to those with two or more previous incarcerations and/or failures to appear; inmates with no previous incarceration eligible if the Mental Health Court determined them to be at risk for recidivism; severe mental health diagnosis; repeated contact with the mental health system; Sonoma County residents; willing to participate; exclusions for history of arrests for serious violent offenses
Study population: Enhanced Treatment 149 enrolled; 90 completed at least one year; no comparison group

Summary Description:
Sonoma County's Forensic Assertive Community Treatment (FACT) Program was a collaboration of multiple agencies involved in the criminal justice and mental health and substance abuse services systems in the County. The FACT Program, in operation from March 1999 to March 2004, was an expansion of the ACT model. It was an integrated service program that included intensive case management incorporating psychiatric consultation and medication management, an on-site probation officer, 24/7 staff availability for crisis intervention, supportive housing and access to residential dual recovery treatment beds.

Goals and Approach:
The goals of the FACT Program were to reduce hospitalization, jail time, convictions and failures to appear (FTA) while providing cost effective services to mentally ill offenders. These goals were addressed by an intensive team approach, involving mental health staff with staff from the Sheriff's Department, Probation Department, the District Attorney, Public Defender, Superior Court and Santa Rosa Police Department. A probation officer was part of the FACT team and was housed on-site at the program. Sonoma County created a Mental Health Court (MHC) which served as the main contact point for FACT clients' with the court system. Eligible offenders, who were willing to participate, were offered the FACT Program as a sentencing option through the MHC. Although participants could elect to withdraw from the FACT Program at any time, such withdrawal could result in reincarceration or the extension of probation.

FACT clients were required to be in attendance at the program's office several days each week, to meet weekly (and often daily) with their assigned case manager and to meet at least monthly with the program's psychiatrist. Clients were offered support and medication management services to stabilize psychiatric symptoms. FACT case managers brokered services for clients, with the most common referrals being to NA and AA meetings, outpatient or residential substance abuse treatment, emergency or transitional housing and supported housing.

Clients were also required to participate in a money management program, to undergo random and scheduled urinalysis and to participate in several groups a week. Groups included education about mental heath/substance abuse issues, recovery support, symptom management, health/nutrition, independent living skills and other topics. Once a client's court-mandated term of FACT participation was completed, the client could 'graduate' from the program but could also elect to continue to participate and work toward stability.

Local Perspective Of What Worked:

Sonoma County reported that "Offenders who participated in the program for one year or more were found to have an 81% reduction in jail days, a 50% reduction in hospitalization, a 66% reduction in FTAs, an 80% reduction in convictions and a 95% reduction in new felonies." [1] The County attributed these outcomes to, among other things, the cohesiveness of the team and its frequent formal and informal communications, which resulted in successful cross-agency collaboration.

Its cost effectiveness study indicated that the FACT Program produced "dramatically lower criminal justice system and hospital costs for the County,"[2] which offset the increased costs of providing Assertive Community Treatment to the FACT population.

What also 'worked' in the FACT Program was that "clients' increased stabilization and well-being motivated them to continue participating, as did the potential sanction of return to jail as a consequence of program failure."[3]

Among the aspects of clients identified as most helpful were the good relationships and consistent support from staff, the opportunity to build supportive relationships with other program participants and the practical support such as information about medication management that helped them feel more stable so they could begin work on building life skills. [4] One client said, "In jail you [just learn] how to go back to jail again. Here we made friends and learned how to stay clean, deal with change and stay out of jail."[5]

Clients who had long histories of having psychiatric medications prescribed for them reported never having been taught how to fill or use medi-sets. They said that learning how to renew their prescriptions increased their likelihood of being consistent with psychiatric medications

Future of the Program:

The FACT Program ended at the end of the extended grant period.

[1] Sonoma County, Department of Health Services Mental Health Division's Forensic Assertive Community Treatment Program: Final Report, Abstract
[2] op. cit., page 17
[3] op. cit., page 10
[4] op. cit., pages 12 - 13
[5] op. cit., page 13

STANISLAUS COUNTY
FORENSIC ASSERTIVE COMMUNITY TREATMENT TEAM (FACT TEAM)

Type of Program: Primarily after custody – community based
Key Strategies: ACT; multi-disciplinary team; intensive case management; probation officer on treatment team; medication support; housing support; transportation

Target Population: Inmates booked into Stanislaus County Jail at or after project start-up; serious mental health disorder (DSM-IV Axis I); direct relationship between instant or most recent offense and Axis I diagnosis and/or co-occurring substance abuse disorder; resident of Stanislaus County; willing to participate; excluded if charged with serious, violent offense per PC Section 667 and /or 'third strike' candidate; if primary diagnosis was substance abuse disorder or personality disorder
Study population: Study results reported only for those who completed at least 3 years of program/treatment – Enhanced Treatment 31; Treatment as Usual 31

Summary Description:
The Forensic Assertive Community Treatment (FACT) Team was a collaboration of the Stanislaus County Sheriff's Department, Behavioral Health & Recovery Services and the Probation Department to provide assertive community treatment (ACT) services to mentally ill offenders. The FACT Team, which featured assertive interactions engaging clients in their respective community based settings, was designed to have a low staff to client ratio – as few as 10 clients might be on a service provider's caseload, depending on the intensity of service required to achieve program outcomes. Flexible, responsive interventions and treatment strategies were tailored to the individual client and could include 24/7 crisis response, safe temporary housing, basic living necessities, medical and/or other treatment services, transportation and vocational training. Working with and through the probation officer member of the FACT Team, the program sought conditions of probation that would encourage clients' involvement with mental health services.

Goals and Approach:
The goals of the FACT Team were to reduce crime committed by participants in the program; reduce their incarceration rates and length of stay if/when they were returned to jail; assist clients to complete probation successfully; and improve their quality of life by increasing their access to mental and physical healthcare, benefit eligibility and maintenance of eligibility, and utilization of safe housing. The interdisciplinary FACT Team functioned "as a bridge to identify and span gaps between mental health and criminal justice systems as well as provide intensive case management services to treatment group participants."[1]

Client's participation began with a comprehensive assessment and development of a treatment plan by a mental health clinician. Once those steps were completed, the client was assigned to one of three full-time mental health case managers, who had primary responsibility for identifying, obtaining and coordinating community services appropriate for the client. Services, in addition to those directly related to mental health and medications, might include substance abuse and health care services as well as benefits application and advocacy. One full-time probation officer worked with the courts and the participants to establish conditions of probation that encouraged participation in mental health services. A full-time peer recovery specialist – a peer with personal experience in how to manage mental illness and, for some, co-occurring substance abuse – was also available to clients in the FACT program.

[1] Stanislaus County MIOCR Report, Final Summary – August 2004, page 1

Participants in FACT, as well as the treatment as usual group, were followed from the time they were enrolled in the study until the end of the project. The County's evaluation study focused only on those individuals who participated for the full three years.[2] Its findings were that, although participants did not show significantly greater reductions in number of crimes charged, court cases and convictions or greater reductions in the number of incarcerations and jail days or psychiatric hospitalization days, they did show a significantly greater decrease in psychiatric emergency contacts after one year of treatment than mentally ill offenders receiving standard treatment. Moreover the quality of life data supported "the superior outcome of FACT over standard treatment. Participants in the FACT group reported improvement in financial status, health, personal safety, social contact and daily activities. There was also a significant trend for [FACT participants] to report improvement in life satisfaction."[3]

Local Perspective Of What Worked:

Stanislaus County said, "This project was made possible because of the commitment and enthusiasm of an informed and dedicated team of criminal justice and mental health professionals. The leadership of the project capitalized on the unique strengths of participating agencies and provided a sense of unity and purpose with regard to both the clinical and research mission of the project."[4]

Also credited with 'working,' i.e., being effective program elements of FACT, were having a probation officer on the team full time; the low caseload ratio; making contact with potential client participants while they were in jail, and using narrow diagnostic criteria according to DSM-IV to select participants.

Clients said that the three most helpful program features were assistance with housing, assistance with law enforcement and easy access to staff for support and assistance on a 24/7 basis.[5]

Future of the Program:

The FACT Team continues to serve clients as an assertive community treatment program through the County's AB 2034 program, using existing funds allocated to Stanislaus County Behavioral Health and Recovery Services.

[2] Stanislaus County FACT Program: Analyses and Report, page 14
[3] op. cit., page 28
[4] op. cit., page 31
[5] Final Summary, page 2

TUOLUMNE COUNTY
CRIME ABATEMENT REHABILITATION / RECOVERY ENHANCEMENT (CARES) PROGRAM

Type of Program: In and after custody – Jail and community based
Key Strategies: Intensive case management; multi-disciplinary team; discharge planning; medication support; housing support; financial assistance; transportation; education enhancement; social services; centralized referral and tracking system; probation officer on treatment team

Target Population: Seriously mentally ill offenders, with multiple bookings over previous three years; formal felony probation; resident of Tuolumne County; dual diagnosis acceptable; highest priority given to felons not currently serving sentence of more than one year and participation in CARES as a condition of probation; excluded if Drug Court or Drug Dependency Program client
Study population: Study results reported for 23 clients; there was no comparison group

Summary Description:
Tuolumne County's Crime Abatement Rehabilitation/Recovery Enhancement (CARES) program was an intensive case management and treatment program which offered coordinated plans for stabilizing clients as well as advocacy and enhanced access to housing, health care, social services and support. A four-member CARES intervention team identified and assessed participants and worked with public defenders, defense attorneys, behavioral health clinicians, community-based organizations, social service providers, probation officers and judges to coordinate conditions of release, discharge planning and treatment options for clients.

Goals and Approach:
CARES was developed to create a framework for interagency collaboration that would establish a continuum of swift, certain and graduated responses to criminal activity by mentally ill people in the community. CARES sought to provide repeat mentally ill offenders intensive case management and treatment – both in and out of custody – as well as coordinated plans for stabilization and probation monitoring. To address its goals, CARES incorporated a four-point strategy which included: 1) focusing client stabilization services, at a minimum, on treatment, housing and basic human needs; 2) training jail custody staff to identify signs of mental illness and make appropriate referrals as well as developing a centralized referral and tracking system for mentally ill offenders who are booked at the jail; 3) creating an intervention team consisting of two behavioral health clinicians, a jail classification officer and a probation officer to assess offenders, develop treatment plans and coordinate service delivery; and 4) investigating new approaches to sentencing and probation to curtail mentally ill offender recidivism.[1]

Potential clients were screened by the intervention team during the team's weekly meetings and, when determined to be eligible, were enrolled in the program. Actual enrollment began when the inmate's offense was deemed to be a felony rendering the individual subject to felony of probation. Clients graduated from CARES when they had completed their goals, had remained substance and arrest free and had complied with medication regimes for 12 months. Unless they graduated or were terminated (criteria for termination were moving out of the area, dying, being sentenced to prison, being determined not to be amenable to treatment and/or completing probation and choosing to leave the program), clients remained in CARES as long as the program was in place. CARES successfully graduated four clients during its three-years of operation.

[1] Tuolumne County, Crime Abatement Rehabilitation/Recovery Enhancement (CARES) Final Program Report, pages I - ii

While CARES' evaluation did not find the program effective in reducing criminal justice involvement of felons with severe and persistent mental illnesses, it did produce other measures of effectiveness. These include the degree to which clients were involved in their communities, were able to reside independently in stable housing, were more compliant with their medication regimes, and/or were less visible and disruptive in their communities.[2] Additionally, the cost benefit analysis showed an overall cost savings of a little over $29,000, mainly the result of fewer jail and hospital inpatient days.

Moreover, CARES program staff noted that the 23 individuals participating were considered to be very high level of care. To be eligible for the program they would have had at least three years of documented mental health history and three years of involvement in the legal system, thus were in the most at risk group for recidivism and non-compliance with mental health treatment. Of the 23 high risk inmates who participated in the program eight were considered by Mental Health staff to have become stable in their treatment, were no longer violating the law, were compliant with medications and were operating at a much higher level of function in the community. The stability demonstrated by this group of participants represented a significant lessening in contacts with law enforcement, in-patient psychiatric care, emergency room services, homeless resources and other community agencies. The program postulated that the successes enjoyed by this very high risk group of client/inmates might suggest greater effects by offering the program to individuals at an earlier point in their mental health and criminal justice histories.

Local Perspective Of What Worked:

Tuolumne County described the components and aspects of CARES that worked best as: identifying clients in jail; having an internal case manager and pre-release planning; the collaborative, intervention team model; collaboration with the court; helping clients with needed resources; intensive case management; flexibility; helping clients create support systems; having team members available to clients in times of crisis; training jail deputies in mental health; and providing structure to clients' lives.[3]

Stakeholders and clients were reported to have "overwhelmingly agreed that the CARES program benefited people.... It encouraged collaboration among agencies and departments; it enhanced the availability of and access to local resources; and it provided services directly to clients. ...Two elements – inter-agency collaboration and the increase in resources and services for clients – were viewed as particularly effective."[4]

Future of the Program:

While the full CARES Program could not be continued without external funding, Tuolumne County is continuing to identify mentally ill inmates in the jail, to provide pre-discharge services and to link mentally ill offenders with existing community-based services after release. "Perhaps most importantly, ... the collaboration and inter-agency relationships built up through the process of implementing this program – arguably the program's greatest strength – will be sustained in the future."[5] The program's Strategy Committee continues to meet on a quarterly basis to oversee the remaining components and to prepare for other funding opportunities.

[2] op. cit., page vi
[3] op. cit., page 52
[4] op. cit., page vii
[5] op. cit., page 93

VENTURA COUNTY
MULTI-AGENCY REFERRAL AND TREATMENT (MART) PROGRAM

Type of Program: Primarily in lieu of completion custody – community based
Key Strategies: ACT; intensive case management; probation officer on treatment team; medication support; housing support; assistance with money management; transportation

Target Population: Mentally ill offenders, age 18 or older, with current misdemeanor offense; serious mental disorder excluding primary substance abuse, developmental disorder or acquired organic brain disorder; GAF score of 65 or less; resident of Ventura County; willing to participate; excluded if charged with a felony, DUI, or domestic violence; on parole; not a legal resident; and/or history of violence
Study population: Study results reported for those who completed at least a year of program/treatment – Enhanced Treatment 77; Treatment as Usual 76

Summary Description:
The Multi-Agency Referral and Treatment (MART) Program began operating in October 2001 and ended as a grant-funded program in July 2004. Using the Assertive Community Treatment (ACT) approach, the MART Program sought to reduce the criminal involvement of mentally ill offenders by providing intensive case management, multiple community services, the aid of specially trained probation officers, consultations with the Superior Court Judges and the cooperation of the Sheriff, District Attorney and Public Defender.

Goals and Approach:
The MART Program created interagency collaborations to treat mentally ill offenders in order to improve their lives and lessen the risk of their becoming chronic users of the criminal justice system. This was achieved through the use of appropriate housing, psychiatric treatment and intensive case management. The operating assumption was that if clients had their practical needs met (i.e., for housing, medical care and social support) and their mental illnesses treated, the behaviors that led to their arrests would be reduced and their lives would be improved.

Case managers helped MART clients get needed medical attention and helped them understand the function of their psychiatric medications. Case managers were available to help negotiate housing problems and teach clients how to avoid eviction. They helped clients reduce impulsivity and stay with treatments long enough for the benefits to show. They were aided by the probation officers on the treatment team who accompanied the case managers when they were experiencing problems with clients. The MART psychiatrist approved each client's Behavioral Health treatment plan and directed client care, seeing each client at least monthly.

Because recruiting housing for its clients was a major element of the MART Program, MART negotiated for housing in blocks. This allowed the program to offer stable funding to the housing provider while also promising the accessibility of MART case managers and probation officers for quick response should problems arise.

Program partners – the MART Probation Officers, Public Defender, Deputy District Attorney and Behavioral Health manager and treatment staff – had weekly meetings. Additionally, Strategy Meetings were held monthly attended by administrators of the partner agencies and the Superior Court Judge. This fostered and enhanced the continuous inter-agency cooperation that was central to the program's operation and its successful intervention with its clients.

Local Perspective Of What Worked:

Intensive case management worked. The low client-to-staff ratio was said to have allowed staff to address client needs that had been left unattended for years. Having Behavioral Health staff in the jail was credited with facilitating the timely processing of referrals as well as increasing understanding of the respective agencies' cultures and mandates. The program's two full-time probation officers were said to have "[embodied] the entire criminal justice system, serving as the ambassadors of that system, not only to the clients, but also to the Behavioral Health treatment staff … and helping their colleagues in the criminal justice system understand the dynamics of mentally ill offenders [as well]." [1]

The Program's housing component combined with its intensive case management and psychiatric treatment provided what clients called "an unprecedented level of attention and structure."[2] The presence of a drug and alcohol specialist during the latter part of the grant period was further considered important, in as much as it was said to have "enabled a seamless treatment milieu that was fully compatible with psychiatric treatment."[3]

MART's multi-agency collaboration was considered very successful and was reported to be continuing on after the grant's end. The emphasis on collaboration aided Ventura "in increasing understanding among the agencies and solidified the willingness to address this unique population in a sensitive and alternative fashion. The support from all team partners [was] very strong but, due to budget limitations, [was] restricted to developing strategies for continuing in a more limited fashion. The development of a mental health court has not yet been realized."[4]

Future of the Program:

Although the MART Program ended at the conclusion of the grant period, Ventura County has developed a Forensic Services Program, which evolved from the MART Program and is continuing another forensic program that preceded MART. Intensive case management, the mobile team and the dedicated psychiatrist are elements that were retained from the MIOCR grant. A behavioral health clinician continues to be located in the main custody facility to provide assessments and jail discharge planning.

[1] Ventura County Multi-Agency Referral and Treatment (MART) Program Final Report, page 94
[2] op. cit., pages 78 - 79
[3] op. cit., page 80
[4] Ventura County Multi-Agency Referral and Treatment (MART) Program Summary, page 2

YOLO COUNTY
PROJECT NOVA

Type of Program: In and primarily after custody – community based
Key Strategies: ACT; assertive case management; multidisciplinary team; individual, group and substance abuse counseling; housing support; crisis intervention; transportation; medication support; funding eligibility; day treatment socialization support; planning for housing; peer groups;

Target Population: Mentally ill offenders, age 18 or older, with a current offense not involving a serious act of violence and at least one prior booking into the County jail; a primary major mental illness diagnosis (Axis I) which produces significant impairment in life functioning; GAF score of 50 or less; resident of Yolo County; willing to participate; excluded if mentally retarded or developmentally disabled; and if ineligible for probation
Study population: Enhanced Treatment 60; Treatment as Usual 60

Summary Description:
Project NOVA offered enhanced, customized services addressing the identified needs of mentally ill offenders in Yolo County, using the Assertive Community Treatment (ACT) and Assertive Community Case Management models. Project NOVA sought to reduce offense and re-offense rates among mentally ill offenders, effectively and efficiently manage resources and linkage to services for this population and enhance the quality of life for people with mental illness.

Goals and Approach:
Project NOVA was based on prompt and effective mental health assessments, Assertive Community Treatment (ACT) and Assertive Case Management (ACM). Clients began treatment in jail with case management services, including pre-planning to access medical services, individual counseling and pre-planning for housing upon release from jail. Participants' releases from jail were coordinated to ensure access to services during the period in which they were most vulnerable to relapse. During the ten-month treatment period, Project NOVA clients worked with their case managers to develop individualized treatment plans and were offered such services, depending on their personal needs, as: alcohol and drug counseling; long-term residential substance abuse treatment; medication management and support for treatment compliance; referral and linkage to a network of NOVA community service partners; group and individual therapy; 24/7 crisis intervention; and vocational and community socialization skills.

Emergency transitional housing was offered on an as-needed basis and upon release from jail for a limited period of 30 days. Individuals who had lost their public assistance benefits or had no current funds for housing were able to stay in transitional housing for up to 90 days. Transportation was provided for program participants to enable their attendance at scheduled appointments and meetings. Program staff assisted participants to restore or develop ties with their families and community, which helped facilitate their re-integration to the community as well as subsequent improvement in the quality of their lives.

Yolo County reported that only 1/3 of Project NOVA participants re-offended during, or six months after, the program, compared with more than half of those in the treatment as usual group. The average number of jail bookings declined by 90% and the time between re-offenses was significantly longer among NOVA participants than those in the TAU group. Most impressively, the average number of detention bed days declined from an average of 65.5 days twelve months prior to program enrollment to 8.1 days during the program and 3.5 days six months after completion.[1]

[1] Consolidated Sciences, Inc., Yolo County Project NOVA; Reducing Recidivism Among Mentally Ill Offenders, page 142

NOVA's evaluation found that clients also showed significant improvements in substance use behaviors, mental health and quality of life indicators. In fact, the evaluators said, "the changes in [these three areas] provided perhaps the most encouraging outcomes of this study. … NOVA group participants showed [consistent decrease of] alcohol use, … the … prevalence of drugs trended down consistently throughout the measurement periods…[and these improvements] were significant and sustained…"[2] Moreover, participants showed "significant positive changes" in their mental health, daily living, role functioning and relating to self and others. Their global assessment of functioning (GAF) scores indicated "significant improvements in the overall level of functioning and ability to carry out activities of daily living. The average GAF score improved significantly from 44 at baseline to 50.9 and 51.1, respectively, during and after the program."[3]

Local Perspective Of What Worked:

Yolo County attributed a great part of its success to assertive case management, saying, "…this approach… holds numerous advantages over intensive case management. ACM deals with clients on a frequent and long-term basis, using a hands-on approach that may necessitate meeting with clients 'on their own turf' or even seeing clients daily. This form of contact and familiarity with clients helps the case manager and client anticipate and prevent significant decompensation."[4]

Yolo County noted that coordinated assessment works. The collaborating partners revised the jail intake form to include more specific questions that identify individuals who may need mental health services. This document coupled with the assessment instruments administered at entry to Project NOVA helped define and direct the individualized treatment plans that were the basis of each participant's programming while in the Project.

Individualized treatment plans worked for Project NOVA, as did medication support services, housing support, determination of funding eligibility, transportation, and socialization support provided through staff and peer group sessions. Access to residential and outpatient substance abuse treatment also worked. This was an important element in the successful community stabilization of more than 90% of NOVA participants.

Intensive psychiatric assessment and medication evaluation and monitoring worked. Participants received frequent assessment and monitoring of medications as a major component of treatment. This helped to insure medication compliance, a treatment modality consistent with maintaining stability of symptoms and functioning.

Moreover, Project NOVA was found to be cost beneficial to the taxpayers of Yolo County. In the period the program was in operation, the evaluation estimated Yolo County enjoyed approximately $1.42 million in avoided costs.

Future of the Program:

Although Project NOVA ended at the conclusion of the grant period, the revised jail intake form developed by the Project NOVA partners continues to be used to identify individuals who may require mental health services during their stay in jail.

[2] op. cit., page 143
[3] ibid.
[4] op. cit., page xxix

APPENDIX D
SELECTED CASE STUDIES

Selected Case Studies

This section offers a sampling of summary case studies provided by case managers from various local Mentally Ill Offender and Crime Reduction Grant (MIOCRG) programs. These case studies attest to the diversity of clients as well as the tremendous challenges faced by each client. They also underscore some of the problems case managers and other program staff experienced in serving their clients.

We are grateful to the projects that voluntarily submitted case studies and apologize for not being able to include them all. Names of counties, case managers and clients are purposely not used to ensure the privacy of the clients described.

Client A is a 41-year-old female who had never received mental health care or medications prior to entering the mentally ill offender Program. She had her first of 4 children at the age of 15. Client A has only had a home when co-habitating with her ex, who was dealing drugs and physically and emotionally abusing her. Client A had been homeless since this relationship ended and had numerous drug-related arrests over the last 6 years. She has never been employed, has supported herself by "muling" drugs for dealers and considered herself lucky when she found an elderly person needing in-home care so she could earn a place to stay and something to eat. She said this was the only time she felt good about herself because she could help someone else.

Client A was diagnosed with major depression and Attention Deficit Disorder (ADD). When she started the program she was very depressed. The only thing of which she was proud was raising her children but, unfortunately, her behavior and drug abuse had forced her children to avoid contact. She longed to see her grandchildren and improve her relationship with her children. Client A was in custody at the beginning of the MIO Program due to her drug use. Her first success was in gaining family support to supervise her during daytime treatment furloughs from jail. This progressed to overnight passes under the supervision of her daughter. The family was clear that they would allow her to be near the family was only because of the team support and treatment she was receiving from the program staff. Client A was able to be present at the birth of her latest grandchild and has been doing community work at her niece's school to help the family get free school pictures. She felt terrific being able to earn something for her family. She had only completed the third grade and her daughter now helps her do her Alcohol and Other Drug Program assignments. Until recently she had not seen a doctor or dentist in years and at her first exam was diagnosed with a pre-cancerous condition. She has been dealing with this very well. She is also beginning biofeedback to prepare for extensive dental work needed to replace her teeth due to lack of care and methamphetamine use. Additionally, she is proud to have been baptized in her faith.

Client B, a 57 year-old white male diagnosed with schizophrenia, began interfacing with the criminal justice system at the age of 14 and had been arrested more than 50 times for a wide variety of crimes ranging from misdemeanor theft, intoxication and a sex offense, to felony weapons, drugs and violence. For 30 years he drifted from place to place, at times being hospitalized at the local and state levels in residential care. Within a week after enrolling in the program Client B was back in custody for public intoxication, then released, and very soon thereafter taken to the psychiatric hospital by local police. Upon his release, medication compliance became an even more focused issue for the treatment team and staff began visiting him twice daily.

Client B graduated from the MIOCR Program over a year ago and continues to enjoy a more functional lifestyle within the community. He has maintained mental health appointments and medication compliance and has done volunteer work at the Food Bank. He has not been charged with any new offenses since he entered the program.

Client C is a 56 year old African-American male diagnosed with Schizophrenia, Paranoid Type, and Alcohol Abuse. Both his legal problems and mental health problems started about 30 years ago. His legal problems generally involved petty theft. He has been hospitalized against his will many times over the last 30 years for paranoid beliefs about his family members and public figures that lead to acute disorganization, grave disability, and, at times, being a potential danger to others. After some of his more lengthy hospitalizations, Client C was able to work and support his family for periods of time. However, due to changes in insurance when working and his own belief that he was not mentally ill, he would stop his psychiatric medication and lose his job. For the same reasons, he would then eventually be re-hospitalized. During the year prior to his most recent arrest he was homeless, disheveled, hording papers, and yelling at people on the street. He would occasionally drop by a Department of Mental Health clinic, but, in spite of repeated efforts by his case manager at the clinic, he was not able to complete the process for evaluation of disability (SSI and Medi-Cal).

After Client C's enrollment in the MIO Program and while still in custody, medication education was provided and rapport was established. After release, support was provided for safe and stable housing, consistent availability of medication and appropriate benefits applications. Several deficits in his skills for daily living were noted and appropriate skill development was provided. Since his enrollment in February of 2002, Client C has completed a 30-day dual diagnosis program, has maintained safe housing for seven months, has obtained SSI and Medi-Cal, and completed classes needed for reinstatement of his driving privileges. He states that he believes his fears and preoccupations with his family and local public figures were "delusinations" and expresses a commitment to take his medication and abstain from alcohol.

Client C currently appears alert, oriented, well groomed and socially appropriate. He has not expressed any paranoid ideation in more than six months. He has worked a few days in a temporary position without any conflicts or return of symptoms. He has not shown any signs of alcohol or drug use at the homeless shelter or with the community rehabilitation staff and, most importantly, he has not been rearrested. His current plans are to wait for the outcome of a Section 8 voucher application through the Department of Mental Health and, with close contact with his doctor and case manager, return to part-time work. This is the most stable he has been for many years.

Client D, a 54 year old Caucasian male, has a criminal history in California dating back to May, 1980. His convictions include possession of a destructive device, felony vandalism, exhibiting a dangerous weapon, carrying a dirk or dagger and battery. His history with Mental Health is extensive. He was a licensed psychiatrist in another state but lost his license. Both he and his wife have had many problems within the community.

Since entering the program in April of this year, Client D has made excellent progress. He has enrolled in a sober living environment and we have paid for a few of his basic needs. He has been attending individual counseling sessions with the external case manager, has made weekly contact with the probation officer and is participating in an impulse control counseling group.

Client D has had no further problems in the community and is considering going to the local community college to learn medical transcription. He is another one of those clients who everyone said was hopeless. The multi-collaborative team feels very good about the progress he has made.

Client E was supervised for about a year on a regular probation caseload as a result of his elder abuse conviction for pushing around his 75-year-old mother with whom he has a love/hate relationship. His Probation Officer knew he had mental problems and was often called to intervene between him and his Mom. She was not supposed to have him around her subsidized housing because he was considered "off his rocker." He would live in cars on the streets, would get arrested for minor violations or failure to appear warrants, would have his vehicle/home impounded and thereafter would run out and squander his SSI check on a new 'junker'. He repeated the cycle over and over again, oftentimes living on the streets or in shelters in between vehicles and SSI checks.

Client E was screened for and got into the MIO program in November 2001. He was placed in a room and board home, and for the first time in a long time, had a real roof over his head. He was appreciative of that and the effort the MIO team put into him. Sadly, because of years of untreated medical problems and out of control diabetes, he died after being in the program for only 2 months. It was comforting to know that he spent his last days in a safe environment with his basic needs being met, instead of dying in a parked 'junker' car behind some shopping center.

Client F, a 49-year-old Hispanic female, was diagnosed with Post Traumatic Stress Disorder (due to severe childhood sexual abuse that started at the age of four) and Substance Dependence (primarily heroin and alcohol). She had been engaging in prostitution since the age of nine, was active in gangs, and had been arrested 40-50 times over her lifetime for offenses ranging from simple burglaries to grand theft and assault, which often resulted in jail or prison time. She began using drugs in her early teens and had graduated to heroin by the age of 17.

She had experienced a number of suicide attempts and psychiatric hospitalizations, and has been homeless multiple times over the past 30 years. Her most recent arrest was a third strike violation, but the court compassionately removed that strike and allowed an alternative sentence to an unlocked residential treatment program and community reintegration program in which she was enrolled in April, 2001.

After one year she is about to graduate from the residential program, where she has come to be considered one of leaders in the program. She is often called on to support the other women, joining them for various appointments they may have to attend to, and helping them with possible 'addict' challenges that come up during the outings. She is respected by the residents and staff and is frequently called upon to aid in the settling of disputes, or to share her experiences and wisdom in the role of counselor/mentor. She is considered by all to be a very positive role model.

Client F has consistently and effectively utilized the community program's multiple therapeutic components. e.g., intensive case management, psychiatric medication, and individual and couples therapy. She is extremely active in her own sobriety with no relapses to date, is medication compliant and has shown a strong, insightful focus towards her positive growth and change. She is currently enrolled in school so that she may obtain her GED (she dropped out of school in the 6th grade) and has plans to follow-up with a drug counseling certificate. She is removing all of her gang/prison tattoos and has her first bank account in over 30 years. The community program's staff has helped her obtain SSI and Medi-Cal, and she has reunited with her children and extended family. With her incredible desire to succeed, and the sustained support of the community program, Client F has a positive prognosis for her future, possibly for the first time in her life.

Client G a 32-year-old, large (6'2" and 275 lbs.) white male, suffers with a dual diagnosis Bi-Polar Disorder, Manic Type and Methamphetamine Abuse. He has had these dual problems since his teenage years when he was first psychiatrically diagnosed and treated. He has had eight contacts with the law since 1994 for possession and/or sales of drugs and petty theft and reports he has had dealings with the criminal underworld and used to do "collections" in this regard. At the time he was enrolled in the community reintegration program, he was in jail for assaulting his stepfather, which has resulted in estrangement from his family. Since his release from jail in May of 2001, he entered a residential substance abuse program. The day he entered the program, all of his psychiatric medications were confiscated, per the policy of that program, although eventually he was allowed to use up his 30-day supply of one of three medications. He felt desperate to succeed and in an attempt to deal with his mood swings without medication, he and three peers formed an informal support group.

Client G has completed his program at the residential facility and has worked his way up to Warehouse Supervisor at the facility. He is responsible for coordinating and scheduling a fleet of trucks for pick up

and delivery of merchandise as well as the maintenance of those vehicles. He also volunteers at a local tabernacle. He was invited to become a "soldier" of the Salvation Army and went through a swearing in ceremony. He is medication compliant and has a long documented history of clean drug tests. Client F's goal is to return to private industry in the transportation field.

APPENDIX E
COMMON DATA ELEMENTS

MENTALLY ILL OFFENDER CRIME REDUCTION GRANT

Common Data Element Dictionary

March 29, 2001

Orientation to the Data Dictionary

In response to language contained in the authorizing legislation (SB 1485), research staff of the Board of Corrections has developed a statewide evaluation program to assess the effectiveness of the Mentally Ill Offender Crime Reduction Program Grants. The design of the evaluation requires that common data be collected on participants in both the treatment and comparison groups and that the data be reported to the BOC at six-month intervals. BOC staff will prepare annual reports to the legislature as well as a final evaluation report after the funding terminates.

To understand the juncture between the statewide mental health databases and the MIOCRG projects, the following is a brief description of each:

These databases are the Medi-Cal Billing system, the Client and Service Information database, and the Performance Outcomes database. The first database has been in use for some time and equates mental health services with particular billing codes in the Medi-Cal system. The last two databases were developed by the California Department of Mental Health to improve client service reporting by the county mental health departments to the state agency. Since the counties are required to use the CSI and the Performance Outcomes reporting systems, and the counties are already using the Medi-Cal billing system, it seemed reasonable that the Mentally Ill Offender (MIO) data elements to conform as much as possible to the existing database data fields.

Database Structure

The MIO common data elements database is a flat SPSS file. The columns have been designated as variables (with variable names) and, when possible, value labels have been designated. Each case should be entered as a longitudinal record, one client per row. The database has been developed in three parts – 1) Intake, Background, and Participation Data, 2) Interventions Data (e.g., services received), and 3) Outcome Data.

Part I – Intake, Background and Participation Data

The Intake, Background, and Participation Data is organized into six sections. The variable names begin with the section identifier:

ID	Identification Data
PI	Participant Identification
MH	Mental Health Status
CJ	Criminal Justice History and Status
CR	Client's Resources
PP	Program Participation

Part II - Intervention Common Data Elements

This section of the data dictionary describes the fields and coding schemes for reporting all interventions received by MIOCRG participants (whether treatment as usual or alternative treatment group). An SPSS data file has been provided that corresponds to this section of the data dictionary.

When determining which data element to use in reporting services, please use the following decision tree:

1. Was the service received while in custody or after release?
2. What was the nature of the service? Don't be concerned about the affiliation or training of the service provider; our focus is on the type of service.
3. Does your county report this service separately or does it aggregate this service with other services and report at the more general level? Please use the most detailed reporting categories possible.

4. When reporting the amount of time a participant received an intervention, report only the actual service delivery time. Please do not include travel or charting time. If the county doesn't break out travel and charting time from service provision time, please determine the proportion of time generally used for travel or charting and subtract it from the time reported by the county. In this way, we can more accurately compare the intensity of services on outcome behavior across counties that vary widely in geography and population density.

Part III – Outcome Common Data Elements

This section of the data dictionary describes the fields and coding schemes for reporting all outcome behaviors of MIOCRG participants (whether treatment as usual or alternative treatment group). A SPSS data file has been provided that corresponds to this section of the data dictionary.

The outcome data elements are arranged in two main groups, with two parts in each group. The two main groups consist of the same data elements and data definitions but for different phases of a participant's participation. The first group contains outcome data that will be collected on participants during their period of program participation. The second group contains outcome data that will be collected on participants after they have completed the program and/or been terminated for one of the reasons identified in each project's program evaluation.

Within each group there is a set of criminal justice data that must be collected and reported on each participant. Also within each group are two sets of data (mental health and conditions of living) that are optional outcome data.

Default Codes

For consistency, please use these conventions for all data elements:

0	use only when the correct response is the number zero.
-3	use when the data element is not applicable to the particular project or client (e.g., use this code for the post-custody interventions field for programs that offer interventions only in the jail).
1/1/11	use in the date fields when the data element is not applicable to the particular project or client
-2	use when the client is unable to respond to question.
-1	use when the expected information is missing.

In all numeric fields, the system missing data values have been set to –3 and –2 in the data definition.

Please do not leave any fields empty or blank. If a field is normally filled with a single character (such as "Y" or "N"), do not include leading or trailing zeros or other characters. The only exception is default codes such as "-3."

Key

For all interventions, use the following key:

Y / N = Yes/No, the service was provided
M = Count of minutes services were provided during reporting period
HD = Count of half-days during which client received service
C = Count of contacts (sufficiently long for meaningful interaction or support). (In the future, we may need to define what constitutes a contact.)

If you have any questions or need more information about these data elements, please feel free to call or e-mail Dick Sheppard, PhD (916)445-7672, dsheppard@bdcorr.ca.gov, Theo Benson, MA (916)322-9666, tbenson@bdcorr.ca.gov or John Kohls, PhD (916) 323-6156 jkohls@bdcorr.ca.gov.

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Part I

Intake, Background, and Program Participation Data Elements
Mentally Ill Offender Crime Reduction Grant

I. VARIABLES FOR IDENTIFYING THE RESEARCH SUBJECTS

ID_1 UNIQUE SUBJECT IDENTIFICATION NUMBER

Source: BOC
Type: Character
Field Length: XXXX

VALID CODES:
ID numbers start with 0001 and continue through 9999 as necessary.

COMMENTS:
Identification numbers are to be assigned each participant, treatment and comparison, by program staff.

ID_2 RESEARCH GROUP

Source: BOC
Type: Character
Field Length: X

VALID CODES:
1 = Treatment
2 = Comparison

ID_3 COUNTY NUMBER

Source: BOC
Type: Character
Field Length: XX

VALID CODES:
Use county codes provided by the Board of Corrections.

ID_4 PROGRAM NUMBER

Source: BOC
Type: Character
Field Length: X

VALID CODES:
1 = First program for the county.
2 = Second program for the county.
3 = Third program for the county.

II. PROGRAM PARTICIPANT IDENTIFICATION AND BASIC INFORMATION

*These questions apply to the clients' situation prior to the qualifying arrest and/or incarceration.

PI_1a YEAR OF BIRTH

Source: BOC
Type: Character
Field Length: XXXX

VALID CODES:
Enter the 4-digit number of the client's birth year.

COMMENTS:
At a minimum, an approximate year of birth must be reported.

PI_1b MONTH OF BIRTH -deleted

PI_1c DAY OF BIRTH -deleted

PI_2 GENDER

Source: CSI: C-05.0
Type: Character
Field Length: XX

VALID CODES:

F = Female
M = Male
O = Other - Includes gender changes, undetermined gender and persons with congenital abnormalities which obscure gender identification.

PI_3a PRIMARY ETHNICITY/RACE IDENTITY

Source: CSI: C-06.0 (A)
Type: Character
Field Length: XX

COMMENTS:
In this field, enter the code below that corresponds to that in the first subfield (A) of C-06.0. Please note that "Multiple" can only be used in PI-3b.

PI_3b SECONDARY ETHNICITY/RACE IDENTITY

Source: C-06.0 (B)
Type: Character
Field Length: XX

COMMENTS:
In this field, enter the code that corresponds to that in the second subfield (B) of C-06.0.

Use the following to code elements PI_3a and PI_3b.

VALID CODES:

1	=	White	N	=	Asian Indian
2	=	Hispanic	P	=	Hawaiian Native
3	=	Black	R	=	Guamanian
5	=	American Native	T	=	Laotian
7	=	Filipino	V	=	Vietnamese
A	=	Amerasian	X	=	Multiple (only valid in subfield B)
C	=	Chinese	4	=	Other Asian or Pacific Islander
H	=	Cambodian	8	=	Other
J	=	Japanese			
K	=	Korean			
M	=	Samoan			

For your convenience, below are the ethnic/race groups displayed in alphabetical order.

A	=	Amerasian	K	=	Korean
5	=	American Native	T	=	Laotian
N	=	Asian Indian	X	=	Multiple (only valid in subfield B)
3	=	Black	8	=	Other
H	=	Cambodian	4	=	Other Asian or Pacific Islander
C	=	Chinese	M	=	Samoan
7	=	Filipino	V	=	Vietnamese
R	=	Guamanian	1	=	White
P	=	Hawaiian Native			
2	=	Hispanic			
J	=	Japanese			

PI_4 PRIMARY LANGUAGE

Source: CSI: C-07.0
Type: Character
Field Length: XX

VALID CODES:

0	=	American Sign Language (ASL)	H	=	Hmong
1	=	Spanish	I	=	Lao
2	=	Cantonese	J	=	Turkish
3	=	Japanese	K	=	Hebrew
4	=	Korean	L	=	French
5	=	Tagalog	M	=	Polish
6	=	Other Non-English	N	=	Russian
7	=	English	P	=	Portuguese
A	=	Other Sign Language	Q	=	Italian
B	=	Mandarin	R	=	Arabic
C	=	Other Chinese Languages	S	=	Samoan
D	=	Cambodian	T	=	Thai
E	=	Armenian	U	=	Farsi
F	=	Ilacano	V	=	Vietnamese
G	=	Mien	Z	=	Unknown / Not Reported

For your convenience, below are the Primary languages displayed in alphabetical

order.

0	=	American Sign Language (ASL)	B	=	Mandarin
R	=	Arabic	G	=	Mien
E	=	Armenian	C	=	Other Chinese Languages
D	=	Cambodian	6	=	Other Non-English
2	=	Cantonese	A	=	Other Sign Language
7	=	English	M	=	Polish
U	=	Farsi	P	=	Portuguese
L	=	French	N	=	Russian
K	=	Hebrew	S	=	Samoan
H	=	Hmong	1	=	Spanish
F	=	Ilacano	5	=	Tagalog
Q	=	Italian	T	=	Thai
3	=	Japanese	J	=	Turkish
4	=	Korean	Z	=	Unknown / Not Reported
I	=	Lao	V	=	Vietnamese

PI_5 MARITAL STATUS

Source: ASI (Family and Social Relationships, Item 1)
Type: Character
Field Length: XX

VALID CODES:

M	=	Married
R	=	Remarried
W	=	Widowed
S	=	Separated
D	=	Divorced
N	=	never married

PI_6 DEPENDENT CHILDREN-deleted

PI_7 NUMBER OF CHILDREN DEPENDENT ON CLIENT

Identifies how many children depend on client for regular care, including food and housing.

Source BOC
Type: Character
Field Length: XX

COMMENTS:
Include minor children (under 18 years old) for whom the client is responsible for providing shelter and food (doesn't matter whether client has a legal obligation to support children or not).

VALID CODES:
Enter the number as a two digit number. If the client identifies between 0 and 9 children, enter a 0 before the number (e.g., 09).

PI_8 EDUCATION

The highest grade level completed by the client.
Source: CSI: P-02.0
Type: Character
Field Length: XX

VALID CODES:

00	=	None, Kindergarten.
01 through 20	=	Grade levels – Indicate highest grade completed. If the highest grade completed is greater than 20, code 20 as the highest grade completed. Code 12 for GED.

PI_8a VOCATIONAL EDUCATION/TRAINING

Identifies whether client completed vocational education or training, other than that received in high school.
Source: CSI: P-02.0
Type: Character
Field Length: XX

VALID CODES:

N	=	No
Y	=	Yes

*PI_9 EMPLOYMENT STATUS

Identifies the current employment status of the client.
Source: CSI: P-03.0
Type: Character
Field Length: XX

VALID CODES:

Employed in competitive job market

A	=	Full time, 35 hours or more per week
B	=	Part time, less than 35 hours per week

Employed in noncompetitive job market (sheltered workshop, protected environment)

C	=	Full time, 35 hours or more per week
D	=	Part time, less than 35 hours per week

Not in the paid work force

E	=	Actively looking for work
F	=	Homemaker
G	=	Student
H	=	Volunteer Worker
I	=	Retired
J	=	Resident / inmate of institution
K	=	Other (use for clients on SSI)
U	=	Unemployed

COMMENTS:
Nonpaid, noncompetitive job market is coded as "H"-Volunteer Worker.

PI_10 LIVING ARRANGEMENT (continued on next page)

Identifies the living arrangement of the client.
Source: CSI: P-09.0
Type: Character
Field Length: XX

VALID CODES:

A	=	House or apartment (includes trailers, hotels, dorms, barracks, etc.)
B	=	House or apartment and requiring some support with daily living activities
C	=	House or apartment and requiring daily support and supervision)
D	=	Supported housing
E	=	Foster family home
F	=	Group Home
G	=	Residential Treatment Center
H	=	Community Treatment Facility
I	=	Board and Care
J	=	Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
K	=	Mental Health Rehabilitation Center (24 hour)
L	=	Skilled Nursing Facility/Intermediate Care Facility/Institute of Mental Disease (IMD)
M	=	Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital
N	=	State Hospital
O	=	Justice related (correctional facility, jail, etc.)
P	=	Homeless, no identifiable residence
Q	=	Other

***PI_11 CONSERVATORSHIP / COURT STATUS**

Identifies whether or not the client has a conservatorship.
Source: CSI: P-08.0
Type: Character
Field Length: XX

VALID CODES:

A	=	Temporary Conservatorship (W&I Code, Section 5353)

Types of Permanent Conservatorship

B	=	Lanterman-Petris-Short (W&I Code, Section 5358)
C	=	Murphy (W&I Code, Section 5008)
D	=	Probate (Probate Code, Division 4, Section 1400)
E	=	PC 2974 (Penal Code, Section 2974)
F	=	Representative Payee Without Conservatorship (W&I Code, Section 5686)
G	=	No conservatorship

III. MENTAL HEALTH DIAGNOSES AND STATUS OF FUNCTIONING UPON ENTRANCE INTO THE PROGRAM

*MH_1 SUICIDE RISK WHEN CLIENT FIRST ENTERED THE CORRECTIONAL FACILITY

Use the county's current suicide risk assessment procedure and identify a breakpoint that distinguishes definite suicide risk from not being a definite suicide risk.

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No, individual does not demonstrate any significant suicide risk characteristics
Y = Yes, individual deemed a definite suicide risk

MH_2 PRIMARY MENTAL HEALTH DIAGNOSIS

Identifies the principal mental health diagnosis, which is the primary focus of attention or treatment for the mental health services. This may be any of the full range of Diagnostic and Statistical Manual (DSM) diagnoses. It may be on either Axis I or Axis II.

Source: CSI: S-09.0
Type: Character
Field Length: XXXXX

COMMENTS:

Please use the Diagnostic and Statistical Manual – Fourth Edition (DSM-IV).

Enter all letters and/or numbers of the DSM-IV code. **Do not enter a decimal point when entering the code. Use trailing zeros if necessary (for example: 320.1 is entered as 32010; V61.12 is entered as V6112).**

VALID CODES:

All DSM-IV codes are accepted.

MH_3 SECONDARY MENTAL HEALTH DIAGNOSIS

Identifies the secondary mental health diagnosis, which is the secondary focus of attention or treatment for the mental health services. This may be any of the full range of Diagnostic and Statistical Manual (DSM) diagnoses. It may be on either Axis I or Axis II.

Source CSI: S-10.0
Type: Character
Field Length: XXXXX

COMMENTS:

Enter all letters and/or numbers of the DSM-IV code for the secondary mental health diagnosis. **Do not enter a decimal point when entering the code. Use trailing zeros if necessary (for example: 320.1 is entered as 32010; V61.12 is entered as V6112).** Enter x's in this field if the client does not have a secondary mental health diagnosis.

VALID CODES:

x = No secondary mental health diagnosis
All DSM-IV codes are accepted.

MH_4 AXIS-V / GAF

Identifies the current functioning level rating of the client.
Source: CSI: P-04.0
Type: Character
Field Length: XX

COMMENTS:
Enter '00' if the GAF score cannot be determined.

VALID CODES:

01 through 99 = Valid numeric GAF score
00 = GAF score cannot be determined due to client's condition.

MH_5 OTHER FACTORS AFFECTING MENTAL HEALTH – SUBSTANCE ABUSE

Indicates if substance abuse affects the mental health of the client.
Source CSI: P-05.0
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

MH_6 OTHER FACTORS AFFECTING MENTAL HEALTH – DEVELOPMENTAL DISABILITIES

Indicates if developmental disabilities affect the mental health of the client.
Source: CSI: P-06.0
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

MH_7 OTHER FA CTORS AFFECTING MENTAL HEALTH – PHYSICAL HEALTH DISORDERS

Indicates if physical health disorders affect the mental health of the client.
Source: CSI: P-07.0
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

IV. VARIABLES FOR DESCRIBING PARTICIPANTS' CRIMINAL JUSTICE HISTORY AND CURRENT STATUS

CJ_1 AGE AT FIRST ARREST

Source: BOC
Type: Character
Field Length: XX

VALID CODES:
The individual's age, in years, at the time of the first arrest.

CJ_2 AGE AT FIRST ADULT CONVICTION

Source: BOC
Type: Character
Field Length: XX

*CJ_3a to CJ_3: PROVIDE THE FOLLOWING DATA FOR THE PERIOD OF TIME BETWEEN 25 AND 36 MONTHS AGO (BEFORE *THE QUALIFYING ARREST*):

*CJ_3a NUMBER OF TIMES INDIVIDUAL WAS BOOKED INTO JAIL (25-36 MONTHS AGO)

Source: BOC
Type: Character
Field Length: XX

COMMENTS:
Enter the number as a two-digit number

CJ_3b NUMBER OF CONVICTIONS

Source: BOC
Type: Character
Field Length: XX

COMMENTS:
Enter the number as a two-digit number

*CJ_3c MOST SERIOUS TYPE OF OFFENSE FOR WHICH INDIVIDUAL WAS BOOKED DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX

VALID CODES:
F = Felony
M = Misdemeanor

CJ_3d MOST SERIOUS CONVICTION DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

1 = Violent offense (including homicide, forcible rape, robbery, assault, kidnapping)
2 = Property offense (including conviction for burglary, theft, motor vehicle theft, forgery, checks and credit card fraud, arson)
3 = Drug offense (possession and/or sale of narcotics, marijuana, dangerous drugs)
4 = All other felony offenses
5 = All other misdemeanor offenses
6 = Violation of probation

CJ_3e NUMBER OF DAYS IN JAIL

Source: BOC
Type: Character
Field Length: XXX

COMMENTS:
Enter the number as a three-digit number.

***CJ_4a to CJ_4e: PROVIDE THE FOLLOWING DATA FOR THE PERIOD OF TIME BETWEEN 13 AND 24 MONTHS AGO (BEFORE *THE QUALIFYING ARREST*):**

***CJ_4a NUMBER OF TIMES INDIVIDUAL WAS BOOKED INTO JAIL (13-24 MONTHS AGO)**

Source: BOC
Type: Character
Field Length: XX

COMMENTS:
Enter the number as a two-digit number

CJ_4b NUMBER OF CONVICTIONS

Source: BOC
Type: Character
Field Length: XX

COMMENTS:
Enter the number as a two-digit number

***CJ_4c MOST SERIOUS TYPE OF OFFENSE FOR WHICH INDIVIDUAL WAS BOOKED DURING THIS PERIOD**

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

F = Felony
M = Misdemeanor

CJ_4d MOST SERIOUS CONVICTION DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

1 = Violent offense (including homicide, forcible rape, robbery, assault, kidnapping)
2 = Property offense (including conviction for burglary, theft, motor vehicle theft, forgery, checks and credit card fraud, arson)
3 = Drug offense (possession and/or sale of narcotics, marijuana, dangerous drugs)
4 = All other felony offenses
5 = All other misdemeanor offenses
6 = Violation of probation

CJ_4e NUMBER OF DAYS IN JAIL

Source: BOC
Type: Character
Field Length: XXX

COMMENTS:
Enter the number as a three-digit number

CJ_5a to CJ_ 5e: PROVIDE THE FOLLOWING DATA FOR THE PERIOD OF TIME BETWEEN THE MOST RECENT ARREST (THE ARREST THAT QUALIFIED THE INDIVIDUAL FOR THE MIO PROGRAM) AND 12 MONTHS AGO:

***CJ_5a NUMBER OF TIMES INDIVIDUAL WAS BOOKED INTO JAIL (0-12 MONTHS AGO)**

Source: BOC
Type: Character
Field Length: XX

COMMENTS:
Enter the number as a two-digit number

CJ_5b NUMBER OF CONVICTIONS

Source: BOC
Type: Character
Field Length: XX

COMMENTS:
Enter the number as a two-digit number

***CJ_5c MOST SERIOUS TYPE OF OFFENSE FOR WHICH INDIVIDUAL WAS BOOKED DURING THIS PERIOD**

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

F = Felony
M = Misdemeanor

CJ_5d MOST SERIOUS CONVICTION DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

1 = Violent offense (including homicide, forcible rape, robbery, assault, kidnapping)
2 = Property offense (including conviction for burglary, theft, motor vehicle theft, forgery, checks and credit card fraud, arson)
3 = Drug offense (possession and/or sale of narcotics, marijuana, dangerous drugs)
4 = All other felony offenses
5 = All other misdemeanor offenses
6 = Violation of probation

CJ_5e NUMBER OF DAYS IN JAIL

Source: BOC
Type: Character
Field Length: XXX

COMMENTS:
Enter the number as a three-digit number

CJ_6a to CJ_6d PROVIDE THE FOLLOWING DATA WITH REGARD TO THE ARREST OR INCARCERATION THAT QUALIFIED THE INDIVIDUAL FOR THE MIO PROGRAM

***CJ_6a MOST SERIOUS QUALIFYING OFFENSE FOR WHICH THE INDIVIDUAL WAS BOOKED**

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

F = Felony
M = Misdemeanor

CJ_6b MOST SERIOUS CONVICTION THAT QUALIFIED INDIVIDUAL

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

1 = Violent offense (including homicide, forcible rape, robbery, assault, kidnapping)
2 = Property offense (including conviction for burglary, theft, motor vehicle theft, forgery, checks and credit card fraud, arson)
3 = Drug offense (possession and/or sale of narcotics, marijuana, dangerous drugs)
4 = All other felony offenses
5 = All other misdemeanor offenses
6 = Violation of probation

***CJ_6c NUMBER OF DAYS IN JAIL FOR QUALIFYING ARREST**

Source: BOC
Type: Character
Field Length: XXX

COMMENTS:
Enter the number as a three-digit number.

***CJ_6d CLIENT RECEIVED/WILL RECEIVE PROBATION FOLLOWING INCARCERATION FOR THE QUALIFYING ARREST?**

Source: BOC
Type: Character
Field Length: X

VALID CODES:

N = No
Y = Yes
U = Uncertain

V. VARIABLES FOR DESCRIBING THE CLIENT'S CURRENT RESOURCES

**This information should reflect the client's status prior to the qualifying arrest.*

***CR_1a to CR_1e ASSESS THE ADEQUACY OF INCOME DURING THE 30 DAYS PRIOR TO THE QUALIFYING ARREST FOR MEETING THE CLIENT'S ... (see below):**

CR_1a BASIC FOOD NEEDS

Source: QOL 13a
Type: Character
Field Length: XX

VALID CODES:
N = No
Y = Yes

CR_1b BASIC CLOTHING NEEDS

Source: QOL 13b
Type: Character
Field Length: XX

VALID CODES:
N = No
Y = Yes

CR_1c BASIC HOUSING NEEDS

Source: QOL 13c
Type: Character
Field Length: XX

VALID CODES:
N = No
Y = Yes

CR_1d BASIC TRANSPORTATION NEEDS

Source: QOL 13d
Type: Character
Field Length: XX

VALID CODES:
N = No
Y = Yes

CR_1e BASIC SOCIAL NEEDS

Source: QOL 13e
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_2 EMPLOYMENT UPON RELEASE

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

***CR_3a to CR_3i RELATE TO WHETHER THE CLIENT RECEIVED ANY OF THE FOLLOWING FORMS OF ASSISTA NCE IN THE 12 MONTHS (PRIOR TO THE ARREST THAT QUALIFIED THE CLIENT FOR THE MIO PROGRAM) SOME OF THESE ITEMS APPEAR ON THE ASI.**

CR_3a UNEMPLOYMENT COMPENSATION

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_3b CALWORKS

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

***CR_3c DPA (GENERAL PUBLIC ASSISTANCE)**

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_3d VETERANS' ADMINISTRATION SUPPORT

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_3e SOCIAL SECURITY INCOME (SSI)

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_3f SOCIAL SECURITY DISABILITY INCOME (SSDI)

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_3g PENSION BENEFITS

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_3h FINANCIAL ASSISTANCE FROM FAMILY OR FRIENDS

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_3i OTHER

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_4 CLIENT WAS RECEIVING PUBLIC ASSISTANCE AT THE TIME OF ENTRY INTO THE PROGRAM.

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

CR_5 PERCEIVED FAMILY SUPPORT

Client's feelings about how things are going, in general, between self and family.
Source: California QOL 6B or Lehman QOL 9
Type: Character
Field Length: XX

VALID CODES:

= Score from CQOL 6B or Lehman 9

CR_6 PROBLEMS WITH ALCOHOL REPORTED

Source: BASIS 32, ASI
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

COMMENTS:
Use score from BASIS 32, ASI, or other assessment instrument to determine appropriate response.

CR_7 PROBLEMS WITH DRUGS REPORTED

Source: BASIS 32, ASI
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

COMMENTS:
Use score from BASIS 32, ASI, or other assessment instrument to determine appropriate response.

VI. PROGRAM PARTICIPATION INFORMATION

*DATE CLIENT ENTERED IN-CUSTODY PROGRAM

Source: BOC
Type: Date
Field Length: mm/dd/yyyy

COMMENTS:
Date *on which some type of activities were started on behalf of the client while in-custody. Could include pre-release planning, contacting resources, etc., and doesn't require contact with the individual.*

*PP_2 DATE CLIENT LEFT IN-CUSTODY PROGRAM

Source: BOC
Type: Date
Field Length: mm/dd/yyyy

VALID CODES:

Enter date in format described.
1/1/2011 ***Not applicable.***

PP_3 CLIENTS STATUS REGARDING LEAVING IN-CUSTODY PROGRAM

At the time that the client left the in-custody program, the client had:
Source: BOC
Type: Character
Field Length: XX

VALID CODES *(Choose most applicable)**:***

1 = Completed all components of the program

Did not complete program for one of the following reasons:

2 = Entered special program (e.g., psychiatric hospital)
3 = Illness or death
4 = Removal from program by caretaker
5 = Removal from program by court
6 = Committed to state prison
7 = Persisted in unacceptable behavior
8 = Chose to leave the program
9 = Other

*PP_4 DATE CLIENT ENTERED POST-CUSTODY PROGRAM

Source: BOC
Type: Date
Field Length: mm/dd/yyyy
VALID CODES: *Enter date in format described.*
1/1/2011 ***Not applicable***
COMMENTS:
Date individual began to participate in the post-custody component of the program, irrespective of earlier involvement in in-custody components.

*PP_5 DATE CLIENT LEFT POST-CUSTODY PROGRAM

Source: BOC
Type: Date
Field Length: mm/dd/yyyy
VALID CODES:

Enter date in format described

1/1/2011 ***Not applicable***

PP_6 CLIENTS STATUS REGARDING LEAVING POST-CUSTODY PROGRAM

Source: BOC
Type: Character
Field Length: XX

VALID CODES *(Choose most applicable):*

1 = Completed all components of the program

Did not complete program for one of the following reasons:

2 = Entered special program (e.g., psychiatric hospital)
3 = Illness or death
4 = Removal from program by caretaker
5 = Removal from program by court
6 = Committed to state prison
7 = Persisted in unacceptable behavior
8 = Chose to leave the program
9 = New offense
10 = New incarceration
11 = Other

*PP_7 DATE OF COLLECTION OF POST-PROGRAM FINAL FOLLOW-UP DATA

Source: BOC
Type: Date
Field Length: mm/dd/yyyy
VALID CODES:

Enter date in format described

1/1/201 1 *Not applicable.*

COMMENTS:
Final data collection date for this individual. For programs that don't have completion criteria, this could be the last date of contact.

Part II

Intervention Data Elements
Mentally Ill Offender Crime Reduction Grant

I. INTERVENTIONS PROVIDED WHILE PARTICIPANT IS IN CUSTODY

The first six data elements (OCMC through OFAC) are to be used only by counties that can separately report receipt of case management, brokerage, medical, dental, housing, and accessing financial support services.

1 OCMC- deleted

2 OBC - deleted

3 OMSC

Preplanning to help clients access medical services upon release from custody.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received this service
N = No, client did not receive this service

COMMENTS:

This data element is to be used only by those counties that can separately document receipt of help accessing medical services. For counties that cannot separate that service, please use #7, CMBC.

4 ODSC

Pre-planning to help clients access dental services upon release from custody.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received this service.
N = No, client did not receive this service.

COMMENTS:

This data element is to be used only by those counties that can separately document receipt of help accessing dental services. For counties that cannot separate that service, please use #7, CMBC.

5 OHC

Pre-planning to help clients find housing upon release from custody.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received service.

N = No, client did not receive this service.

COMMENTS:
This data element is to be used only by those counties that can separately document receipt of help accessing housing. For counties that cannot separate that service, please use #7, CMBC.

6 OFAC

Pre-planning to help clients access financial assistance upon release from custody.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:
Y = Yes, client received service.
N = No, client did not receive service.

COMMENTS:
This data element is to be used only by those counties that can separately document receipt of help accessing financial assistance. For counties that cannot separate that service, please use #7, CMBC.

7 CMBC

Case Management <u>and</u> Brokerage (with or without client or collateral contact) – activities that assist a client to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed service.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XX

VALID CODES:
1 = Individual received case management only
2 = Individual received brokerage only
3 = Individual received case management and brokerage

COMMENTS:
Includes all services generally provided through case management or brokerage, including (but not limited to) medical and dental services, housing, conservatorship, vocational assistance, drug treatment services, or entitlements. May also include involving collateral parties, although neither the client nor the collateral need be present for a service to be provided and counted.

8 ASSTC - deleted

9 PDC - deleted

10 PREPC

Pre-Release Planning Prepare MIO to participate in post-release program.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of whole minutes the client received these services for the relevant six-month reporting period.

COMMENTS:

May include, but not be limited to developing plan for post-release care, consult for coordination of services, case planning, treatment planning, case conferencing, utilizing client's criminal activity history to develop plan, developing results-driven plans, or writing a transition plan, and briefing clients on program services.

11 EVC - deleted

12 COLLC - deleted

13 DSC

Developing support system for the client.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of contacts made on behalf of the client for these services for the relevant six-month reporting period.

COMMENTS:

May include working with families and others in the community, consulting on behalf of the client.

14 MSSC - deleted

15 SJHC

Special jail housing – does <u>not</u> provide intensive treatment, but may provide substance abuse support.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:

16 JIC

Jail Inpatient – a distinct unit within an adult detention facility which is staffed to provide intensive psychological treatment to inmates.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:

May include substance abuse treatment.

17 HIC

Hospital Inpatient – Hospital Inpatient – services provided in acute psych hospital or psych unit within a general hospital.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:

May include substance abuse treatment.

18 SCWC - deleted

19 CIC

Crisis intervention/stabilization – service lasting less than 24 hours, for condition which requires more timely response than a regularly scheduled visit.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXX

VALID CODES:

Enter the number of times the client received these services for the relevant six-month reporting period.

COMMENTS:

This variable represents either intervention or stabilization. When intervention and stabilization were contiguously provided, the event should be counted as **one** event.

20 CSC - deleted

21 JCOC

Jail Counseling-outpatient services within a jail, staffed to provide psychological assessments and counseling (see comment).

Source: County records, Medi-Cal billing data, CSI database
Field Length: XX

VALID CODES:

Y = Yes, client received service.

N = No, client did not receive service.

COMMENTS:

For counties that cannot separately identify individual and group counseling, other than substance abuse counseling.

22 ICC

Individual counseling while in custody, other than substance abuse counseling.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received service.
N = No, client did not receive service.

COMMENTS:

23 GCC

Group counseling while in custody, other than substance abuse counseling.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received counseling.
N = No, client did not receive counseling.

COMMENTS:

24 SACC

Substance abuse counseling while in custody.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Individual received in-custody substance abuse counseling
N = Individual did not receive in-custody substance abuse counseling

COMMENTS:

25 IMHSC - deleted

26 POC

Contact with probation officer.

Source: County records
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of contacts between client and probation officer for the relevant six-month reporting period.

COMMENTS:

Includes any meaningful contact between client and PO.

27 MHCC

Program staff's contact with mental health court or legal personnel on behalf of the client.

Source: County records
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of contacts between mental health program staff and court and legal personnel, on behalf of clients, for the relevant six-month reporting period.

COMMENTS:

Includes mental health court, pre-adjudication planning, and court liaison activities.

28 VSC

Vocation services – facilitates individual motivation and focus upon realistic and attainable vocational goals. Can include special vocational services, such as a horticulture program, job placement service, job skill development and linking clients to vocational services.

Source: County records
Type: Character
Field Length: XX

VALID CODES:

Y = Individual received vocational services
N = Individual did not receive vocational services

COMMENTS:

29 SVSC – deleted.

30 CEC

Contact potential employers on clients' behalf.

Source: County records
Type: Character
Field Length: XX

VALID CODES:

Y = Yes
N = No

COMMENTS:

31 EDC

Meet with client to develop and achieve education goals – includes strongly encouraging and providing referrals or links to educational resources and advocating with educational agencies to gain access for clients.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes
N = No

COMMENTS:

Includes strongly encouraging and providing referrals or links to educational resources and advocating with educational agencies to gain access for clients.

32 EAC – deleted.

33 PMC – deleted.

34 PSC

Attendance at 12-step and other drug/alcohol abuse group meetings.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXX

VALID CODES:

Enter the number of times (sessions) the client attended these meetings for the relevant six-month reporting period.

COMMENTS:

Does not require that attendance be voluntary. Includes mandatory as well as "encouraged" and "referred to" attendance at 12 step, self-help, and other client-run programs that address drug or alcohol abuse.

II. INTERVENTIONS PROVIDED WHILE PARTICIPANT IS OUT OF CUSTODY

The first six data elements (OCMO through OFAO) are to be used only by counties that can separately report receipt of case management, brokerage, medical, dental, and housing services.

35 OCMO - deleted

36 OBO - deleted

37 OMSO

Help clients access medical services.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received this service.
N = No, client did not receive this service.

COMMENTS:

This data element is to be used only by those counties that can separately document receipt of help accessing medical services. For counties that cannot separate that service, please use #41 CMBO.

38 ODSO

Help clients access dental services.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received this service.
N = No, client did not receive this service.

COMMENTS:

This data element is to be used only by those counties that can separately document receipt of help accessing dental services. For counties that cannot separate that service, please use #41 CMBO.

39 OHO

Help clients find housing.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes, client received service.
N = No, client did not receive this service.

COMMENTS:
This data element is to be used only by those counties that can separately document receipt of help accessing housing. For counties that cannot separate that service, please use #41 CMBO.

40 OFAO

Help clients access financial assistance.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:
Y = Yes, client received service.
N = No, client did not receive service.

COMMENTS:
This data element is to be used only by those counties that can separately document receipt of help accessing financial assistance. For counties that cannot separate that service, please use #41 CMBO.

41 CMBO

Case Management/Brokerage (with or without client or collateral contact) – activities that assist a client to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed service.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:
0 = Individual received no case management or brokerage
1 = Individual received case management only
2 = Individual received brokerage only
3 = Individual received case management **and** brokerage

COMMENTS:
Includes all services generally provided through case management or brokerage, including (but not limited to) medical and dental services, housing, conservatorship, vocational assistance, drug treatment services, or entitlements. May also include involving collateral parties, although neither the client nor the collateral need be present for a service to be provided and counted.

42 ASSTO - deleted

43 PDO

Plan Development – development of coordination plans, treatment plans or service plans, verification of medical necessity, monitoring of client's progress.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:
Enter the number of whole minutes the client received these services for the

relevant six-month reporting period.

COMMENTS:
May include, but not be limited to, consulting for the coordination of services, case planning, treatment planning, and case conferencing, utilizing the clients' criminal history to develop plan, and developing results-oriented case plans.

44 EVO - deleted

45 COLLO - deleted.

46 DSO

Developing support system for the client.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:
Enter the number of contacts made on behalf of the client for these services for the relevant six-month reporting period.

COMMENTS:
May include working with families and others in the community, consulting on behalf of the client.

47 MSSO

Medication support services - Medication support services – prescribing, dispensing and monitoring psychiatric medications or biologicals to alleviate symptoms of mental illness.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:
Enter the number of whole minutes the client received these services for the relevant six-month reporting period.

COMMENTS:

48 ICO

Individual counseling after release, other than substance abuse counseling.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:
Y = Individual received counseling
N = Individual did not receive counseling

COMMENTS:

49 GCO

Group counseling after release, other than substance abuse counseling.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Individual received group counseling
N = Individual did not receive group counseling

COMMENTS:

50 SACO

Substance abuse counseling after release.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Individual received substance abuse counseling
N = Individual did not receive substance abuse counseling

COMMENTS:

51 IMHSO - deleted

52 POO

Contact with probation officer.

Source: County records
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of contacts between client and probation officer for the relevant six-month reporting period.

COMMENTS:

Includes any meaningful contact between client and PO.

53 MHCO

Program staff's contact with mental health court or legal personnel on behalf of the client.

Source: County records
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of contacts between program staff and court or legal personnel, on behalf of clients for the relevant six-month reporting period.

COMMENTS:
Mental health court, pre-adjudication planning, and court liaison activities.

54 HIO

Hospital Inpatient – services provided in acute psychiatric hospital or psychiatric unit within a general hospital.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:
Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:
May include substance abuse treatment.

55 CIO

Crisis intervention/stabilization – service lasting less than 24 hours, for condition that requires more timely response than a regularly scheduled visit.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:
Enter the number of times the client received these services for the relevant six-month reporting period.

COMMENTS:
A contiguous intervention and stabilization should be counted as one event.

56 CSO - deleted

57 PHFO

Psychiatric Health Facility – therapeutic and/or rehabilitation services in non-hospital 24-hour inpatient.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:
Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:

58 SNFO - deleted

59 IMDO - deleted

60 PHO - deleted

61 UHO

Client used housing arranged, secured or provided by the program. Excludes residential treatment facilities.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:

62 ARO

Adult residential – rehabilitation services, non-institutional residential setting (can include board and care homes), provides therapeutic community with range of services to help individual avoid hospital. Includes semi-supervised and independent living support.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:

Can include substance abuse residential treatment if it can't be separated from other types of residential treatment facilities.

63 SARO - deleted

64 PSRCO

Psychosocial rehabitation center – 24-hour program to provide intensive support and rehabilitation services to develop skills for self-sufficiency and higher level of independent living.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of days client received these services for the relevant six-month reporting period.

COMMENTS:

65 VSO

Vocation services – facilitates client's motivation and focus upon realistic and attainable vocational goals. Can include job skill development, job coaching and linking clients to vocational services.

Source: County records
Type: Character
Field Length: XX

VALID CODES:

Y = Individual received vocational services
N = Individual did not receive vocational services

COMMENTS:

66 JCC - deleted

67 VSO - deleted

68 CEO

Contact potential employers on clients' behalf.

Source: County records
Type: Character
Field Length: XX

VALID CODES:

Y = Yes
N = No

COMMENTS:

69 EDO

Help client develop and achieve education goals – includes providing referrals to educational resources, and advocating with educational agencies to gain access for the client.

Source: County records, Medi-Cal billing data, CSI database
Type: Character
Field Length: XX

VALID CODES:

Y = Yes
N = No

COMMENTS:

70 EAO deleted

71 SO - deleted

72 DCT

Day treatment/socialization activities. Includes both organized and structured multi-disciplinary treatment programs and socialization activities that provide an alternative to hospitalization and to maintain clients in a community setting. Helps clients to develop social skills.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXX

VALID CODES:
Enter the number of times (sessions) the client attended these meetings for the relevant six-month reporting period.

COMMENTS:
Does not require that attendance be voluntary. Includes mandatory as well as "encouraged" and "referred to" attendance at 12 step, self-help, and other client-run programs that address drug or alcohol abuse.

73 PMO - deleted

74 PSO

Attendance at 12-step and other drug/alcohol abuse group meetings.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXX

VALID CODES:
Enter the number of half days the client received service during the relevant six-month reporting period.

COMMENTS:
Can include life skills development, leisure time activities, social skills development, and participation in-group activities, on and off site.

75 PTO deleted

76 PTCO

Provided transportation for the client.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:
Enter the number of destinations the client was transported to for the relevant six-month reporting period.

COMMENTS:
Count each destination, excluding a return trip home, as a provision of transportation.

77 SATO

Substance abuse testing.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXX

VALID CODES:

Enter the number of times the client was tested for substance use.

COMMENTS:

Includes mandatory or voluntary, weekly or random testing and when used as a therapeutic tool.

78 EMO

Electronic monitoring.

Source: County records, Medi-Cal billing data, CSI database
Type: Numeric
Field Length: XXXX

VALID CODES:

Enter the number of days in which the client received these services for the relevant six-month reporting period.

COMMENTS:

Part III

Outcome Common Data Elements Dictionary
Mentally Ill Offender Crime Reduction Grant

I. VARIABLES FOR IDENTIFYING THE RESEARCH SUBJECTS

ID_1 UNIQUE SUBJECT IDENTIFICATION NUMBER

Source: BOC
Type: Character
Field Length: XXXX
VALID CODES:
ID numbers start with 0001 and continue through 9999 as necessary.
COMMENTS:
Identification numbers are to be assigned each participant, treatment and comparison, by program staff.

ID_2 RESEARCH GROUP

Source: BOC
Type: Character
Field Length: X
VALID CODES*:*
1 = Treatment
2 = Comparison

ID_3 COUNTY NUMBER

Source: BOC
Type: Character
Field Length: XXX
VALID CODES*:*
Use county codes provided by the Board of Corrections.

ID_4 PROGRAM NUMBER

Source: BOC
Type: Character
Field Length: X
VALID CODES:
1 = First program for the county.
2 = Second program for the county.
3 = Third program for the county.

II. OUTCOME BEHAVIOR DURING THE TREATMENT PROGRAM

A. CRIMINAL JUSTICE OUTCOMES

These questions pertain to arrests or criminal justice activities that have occurred during this reporting period.

CJOD_1a LEAVE THIS FIELD BLANK FOR NOW.

It will eventually contain data that identifies the number of times project crisis team members responded to a client and prevented an arrest and booking that would have otherwise taken place.

CJOD_1b NUMBER OF TIMES INDIVIDUAL WAS BOOKED INTO JAIL

Source: BOC
Type: Character
Field Length: XX
COMMENTS:
Enter the number as a two-digit number.

CJOD_1c NUMBER OF CONVICTIONS

Source: BOC
Type: Character
Field Length: XX
COMMENTS:
Enter the number as a two-digit number.

CJOD_1d MOST SERIOUS TYPE OF OFFENSE FOR WHICH INDIVIDUAL WAS BOOKED DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX
VALID CODES*:*
F = Felony
M = Misdemeanor

CJOD_1e MOST SERIOUS CONVICTION DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
1 = Violent offense (including homicide, forcible rape, robbery, assault, kidnapping)
2 = Property offense (including conviction for burglary, theft, motor vehicle theft, forgery, checks and credit card fraud, arson)
3 = Drug offense (possession and/or sale of narcotics, marijuana, dangerous drugs)
4 = All other felony offenses
5 = All other misdemeanor offenses
6 = Violation of probation

CJOD_1f NUMBER OF DAYS IN JAIL

Source: BOC
Type: Character
Field Length: XXX
COMMENTS:
Enter the number as a three -digit number

B. MENTAL HEALTH DATA ELEMENTS

MHD_1a PRIMARY MENTAL HEALTH DIAGNOSIS

Identifies the principal mental health diagnosis, which is the primary focus of attention or treatment for the mental health services. This may be any of the full range of Diagnostic and Statistical Manual (DSM) diagnoses. It may be on either Axis I or Axis II.
Source: CSI: S-09.0
Type: Character
Field Length: XXXXX
COMMENTS:
Please use the Diagnostic and Statistical Manual – Fourth Edition (DSM-IV).

Enter all letters and/or numbers of the DSM-IV code. **Do not enter a decimal point when entering the code. Use trailing zeros if necessary (for example: 320.1 is entered as 32010; V61.12 is entered as V6112).**
VALID CODES:
All DSM-IV codes are accepted.

MHD_1b SECONDARY MENTAL HEALTH DIAGNOSIS

Identifies the secondary mental health diagnosis, which is the secondary focus of attention or treatment for the mental health services. This may be any of the full range of Diagnostic and Statistical Manual (DSM) diagnoses. It may be on either Axis I or Axis II.
Source CSI: S-10.0
Type: Character
Field Length: XXXXX
COMMENTS:
Enter all letters and/or numbers of the DSM-IV code for the secondary mental health diagnosis**. Do not enter a decimal point when entering the code. Use trailing zeros if necessary (for example: 320.1 is entered as 32010; V61.12 is entered as V6112).**
Enter x's in this field if the client does not have a secondary mental health diagnosis.
VALID CODES:
X = No secondary mental health diagnosis
All DSM-IV codes are accepted.

MHD_1c AXIS-V / GAF

Identifies the current functioning level rating of the client.
Source: CSI: P-04.0
Type: Character
Field Length: XX

COMMENTS:
Enter '00' if the GAF score cannot be determined.
VALID CODES*:*

01 through 99	=	Valid numeric GAF score
00	=	GAF score cannot be determined due to client's condition.

MHD_1d PROBLEMS WITH ALCOHOL REPORTED

Source: BASIS 32, ASI
Type: Character
Field Length: XX
VALID CODES*:*
N = No
Y = Yes
COMMENTS:
Use scores from the BASIS 32, ASI, or other assessment instrument to determine appropriate response.

MHD_1e PROBLEMS WITH DRUGS REPORTED

Source: BASIS 32, ASI
Type: Character
Field Length: XX
VALID CODES*:*
N = No
Y = Yes
COMMENTS:
Use scores from the BASIS 32, ASI, or other assessment instrument to determine appropriate response.

C. PARTICIPANT INFORMATION AND BASIC (LIFESTYLE) INFORMATION

PID_1a EMPLOYMENT STATUS

Identifies the current employment status of the client.
Source: CSI: P-03.0
Type: Character
Field Length: XX
VALID CODES:

Employed in competitive job market

A = Full time, 35 hours or more per week
B = Part time, less than 35 hours per week

Employed in noncompetitive job market (sheltered workshop, protected environment)

C = Full time, 35 hours or more per week
D = Part time, less than 35 hours per week

Not in the paid work force

E = Actively looking for work
F = Homemaker
G = Student
H = Volunteer Worker
I = Retired
J = Resident / inmate of institution
K = Other (use for clients on SSI)
U = Unemployed

COMMENT
Non-paid, noncompetitive job market is coded as "H" – Volunteer Worker.

PID_1b LIVING ARRANGEMENT

Identifies the living arrangement of the client.
Source: CSI: P-09.0
Type: Character
Field Length: XX
VALID CODES:

A = House or apartment (includes trailers, hotels, dorms, barracks, etc.)
B = House or apartment and requiring some support with daily living activities
C = House or apartment and requiring daily support and supervision)
D = Supported housing
E = Foster family home
F = Group Home
G = Residential Treatment Center
H = Community Treatment Facility
I = Board and Care
J = Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
K = Mental Health Rehabilitation Center (24 hour)

L = Skilled Nursing Facility/Intermediate Care Facility/Institute of Mental Disease (IMD)

M = Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital
N = State Hospital
O = Justice related (correctional facility, jail, etc.)
P = Homeless, no identifiable residence
Q = Other

PID_1c CONSERVATORSHIP/COURT STATUS

Identifies whether or not the client has a conservatorship.
Source: CSI: P-08.0
Type: Character
Field Length: XX
VALID CODES:
A = Temporary Conservatorship (W&I Code, Section 5353)

Types of Permanent Conservatorship
B = Lanterman-Petris-Short (W&I Code, Section 5358)
C = Murphy (W&I Code, Section 5008)
D = Probate (Probate Code, Division 4, Section 1400)
E = PC 2974 (Penal Code, Section 2974)
F = Representative Payee Without Conservatorship (W&I Code, Section 5686)

G = No conservatorship

PID_1d1-9 HAS THE CLIENT RECEIVED ANY OF THE FOLLOWING FORMS OF ASSISTANCE...

PID_1d1 UNEMPLOYMENT COMPENSATION

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PID_1d2 CALWORKS

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PID_1d3 DPA (GENERAL PUBLIC ASSISTANCE)

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PID_1d4 VETERANS' ADMINISTRATION SUPPORT

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PID_1d5 SOCIAL SECURITY INCOME (SSI)

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PID_1d6 SOCIAL SECURITY DISABILITY INCOME (SSDI)

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PID_1d7 PENSION BENEFITS

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PID_1d8 FINANCIAL ASSISTANCE FROM FAMILY OR FRIENDS

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

PID_1d9 OTHER

Source: BOC
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

III. OUTCOME BEHAVIOR AFTER COMPLETING THE TREATMENT PROGRAM

A. CRIMINAL JUSTICE DATA ELEMENTS

These questions pertain to arrests or criminal justice activities that have occurred during this reporting period.

CJOA_1a LEAVE THIS FIELD BLANK FOR NOW.

It will eventually contain data that identifies the number of times project crisis team members responded to a client and prevented an arrest and booking that would have otherwise taken place.

CJOA_1b NUMBER OF TIMES THE INDIVIDUAL WAS BOOKED INTO JAIL

Source: BOC
Type: Character
Field Length: XX
COMMENTS:
Enter the number as a two-digit number.

CJOA_1c NUMBER OF CONVICTIONS

Source: BOC
Type: Character
Field Length: XX
COMMENTS:
Enter the number as a two-digit number.

CJOA_1d MOST SERIOUS TYPE OF OFFENSE FOR WHICH THE INDIVIDUAL WAS BOOKED DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
F = Felony
M = Misdemeanor

CJOA_1e MOST SERIOUS CONVICTION DURING THIS PERIOD

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
1 = Violent offense (including homicide, forcible rape, robbery, assault, kidnapping)
2 = Property offense (including conviction for burglary, theft, motor vehicle theft, forgery, checks and credit card fraud, arson)
3 = Drug offense (possession and/or sale of narcotics, marijuana, dangerous drugs)
4 = All other felony offenses
5 = All other misdemeanor offenses
6 = Violation of probation

CJOA_1f NUMBER OF DAYS IN JAIL

Source: BOC
Type: Character
Field Length: XXX
COMMENTS:
Enter the number as a three -digit number.

B. MENTAL HEALTH DATA ELEMENTS

MHA_1a PRIMARY MENTAL HEALTH DIAGNOSIS

Identifies the principal mental health diagnosis, which is the primary focus of attention or treatment for the mental health services. This may be any of the full range of Diagnostic and Statistical Manual (DSM) diagnoses. It may be on either Axis I or Axis II.
Source: CSI: S-09.0
Type: Character
Field Length: XXXXX
COMMENTS:
Please use the Diagnostic and Statistical Manual – Fourth Edition (DSM-IV).
Enter all letters and/or numbers of the DSM-IV code. **Do not enter a decimal point when entering the code. Use trailing zeros if necessary (for example: 320.1 is entered as 32010; V61.12 is entered as V6112).**
VALID CODES*:*
All DSM-IV codes are accepted.

MHA_1b SECONDARY MENTAL HEALTH DIAGNOSIS

Identifies the secondary mental health diagnosis, which is the secondary focus of attention or treatment for the mental health services. This may be any of the full range of Diagnostic and Statistical Manual (DSM) diagnoses. It may be on either Axis I or Axis II.
Source CSI: S-10.0
Type: Character
Field Length: XXXXX
COMMENTS:
Enter all letters and/or numbers of the DSM-IV code for the secondary mental health diagnosis. **Do not enter a decimal point when entering the code. Use trailing zeros if necessary (for example: 320.1 is entered as 32010; V61.12 is entered as V6112).** Enter x's in this field if the client does not have a secondary mental health diagnosis.
VALID CODES*:*
X = No secondary mental health diagnosis
All DSM-IV codes are accepted.

MHA_1c AXIS-V / GAF

Identifies the current functioning level rating of the client.
Source: CSI: P-04.0
Type: Character
Field Length: XX
COMMENTS:
Enter '00' if the GAF score cannot be determined.

VALID CODES:

01 through 99	=	Valid numeric GAF score
00	=	GAF score cannot be determined due to client's condition.

MHA_1d PROBLEMS WITH ALCOHOL REPORTED

Source: BASIS 32, ASI
Type: Character
Field Length: XX

VALID CODES:

N = No
Y = Yes

COMMENTS:

Use scores from the BASIS 32, ASI, or other assessment instrument to determine appropriate response.

MHA_1e PROBLEMS WITH DRUGS REPORTED

Source: BASIS 32, ASI
Type: Character
Field Length: XX

VALID CODES*:*

N = No
Y = Yes

COMMENTS:

Use scores from the BASIS 32, ASI, or other assessment instrument to determine appropriate response.

C. PARTICIPANT INFORMATION AND BASIC (LIFESTYLE) INFORMATION

PIA_1a EMPLOYMENT STATUS

Identifies the current employment status of the client.
Source: CSI: P-03.0
Type: Character
Field Length: XX

VALID CODES*:*

Employed in competitive job market

A = Full time, 35 hours or more per week
B = Part time, less than 35 hours per week

Employed in noncompetitive job market (sheltered workshop, protected environment)

C = Full time, 35 hours or more per week
D = Part time, less than 35 hours per week

Not in the paid work force

E = Actively looking for work
F = Homemaker
G = Student
H = Volunteer Worker

I = Retired
J = Resident / inmate of institution
K = Other (use for clients on SSI)
U = Unemployed

COMMENT:
Non-paid, noncompetitive job market is coded as "H" – Volunteer Worker.

PIA_1b LIVING ARRANGEMENT

Identifies the living arrangement of the client.
Source: CSI: P-09.0
Type: Character
Field Length: XX
VALID CODES*:*
A = House or apartment (includes trailers, hotels, dorms, barracks, etc.)
B = House or apartment and requiring some support with daily living activities
C = House or apartment and requiring daily support and supervision)
D = Supported housing
E = Foster family home
F = Group Home
G = Residential Treatment Center
H = Community Treatment Facility
I = Board and Care
J = Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
K = Mental Health Rehabilitation Center (24 hour)
L = Skilled Nursing Facility/Intermediate Care Facility/Institute of Mental Disease (IMD)
M = Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital
N = State Hospital
O = Justice related (correctional facility, jail, etc.)
P = Homeless, no identifiable residence
Q = Other

PIA_1c CONSERVATORSHIP/COURT STATUS

Identifies whether or not the client has a conservatorship.
Source: CSI: P-08.0
Type: Character
Field Length: XX
VALID CODES:
A = Temporary Conservatorship (W&I Code, Section 5353)

Types of Permanent Conservatorship
B = Lanterman-Petris-Short (W&I Code, Section 5358)
C = Murphy (W&I Code, Section 5008)
D = Probate (Probate Code, Division 4, Section 1400)
E = PC 2974 (Penal Code, Section 2974)
F = Representative Payee Without Conservatorship (W&I Code, Section 5686)
G = No conservatorship

PIA_1d1-9 HAS THE CLIENT RECEIVED ANY OF THE FOLLOWING FORMS OF ASSISTANCE...

PIA_1d1 UNEMPLOYMENT COMPENSATION

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d2 CALWORKS

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d3 DPA (GENERAL PUBLIC ASSISTANCE)

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d4 VETERANS' ADMINISTRATION SUPPORT

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d5 SOCIAL SECURITY INCOME (SSI)

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d6 SOCIAL SECURITY DISABILITY INCOME (SSDI)

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d7 PENSION BENEFITS

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d8 FINANCIAL ASSISTANCE FROM FAMILY OR FRIENDS

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

PIA_1d9 OTHER

Source: BOC
Type: Character
Field Length: XX
VALID CODES:
N = No
Y = Yes

APPENDIX F
PROGRAM CONTACTS

MENTALLY ILL OFFENDER CRIME REDUCTION GRANT
DIRECTORY OF PROJECT MANAGERS

MIOCRG I - Updated May 2004

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MENTALLY ILL OFFENDER CRIME REDUCTION GRANT
DIRECTORY OF PROJECT MANAGERS

MIOCRG II - Updated May 2004

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