SAN DIEGO COUNTY’S CONNECTIONS PROGRAM
BOARD OF CORRECTIONS
FINAL REPORT

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Sandy Keaton

This research was supported with funding from the California Board of Corrections. Findings and conclusions of this study are those of the authors and do not necessarily reflect the official position or policies of the San Diego County Sheriff’s and Probation Departments, SANDAG, or its Board of Directors.
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ABSTRACT

This final report describes and presents outcomes for the Connections Program in San Diego County that targeted mentally ill criminal offenders. Given the high proportion of mentally ill offenders in the arrest population and the fact that few programs exist to serve them, this specific sub-group revolves through the criminal justice system. Through a grant application process, the State of California provided funding support to those counties that successfully competed to develop programs that provided immediate assessment and aftercare in the community following release from jail. Locally, the San Diego County Sheriff’s Department was the program administrator in partnership with the County Probation Department. Teams of Social Workers and Probation Officers collaborated to develop a program based on a mental health model called Assertive Community Treatment or ACT.

As the oversight administrator for the statewide projects, the California Board of Corrections (BOC) required a sophisticated research approach to determine if the programs were effective in reducing re-offending and providing assistance with life skills to improve client well-being and stability. The Sheriff’s Department contracted with the Criminal Justice Research Division of the San Diego Association of Governments (SANDAG) to provide the technical research expertise to conduct both a process evaluation of program evolution and an impact assessment of effectiveness. The evaluation incorporated a variety of research procedures including experimental design, within group comparison, correlational analyses, and case studies. This final report describes the Connections model, implementation activities, research methodology, and provides the characteristics of the treatment and comparison groups. In addition, program outcomes are described, along with recommendations for future research and program implementation.
ACKNOWLEDGEMENTS

This final report would not have been possible without the help from numerous individuals. Special thanks are extended to those individuals who reviewed and commented on this report, including Ann Herbert, Project Director, Anna Guzman, Supervising Probation Officer, and Dick Conklin, Chief Clinical Social Worker. In addition, the cooperation of Veronica Velez and all of the Connections program staff are gratefully acknowledged for compiling the information necessary for the evaluation and this report. Although anonymous, the Connections clients who allowed the researcher to be involved in their case are greatly appreciated. Finally, the production of this report was made possible through the assistance of numerous SANDAG staff Donna Allnutt, Christine Brena, Mara Bernd, Ami Caldwell, Debbie Correia, Laura Curtis, Liz Doroski, Michelle Gonnam, Becki Hammett, Lisbeth Howard, Lori Jones, Liliana Mercado, Gina Misch, Erin Oliver, and Jessica Sippy.
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INTRODUCTION AND BACKGROUND

Since the 1950s, the number of mentally ill entering the criminal justice system has increased, while the number that are being cared for in mental hospitals has decreased. This inverse relationship can be attributed to several factors including deinstitutionalization, a decrease in involuntary commitments, lack of available treatment, and the criminalization of the mentally ill. Once incarcerated, the mentally ill have a difficult time accessing the necessary community services to aid them in meeting their conditions of probation or parole, creating a revolving door to incarceration. This national issue has garnered the attention of the mental health and criminal justice communities, advocates, and the legislature, all of which are searching for means to reverse this trend.

In response to the growing number of inmates requiring mental health services, the California Legislature passed Senate Bill 1485 in 1998. This Bill required the Board of Corrections (BOC) to award and administer mentally ill offender (MIO) crime reduction grants on a competitive basis to counties that planned to expand or establish a continuum of swift, certain, and graduated responses to reduce crime, jail crowding, and criminal costs related to mentally ill offenders.

In 1999, with the Sheriff’s Department as the lead agency, the San Diego County Strategy Committee, which was formed with funding from a BOC planning grant, submitted a formal proposal for MIO funds and was awarded such funds the same year. The Connections program that was developed through this grant involved the provision of intensive case management to local probationers using the principles of Assertive Community Treatment (ACT), as opposed to the standard level of service. Originally intended as a community-based alternative to institutionalization, the goal of ACT is to ensure that clients who are at high risk for relapse or re-incarceration receive a high level of supportive case management services in the community. Key features of the Connections program included teams of Social Workers and Probation Department staff working together, a staff to client ratio of 1:10, 24-hour staff availability, pre-release treatment planning, and linkages to community-based interventions.

To fulfill the evaluation requirements of the BOC grant, the San Diego County Sheriff’s Department contracted with researchers from the Criminal Research Justice Division of the San Diego Association of Governments (SANDAG) to determine if the ACT model was more effective than the standard level of service.

PROGRAM DESCRIPTION

The goal of Connections was to utilize five service coordinating teams to help mentally ill offenders integrate successfully into the community by focusing on teaching them new skills so they would not reoffend. Each team was composed of a Social Worker, Deputy Probation Officer (DPO), and Correctional Deputy Probation Officer (CDPO) and served different areas of the county. Each team could serve a maximum of 30 clients at any one time. Other available staff included two consulting Psychiatrists and an Employment Specialist.
In June 2000, the first individuals were randomized into Connections, with the last one entering the program in February 2003. Individuals were eligible for the program if they were currently in jail, under Probation supervision, and had a DSM-IV (Diagnostic & Statistical Manual of Mental Health Disorders) Axis I Psychiatric Diagnosis and a Global Assessment of Function (GAF) Axis V score equal to or less than 50. GAF scores can vary from 1 (when an individual is in persistent danger of severely hurting themselves or others) to 100 (superior functioning in a wide range of activities). A GAF of 50 or less is categorized as having serious symptoms or serious impairment in social, occupational, or school functioning. A six-phase process, which started with an initial health screen at one of the local detention facilities, was used to identify and screen potential clients. After staff from the Medical Services Division of the jail verified the psychiatric diagnosis of an individual, an in-depth screening and intake interview was conducted and all eligible clients were randomized to either receive Connections services or “treatment as usual.” For clients randomized to the comparison group, “treatment as usual” was concentrated in the jail setting, with the degree and intensity of services dependent on the inmate’s willingness to participate and seek services. After release, their service provision was dependent upon the level of Probation supervision they received, either intensive or mid-level. The majority received mid-level, where they would only see their Probation Officer once and were provided a list of referrals to available services in the community.

Clients in the Connections program received services from 9 to 12 months after release from jail. The intensity of service was expected to decrease during this period as a function of the client becoming more stable and being linked to community resources. Individual service plans were designed collaboratively with the clients, families, and significant others to ensure that all aspects of the program were client-centered. The five phases of treatment included pre-release planning, engagement, and assessment during the first month post-release, support and monitoring for the second three-month period, transfer of care for the third three-month period, and either discharge or continuation of services for another three months.

**EVALUATION METHODOLOGY**

A mandatory aspect of the Connections project was the evaluation to determine if the program was implemented as designed and to measure if the expected outcomes were realized. A variety of different methods were used to collect the qualitative data necessary to document program implementation and modification. These included attending team meetings and trainings, reviewing program documentation, documenting service provision and client behavior, surveying program staff, surveying program participants at exit, and conducting case studies.

To determine if the ACT model was more effective than the standard level of service, an experimental design was used. Specifically, 449 (one was non-sampled after randomization was complete) eligible clients were randomly assigned to either participate in the Connections program or to receive “treatment as usual.” Random assignment to conditions was important because it ensured that the two groups were equivalent from the outset and all eligible candidates had an equal chance of being assigned to either group. If any differences between the two groups were later documented and the only difference between the two groups was the type of services received, then it could be concluded that it was the treatment and not initial differences that was the cause. Randomization was completed in February 2003 and the program continued to accept all
eligible clients through December 2003. Data for the impact evaluation were collected from criminal and Probation records and through exit and follow-up interviews with Connections clients.

Descriptive information from the two groups indicated that they were well matched on most characteristics. Slightly more than half of the Connections clients were male, as were slightly less than two-thirds of the comparison group. Both groups represented a variety of ethnic backgrounds, with over half being White and around a quarter being Black. Almost all reported English as their primary language and the majority were single and did not have any dependents. The average age of Connections clients was 36.2 years (SD = 10.6) and 34.2 years (SD = 9.7) for the comparison clients.

**PROCESS EVALUATION RESULTS**

The results of the process evaluation revealed that Connections clients possessed the same personal characteristics, lengthy criminal histories, and high level of need as documented in other research studies of mentally ill offenders. Overall, staff and clients were very satisfied with the implementation and structure of the program and the array of services that were provided to the Connections clients.

Four hypotheses, each with specific research questions, were addressed through the process evaluation to determine if Connections was implemented as planned. These included:

**Hypothesis 1:** Connections will target mentally ill individuals with extensive needs and criminal histories.

**Hypothesis 2:** Connections team members will be committed to the program model and satisfied with project implementation and management.

**Hypothesis 3:** Connections clients will receive intensive case management services as they integrate back into the community.

**Hypothesis 4:** Connections clients will be satisfied with the services they received.

A variety of different methods was used to collect the qualitative data necessary to document program implementation and modification. These included research staff attending team meetings and trainings, reviewing program documentation, documenting service provision and client behavior, surveying project staff, surveying program participants at exit, and conducting case studies.

**How Many Individuals Were Screened and Eligible for the Program?**

Between June 2000 and February 2003, program staff received 4,786 referrals for individuals potentially eligible for program participation. Four hundred and sixty-three (463) of these completed the screening process and were eligible for randomization. Some of those who were not eligible had been released from jail prior to completion of the intake, were sentenced to state prison, or were not placed on formal probation.
During randomization, 225 individuals were assigned to receive Connections services, while 224 (one was non-sampled after randomization was complete) were assigned to the comparison group. After randomization was complete, Connections continued to accept referrals and all eligible clients were placed in the program, but not included in the study.

What Was the Level of Client Need?

The level of need for both groups was consistent with other studies on the mentally ill, with individuals presenting a high level of need at the time the intake process was completed. Over half were not employed and were not looking for work and around half reported that they had not worked at all in the past 12 months. Many revealed that they lacked adequate income in the 30 days prior to their arrest to meet basic needs, including food, clothing, housing, transportation, and other social needs, and around half reported not having health insurance. Around one-third reported being homeless, but this percentage may be even higher due to client underreporting. In addition, clients in both groups were often dual-diagnosed individuals with a history of alcohol and/or other drug abuse, which presented unique challenges in regard to service plan development.

What Was the Mental Health Status of Clients?

The most common diagnosis at intake for these clients was schizophrenia, followed by depression, and bi-polar disorder. In addition, over half had a secondary diagnosis for alcohol or drug dependence or abuse. The average GAF score was 42.0 ($SD = 9.14$) for Connections clients and 41.0 ($SD = 8.5$) for the comparison group, indicating severe impairment in their social, occupational, and/or school functioning. In addition, around two-thirds of both groups had received mental health treatment in the 12 months prior to arrest. For the majority, this took the form of medication management.

What Was the Level of Criminal History of Clients?

The majority of clients had a criminal history prior to the current offense. Around nine out of ten reported that the current arrest was not their first and official records from the county indicated that around 85 percent had been booked into jail at least one other time in the past three years.

How Did the Connections Staff Feel About the Multi-Disciplinary, Collaborative Team Model?

Almost all of the program staff surveyed felt the collaborative model was “very effective” or “somewhat effective” in providing services to the target population. Benefits included the different perspectives and experiences that were brought by the members and the sharing of ideas. However, staff also acknowledged that maintaining communication and balancing these different perspectives was a challenge. The teams had to collaborate with community-based organizations and other governmental agencies and this entailed challenges including locating high quality services and dealing with cumbersome bureaucracies.
What Did Staff See as the Greatest Strengths and Weaknesses of Connections?

Staff recognized the interdisciplinary teams as the primary strength of Connections, both for combining two different disciplines and increasing the availability of staff to clients. The availability of wrap-around services, the expertise of the Connections staff, and the goals of assisting this population and reducing recidivism were also noted as strengths. Specific weaknesses noted included adjusting to the different professional perspectives of Probation staff and Social Workers, dealing with different personalities, and operating out of different offices.

How Did Connections Staff Feel About Program Implementation and Management?

Overall, staff was satisfied with program implementation and management. The most common suggestion for improvement centered on the dynamics of the partnership between Probation staff and the Social Workers, specifically, increasing staffs understanding of each other’s perspective and more inclusion and equity of all members. As the program progressed, staff satisfaction with the management of Connections increased, as the majority believed it was being managed “very effectively” and felt they had received the support and resources necessary to do their job.

What Were the Types and Frequency of Services Provided to Participants?

As expected, Connections clients received significantly more services post-release from jail, in comparison to those who received “treatment as usual.” Specifically, those in Connections were more likely be assessed and receive case management, medication support services, individual counseling, crisis intervention, vocational services, and collateral services. This difference was not sustained during the six-month follow-up period. Only successful Connections clients received more services in two areas (i.e., medication support and individual counseling) than the comparison group.

How Many Clients Completed the Program and How Long Were They Served?

Fifty-eight percent (58%) or 131 clients successfully completed Connections as of December 31, 2003. On average, these individuals were in the program for approximately eleven months (336.1 days, \( SD = 64.3 \)). Sixteen percent (16%) chose to leave the program (AWOL), 16 percent had either a new offense, were incarcerated, or were sentenced to jail, and 7 percent were asked to leave because of unacceptable behavior.

How Did Clients Feel About Their Participation?

More than nine out of ten clients expressed satisfaction with the services they received. The consistent attention and concern from the team, as well as the team members themselves, were most often cited as the “best” part of the program. Some clients noted that Connections had
helped improve their behavior and others were impressed by the team’s knowledge of resources and mental health issues. One client put it simply, “They were always on time and there when you needed them. Thank you.”

**How Did Clients Feel About Changes in Their Lives?**

Almost all (95%) of the clients reported improvement in their emotional well-being as a result of program participation. In addition, more than 80 percent reported the same in terms of their family relationships and housing status.

**IMPACT EVALUATION RESULTS**

The results from the impact evaluation demonstrated that Connections was able to accomplish its primary goals of linking clients to the community, while also helping to improve their life skills and reduce their recidivism. The following hypothesis guided the research for the impact evaluation.

Hypothesis 5: Connections clients will be integrated into the community and less likely to recidivate after program participation.

Quantitative data were collected from Sheriff’s and Probation Department records, as well as intake, exit, and follow-up interviews.

Those clients who successfully completed the program (i.e. received the full dosage of treatment) showed significant gains in their overall quality of life and had significantly less bookings and convictions for a new offense, both during the program and in the six months after program exit. Tables 1 and 2 summarize some of the statistically significant findings.

**Table 1**

**IMPACT EVALUATION RESULTS – CRIMINAL HISTORY OUTCOMES**

<table>
<thead>
<tr>
<th>Connections</th>
<th>Comparison</th>
<th>Criminal History Variable</th>
<th>Statistical Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>19%</td>
<td>46%</td>
<td>Booked into jail during program participation</td>
<td>$\chi^2(1) = -3.882$</td>
</tr>
<tr>
<td>$\mu = 8.7$</td>
<td>$\mu = 34.6$</td>
<td>Average days in jail during program participation</td>
<td>$t_{(353)} = -3.882$</td>
</tr>
<tr>
<td>12%</td>
<td>26%</td>
<td>Booked into jail during follow-up</td>
<td>$\chi^2(1) = 5.878$</td>
</tr>
<tr>
<td>$\mu = 2.1$</td>
<td>$\mu = 19.3$</td>
<td>Average days in jail during follow-up</td>
<td>$t_{(253)} = -4.098$</td>
</tr>
<tr>
<td>8%</td>
<td>21%</td>
<td>Conviction for new offense during program participation</td>
<td>$\chi^2(1) = 9.960$</td>
</tr>
<tr>
<td>2%</td>
<td>10%</td>
<td>Conviction for new offense during follow-up</td>
<td>$\chi^2(1) = 3.886$</td>
</tr>
</tbody>
</table>

SOURCE: SANDAG
Table 2
IMPACT EVALUATION RESULTS - QUALITY OF LIFE OUTCOMES

<table>
<thead>
<tr>
<th>Intake</th>
<th>Exit</th>
<th>Variable</th>
<th>Statistical Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>54%</td>
<td>14%</td>
<td>Used alcohol in the past 30 days</td>
<td>Sign Test, n = 157, 69 negative differences</td>
</tr>
<tr>
<td>65%</td>
<td>9%</td>
<td>Used some type of drug in the past 30 days</td>
<td>Sign Test, n = 158, 92 negative differences</td>
</tr>
<tr>
<td>46%</td>
<td>61%</td>
<td>Received public financial support</td>
<td>Sign Test, n = 158, 33 positive differences</td>
</tr>
<tr>
<td>61%</td>
<td>86%</td>
<td>Enough income for food</td>
<td>Sign Test, n = 158, 49 positive differences</td>
</tr>
<tr>
<td>51%</td>
<td>78%</td>
<td>Enough income for clothing</td>
<td>Sign Test, n = 158, 53 positive differences</td>
</tr>
<tr>
<td>49%</td>
<td>82%</td>
<td>Enough income for housing</td>
<td>Sign Test, n = 158, 64 positive differences</td>
</tr>
<tr>
<td>54%</td>
<td>82%</td>
<td>Enough income for transportation</td>
<td>Sign Test, n = 158, 52 positive differences</td>
</tr>
<tr>
<td>40%</td>
<td>67%</td>
<td>Enough income for social needs</td>
<td>Sign Test, n = 158, 58 positive differences</td>
</tr>
<tr>
<td>34%</td>
<td>69%</td>
<td>Feel positively about family relations</td>
<td>Sign Test, n =158, 66 positive differences</td>
</tr>
<tr>
<td>15%</td>
<td>72%</td>
<td>Feel positively about emotional well-being</td>
<td>Sign Test, n =156, 93 positive differences</td>
</tr>
<tr>
<td>23%</td>
<td>68%</td>
<td>Feel positively about life in general</td>
<td>Sign Test, n =158, 80 positive differences</td>
</tr>
<tr>
<td>39%</td>
<td>68%</td>
<td>Feel positively about living arrangements</td>
<td>Sign Test, n =158, 62 positive differences</td>
</tr>
<tr>
<td>40%</td>
<td>59%</td>
<td>Feel positively about privacy</td>
<td>Sign Test, n = 158, 54 positive differences</td>
</tr>
</tbody>
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\[ \mu = 42.4 \quad \mu = 53.7 \quad \text{Average GAF Score} \]

\[ t (154) = -11.198 \]

SOURCE: SANDAG

Were Connections Clients Less Likely to be Booked into Jail?

Individuals in the comparison group were significantly more likely to be booked into jail in the “during” time period compared to the Connections clients. Comparison clients also served a significantly greater number of days in jail during this time, compared to Connections clients (34.6, $SD = 72.1$ versus 8.7, $SD = 33.1$). In addition, during follow-up, Connections clients who had successfully completed the program were less likely to be booked into jail compared to the comparison group and also served significantly fewer days in jail (2.1, $SD = 9.1$ versus 19.3 $SD = 39.3$).
Were Connections Clients Less Likely to be Convicted of a New Offense?

Successful Connections clients were significantly less likely to be convicted of a new offense during program participation (8%) and six-months after program exit (2%) than individuals in the comparison group (21% and 10%, respectively).

Were Connections Clients Less Likely To Use Alcohol or Other Drugs?

Over half of the Connections clients were dual-diagnosed, which complicated service provision. However, after program participation, Connections clients reported a significant decrease in their alcohol and drug use at program exit and at six-month follow-up, compared to at intake. While over half of the clients at intake reported using alcohol in the past 30 days, less than one-fifth did so at exit. Similarly, while two-thirds reported some drug use in the past 30 days at intake, less than one in ten did so at program exit. This decrease continued during follow-up, with nearly nine out of ten reporting that they had not used alcohol or drugs in the past 30 days (88% and 91%, respectively).

Did Connections Clients Have More Resources Available to Them?

Feedback from Connections clients who had exited the program revealed that these individuals were significantly better off after participating in the program. Areas of improvement included being more financially secure, more likely to have a stable residence, and more capable of meeting their basic needs. Also, more clients had someone to assist them at the completion of the program compared to at intake.

Were Connections Clients More Likely to Report Emotional Satisfaction?

Connections clients also expressed greater emotional satisfaction after program participation, reporting significant improvement in their relationship with their family, their own emotional well-being, and their living arrangements, as well as with their life in general. In addition, the GAF score also increased over time, to an average above 50, demonstrating increased self-reliance on the part of the participants.

SUMMARY AND CONCLUSIONS

Findings from both the process and impact evaluations showed that the program achieved its outcomes and met its intended goals. Connections clients reported a higher quality of life, with sufficient income to meet their basic needs such as housing, food, and clothing. They reported using less alcohol and drugs and exhibited a higher level of functioning. The program also 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.
What We Found That Works

• Essential to the success of Connections was the collaboration between two county agencies that worked with this population to form a multi-disciplinary team (MDT) approach to intervention. The teaming of a Social Worker with Probation Officers enhanced the understanding and service provision to the client.

• Intensive case management that was client-centered facilitated a continuum of care for the clients. Long waiting lists, cumbersome bureaucracies, lack of community resources, and numerous appointments were all potential barriers for Connections clients. Having a clear plan based on the client’s needs and staff to help navigate the various systems allowed clients to receive their needed services and establish a routine in the community.

• The staff made a conscientious effort to create relationships with community agencies in order to increase the accessibility of services for Connections clients. Part of the Connections staff’s role involved educating the community to treat mentally ill offenders as citizens, not as criminals.

• Extensive and on-going training was essential to the development of the MDT and staff members’ understanding the complexities associated with working with the mentally ill.

What Didn’t Work – Lessons Learned

• Despite the advocacy of the Connections staff, maneuvering the current system of care available in the community was difficult, frustrating, and a barrier for clients to obtain services. The teams were never able to consistently obtain emergency mental health care in the field. They were also not able to overcome the long application and appeals process to establish Social Security Insurance (SSI) benefits for their clients. An entire paradigm shift in the community’s treatment of the mentally ill is necessary to successfully help this population remain out of the justice system.

• Staff turnover was disruptive to both continuity of care and the client staff relationship. As part of standard practice, Probation often has staff rotate positions every couple of years or, as was often the case with Connections, staff were promoted and assigned to a new duty. Both the intensive training required to maintain the model and the need to build relationships with clients and team members requires a consistency among staff.

• It became apparent to management that staff turnover and the shift of focus from developing to ending the program impacted the integrity of the program model. This breakdown was visible in less stringent and immediate accountability of client behavior, inconsistent interpretation of the philosophy among team members, and fewer staff members understanding and implementing the core elements of the model.

• Some staff and clients felt that the prescribed program length of 12 months was not long enough to transition clients back into the community. Because of the complexity of clients’ needs and periods of non-contact, an optional six-month extension was suggested as a means to improve the program.
• The Employment Specialist was under-utilized as designed and spent most of her time providing mental health support to the teams. Vocational development was not a priority in the case plans and clients did not receive the intensive intervention that would be required to successfully place this population in some type of work environment. Involving the Employment Specialist at the beginning of engagement, coupled with more stringent employment requirements, would be needed to improve the vocational development of clients.

FUTURE PLANS FOR CONNECTIONS

The future of Connections as designed and implemented is unknown and the program does not currently exist. However, both Probation and the Sheriff’s Department remain committed to providing specialized services to this population. Probation has continued to use the Target Case Management (TCM) billing to help sustain a specialized unit of two DPOs and two CDPOs, who were part of Connections. The new program is entitled Mentally Ill Offenders (MIO) and the two DPOs carry a reduced case load of 30 per officer. Although, there is not a mental health professional on the teams, Probation is able to consult with a psychologist when needed. The Sheriff’s Department continues to build partnerships in the community, especially with County Mental Health (CMH), to help link inmates to outside services when they are released from custody. In addition, the Sheriff utilizes the streamlined system that was created as result of Connections to quickly obtain medication and mental health services for clients leaving jail.

RECOMMENDATIONS

Recommendations for Other Counties

• Establish formal agreements between the county partners. The success of Connections depended on the support from top management. Although Connections worked closely with County Mental Health, it may have been more beneficial had they been a formal partner.

• Make the selection of staff a priority. It is important to have the appropriate staff members who want to work with this population and in an MDT environment. Ill-suited staff can interfere with the effectiveness of the team.

• Provide intensive and on-going training and monitoring. Training is vital to creating cooperative working relationships between two distinct professions, maintaining program fidelity, and being able to work effectively with this population. It is also important to institute a quality assurance plan to routinely monitor how the program is being implemented.

• Devote time and effort to nurturing the development of the teams. Utilize team building exercises, retreats, and individual team meetings with management staff to help support the teams.
• Allow for reduced probation case loads. This model requires staff to spend more time with each client, especially at the beginning. A traditional probation case load would not permit the intensity of intervention needed for this population or this model.

• Anticipate working with individuals with co-occurring disorders. Identify available resources in the community at the start of the project and attempt to build partnerships with these providers. Also, incorporate trainings about co-occurring disorders in the training curriculum.

• Utilize the court system as a means to support clients to complete their case plans. Include periodic court review hearings as part of the case plan to help motivate the clients and keep them on task.

• Include wrap-around funds in the budget. Having the flexibility and resources to address the individual needs of clients was very helpful. This type of discretionary funding supports a continuum of care for clients by allowing staff to immediately address each need as it arises.

Recommendations for the Future of the Program

Based on the lessons learned during the four years of program operation, as well as the evaluation results, the following are recommendations to enhance Connections if funding becomes available again.

• Because of the prevalence of clients with a co-occurring diagnosis, it would be useful to include an Alcohol and Drug Specialist on the staff. This would provide the team with extra support and insight into the particular issues associated with dual-diagnosed clients.

• Allow for an optional six-month extension to the program length for those clients who need it to help them transition into the community.

• Allot funds in the budget to purchase treatment beds in the community, especially for dual-diagnosed clients.

• Require at least a two-year commitment to the program from staff to allow for continuity among the teams and with the clients.

• Institutionalize a quality assurance plan to maintain the rigor of the program model.

• Require that all staff receive the same core training prior to joining a team and assuming a case load. Also, provide on-going refresher trainings and specific trainings related to the population as needed.

• If employment services are to be provided to clients, they should be emphasized from the beginning of the program and given more attention by the team.
CHAPTER 1
INTRODUCTION/PROJECT BACKGROUND
CHAPTER 1
INTRODUCTION/PROJECT BACKGROUND

INTRODUCTION

Since the late 1980s, the number of San Diego County inmates requiring mental health services has almost doubled and is currently estimated to be around 15 to 20 percent. Based on an average daily jail population of 5,000 individuals, this equates to approximately 800 to 900 mentally ill offenders on any given day (San Diego County Sheriff’s Department, 2004).

In response to the phenomenon of increased representation of the mentally ill in the justice system, the California Legislature passed Senate Bill 1485 in 1998 requiring the Board of Corrections (BOC) to award and administer mentally ill offender (MIO) crime reduction grants on a competitive basis to counties that planned to expand or establish a continuum of swift, certain, and graduated responses to reduce crime and criminal costs related to mentally ill offenders. In 1999, the San Diego County Sheriff’s Department received a planning grant from the BOC and formed a Strategy Committee to develop a local action plan that would address issues related to mentally ill offenders. Members of this group included the Sheriff, the Chief Probation Officer, the County Mental Health Director, a Superior Court Judge, the Chief of Police for the City of San Diego, a mental health consumer, the Administrator of Sharp Mesa Vista Psychiatric Hospital, the Director of the Public Defender’s Office, and the Director of the Alliance for the Mentally Ill. Based on the work of this group, a formal proposal was submitted to the BOC and the grant was awarded the same year.

SCOPE OF THE PROBLEM

Increase of Mentally Ill in the Justice System

The United States has the dubious honor of being the world leader in incarceration, with a higher proportion of its population behind bars than any other country (The Sentencing Project, 2002). Contributing to this trend is the increase in the number of mentally ill offenders that have entered the criminal justice system over the past three decades (Sigurdson, 2000; The Sentencing Project, 2002). For example, there are a disproportionate number of mentally ill individuals in prison, with double the percentage incarcerated compared to the general population. In addition, there are three times as many mentally ill in prisons than in mental hospitals (Human Rights Watch, 2003). The Bureau of Justice Statistics (BJS) reports that approximately 16 percent of inmates in state prisons and local jails self-report current mental illness or an overnight stay in a mental hospital (Ditton, 1999).

These numbers are also reflected in the California system. According to the BOC, an average of 9,785 new mental health case files were opened each month in 2002, representing 13 percent of the average daily population (ADP) (California Board of Corrections, 2002). In addition, 24 percent of the ADP had an open mental health case file and 11 percent were prescribed some type of psychotropic medication. This trend of incarcerating the mentally ill seems to be increasing. For example, there was a 280 percent increase in the number of inmates in mental health beds from 1,331 in 1996 to 3,731 in 2002. In addition, the number of individuals receiving outpatient services
in a California jail facility increased 158 percent from 60,272 in FY 1990-1991 to 155,574 in FY 1999-2000. It is estimated that in California there are 21,000 mentally ill offenders in state prisons and 2,500 in county jails, costing the state over $500 million annually (Legislative Analyst’s Office, 2000b; California Health and Human Services Agency, 2002).

Why Has the Number of Mentally Ill Inmates Increased?

The question of why there has been this increase in the number of incarcerated mentally ill, generally distills down to four factors. These include deinstitutionalization, decrease in involuntary commitments, lack of available treatment, and the criminalization of the mentally ill.

Deinstitutionalization: In the 1950s, there were 592,853 patients in county mental hospitals nationwide, compared to 56,955 reported in 1998 (Kiesler & Sibulkin 1987; Lamb & Weinberger, 1998; Manderscheid et al., 2000). Similarly, between 1956 and 1957, California had an estimated 36,319 individuals in state hospitals, which decreased to 4,095 between 1999 and 2000 (Legislative Analyst’s Office, 2000a). This decline in numbers started in the 1950s with the enactment of the Short-Doyle Act of 1957, which required local governments to assume a larger role in the care of the mentally ill. However, counties were ill-equipped and under funded to provide adequate care in the communities (Nieto, 1999). As a result, more individuals were released from state hospitals and often found themselves in the communities with no support.

Decrease in Involuntary Commitments: In the 1960s, more stringent criteria for civil commitments were enacted with the passage of the Lanterman-Petris-Short Act (LPS). This shift resulted in a reduction in the number of state hospitals and another redirection of the funds to the counties. However, the local governments did not receive the designated funds as planned, which placed an even greater burden on local communities and left the mentally ill without adequate support and options (Legislative Analyst’s Office, 2000a; The Sentencing Project, 2002).

Lack of Available Treatment: Research has demonstrated that the mentally ill can function in society with the proper treatment (Ventura, Cassel, Jacoby, & Huang, 1998; National Alliance for the Mentally Ill). However, approximately 40 percent of the severely mentally ill are not receiving treatment at any given time and resources directed toward mental health services have decreased at a higher rate than health care in general (Treatment Advocacy Center, 1999; Substance Abuse and Mental Health Services Administration, 1998). A startling fact is that funds for treating the mentally ill are one-third of what they were in the 1950s (Bazelon Center for Mental Health Law, 1999). Compounding this lack of availability, the mental health system is fragmented, ill-equipped to handle individuals with multiple needs, and often requires a level of sophistication to access that an individual with a severe mental illness does not have (Human Rights Watch, 2003; Lamb & Weinberger, 1998; The Sentencing Project, 2002).

This lack of resources or the inability to access them leaves the mentally ill at risk for committing minor crimes in their quest to survive. Due to their mental health needs, impaired reasoning, and tendency to decompensate in unstructured environments, mentally ill offenders may commit “crimes of survival”, such as petty theft or loitering. Some of the symptoms of mental illness can also be displayed in forms of aggression, such as aggravated assault and battery (Nieto, 1999).
Criminalization of the Mentally Ill: In addition to the above mentioned systemic issues contributing to the increase in the incarceration of the mentally ill, society has become less tolerant of aberrant behavior. More punitive sanctions have been put in place, such as mandatory drug sentencing and revoking necessary public support, such as welfare (The Sentencing Project, 2002). When an individual is arrested s/he loses access to public benefits (e.g. SSI, SSDI, Medicaid) and has to reapply upon release. The period between jail release and reinstatement of benefits leaves an individual without resources to survive, and s/he can easily drift back to the streets and commit a crime that might not have been done had secure housing and finances for basic needs been available (Human Rights Watch, 2003). In addition, mentally ill offenders are typically in a worse situation when they are released from prison or jail than when they were initially incarcerated. Incarceration can be stressful, they are often released without medication, they may not have housing, and they have to navigate a system that is confusing even for the most stable of individuals. This leaves a mentally ill individual at risk of not making scheduled parole or probation appointments or being able to comply with conditions, which can easily lead to incarceration (Barr, 1999).

Who Are the Mentally Ill Offenders?

Research has shown that mentally ill offenders have distinct characteristics that set them apart from the general inmate population. According to BJS, 30 percent of male and 78 percent of female mentally ill offenders reported prior physical or sexual abuse (Ditton, 1999). According to the same study, Whites, more so than Blacks or Hispanics, reported a mental illness (22% of White inmates, compared to 14% of Blacks and 11% of Hispanics). In turn, a higher percentage of women identified as having a mental illness (24%), compared to men (16%).

Mentally ill inmates tend to have longer criminal histories than other inmates. One study found that nine out of ten mentally ill offenders were repeat offenders (Nieto, 1999). In addition, over half (53%) of mentally ill prison inmates were incarcerated for a violent offense, compared to 46 percent of other inmates. Among inmates in jails, 30 percent who were mentally ill committed a violent offense, compared to 26 percent of other jail inmates. Likewise, an estimated 28 percent of mentally ill probationers, compared to 18 percent of other probationers, reported their current offense was a violent crime (Ditton, 1999).

The mentally ill also have a higher rate of homelessness, unemployment, and substance use. It is estimated that 50 to 70 percent of the mentally ill have a co-occurring substance abuse disorder (Latessa, 1996; National Alliance for the Mentally Ill, 2002). After release from jail, the mentally ill are at risk for recidivism. They are three times more likely to be homeless than other inmates, they have an inadequate or no supply of medication upon release, and there are limited treatment resources available to them (Barr, 1999; Ditton, 1999; Sigurdson, 2000).

What Solutions Are There to Decrease the Incarceration of the Mentally Ill?

In general, diverting individuals with mental illness whose arrests are attributed to their illness and providing a system of care for re-entry into the community, underlies many of the proposed solutions for reducing the number of mentally ill offenders. This includes educating police officers who are usually the first point of contact and providing them with alternatives for individuals who
commit “survival crimes,” increasing and improving inpatient services to inmates, providing discharge planning which includes links to the community and adequate medication, and creating an integrated system of care in the community (Barr, 1999; Human Rights Watch, 2003; The Sentencing Project, 2002). Although the components may vary, it is essential for communities to create a comprehensive approach to taking care of the mentally ill offenders.

With the passage of America's Law Enforcement and Mental Health Project by Congress in 2000, several communities established mental health courts as a means to address criminalization of the mentally ill. The philosophy underlying mental health courts is to divert individuals with a mental illness from the criminal justice system and into treatment or other resources (National Conference of State Legislatures, 2001; National Alliance for the Mentally Ill, 2002). However, there is no standard model for operating mental health courts and individuals working in the field caution that mental health courts run the risk of increasing the involvement of the mentally ill in the criminal justice system. Guidelines for implementing mental health courts have been suggested in an effort to create an effective diversion from the criminal justice system. In general, the guidelines emphasize the need for the courts to be focused on diversion, rather than coercion, and that they should operate within a larger comprehensive system of care to truly be effective (Bazelon Center for Mental Health Law, 2003; National Mental Health Association, 2004).

Another approach that has demonstrated varying degrees of success with the mentally ill is the provision of intensive case management services (Chandler, Spicer, Wagner & Hargreaves, 1999; Lamb & Weinberger, 1998; Ventura et al., 1998). This type of management is guided by an individualized case plan, with frequent and long-term contact with a case manager that guides an individual through his/her treatment. One such model that has received a good amount of attention is Assertive Community Treatment (ACT). Although there is some variation, the core of the model involves the provision of intensive case management by a multi-disciplinary team, to individuals in a non-institutional setting, with 24-hour availability to the client. The client-to-staff ratio is low (1:10 or 1:15), with the goal of providing long-term, continuous service to clients (Bond & McDonel, 1991). Depending on the implementation and research methodology, the outcomes of ACT demonstrate different degrees of success (McHugo, et al., 1998). Research studies have shown ACT to reduce hospitalization days, improve client functioning and satisfaction, and increase cost effectiveness (Bond & McDonel, 1991; Chandler, et al., 1999). However, the actual effectiveness and positive outcomes of ACT have been challenged by other research, noting that ACT actually relies on coercion and could be harmful to clients (Gomory, 1999). These inconsistencies highlight the need for additional research on the model.

**PROJECT OVERVIEW**

Funded for four years, the Connections program involved the provision of intensive case management to local probationers using the principles of Assertive Community Treatment (ACT), as opposed to the standard level of service. ACT differs from the standard level in that ACT teams provide more intensive services, which may include direct services to the mentally ill. The standard level of service includes the provision of routine referrals to community agencies. While the ACT

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1 The original grant was for four years, but the program received a no-cost one-year extension. However, due to the State budget crisis, the evaluation portion of the program ended six months prior to the end of the five-year period (December 2003).
model of care has been extensively researched and found to be more effective than traditional case management for severely mentally ill individuals, it has never been studied with this population of jail inmates. Originally intended as a community-based alternative to institutionalization, the goal of ACT is to ensure that clients who are at high risk for relapse or re-incarceration receive a high level of supportive case management services in the community. Connections services were made available to clients upon release from jail to ensure that they could remain in the community while functioning at the highest possible level.

With an emphasis on current functioning, clients in the Connections program were encouraged to formulate individual, meaningful goals with their case management team that emphasized self-help and independence. Services were personalized to meet the needs of clients and all were provided close monitoring and a high level of support on occasions when they were subjected to negative sanctions or consequences as a result of poor choices or negative behavior.

Key features of the Connections program included:

- teams of Social Workers and Probation Department staff working together;
- staff to client ratio of 1:10;
- pre-release treatment planning;
- 24-hour staff availability, seven days a week;
- linkages to community-based interventions including mental health clinics;
- payee program to assist clients in managing finances;
- early intervention by the Psychiatric Emergency Response Team (PERT)\(^2\);
- case management focusing on long-term stability;
- involvement of families and significant others; and
- substance abuse monitoring and intervention.

State legislation mandated an intensive evaluation of all programs funded through the MIO program. To fulfill this requirement, the Sheriff’s Department contracted with researchers from the Criminal Justice Research Division of the San Diego Association of Governments (SANDAG) to conduct the process and impact evaluations of this project to determine if the ACT model was more effective than the standard level of service.

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\(^2\) Due to intensity of supervision provided by Connections and the limited availability of the PERT teams (as a result of funding constraints), this intervention was rarely used.
REPORT OUTLINE

This final evaluation report on the Connections program is being submitted to the BOC. Chapter 2 follows, which provides detailed information regarding the Connections model and its implementation and development. In Chapter 3, the evaluation methodology is described and the results of the process evaluation are presented in Chapter 4. Chapter 5 includes two case studies of Connections clients who completed the program. Results from the impact evaluation are provided in Chapter 6, followed by a summary and study conclusions in Chapter 7.
CHAPTER 2
PROGRAM DESCRIPTION
CHAPTER 2
PROGRAM DESCRIPTION

INTRODUCTION

The goal of Connections was to utilize coordinated service teams to help mentally ill offenders integrate successfully into the community by focusing on teaching new skills so they would not reoffend. To accomplish this, Connections involved the provision of case management brokerage, mental health interventions, crisis intervention, and collateral services/contacts. Connections provided services from June 2000 to December 2003. However, due to budgetary restraints, the model as implemented ended. The future of the program is described in Chapter 7. The current chapter describes how the process of implementing the Connections program proceeded since staff members were first hired and the first clients were served. In addition, a detailed description of the intake process and the types and duration of interventions provided by the service teams is provided. Table 2.1 provides a summary of major program events.
Table 2.1
CONNECTIONS IMPLEMENTATION AND DEVELOPMENT TIMELINE

<table>
<thead>
<tr>
<th>Date</th>
<th>Implementation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1999</td>
<td>San Diego County Sheriff receives MIOCRG grant from the BOC.</td>
</tr>
<tr>
<td>September 1999</td>
<td>Filled all management staff positions and begin the hiring process.</td>
</tr>
<tr>
<td>October 1999</td>
<td>First monthly meeting between program staff and evaluation staff.</td>
</tr>
<tr>
<td>February 2000</td>
<td>All Probation DPO and CDPO positions are filled.</td>
</tr>
<tr>
<td>April 2000</td>
<td>All positions filled with the exception of one Social Worker position.</td>
</tr>
<tr>
<td></td>
<td>Staff training begins.</td>
</tr>
<tr>
<td>June 2000</td>
<td>Client randomization begins.</td>
</tr>
<tr>
<td>September 2000</td>
<td>Management staff institutes a team member rotation schedule.</td>
</tr>
<tr>
<td>November 2000</td>
<td>First staff retreat is held.</td>
</tr>
</tbody>
</table>

**Staff & Schedule**

<table>
<thead>
<tr>
<th>Date</th>
<th>Implementation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2001</td>
<td>Staff begin working a 9/80 work schedule.</td>
</tr>
<tr>
<td>July - December 2001</td>
<td>First round of staff changes occur, including the turnover of the first Supervising Probation Officer.</td>
</tr>
<tr>
<td>January - June 2002</td>
<td>Changes in Probation’s retirement policy are responsible for numerous changes in the Connections DPO and CDPO positions.</td>
</tr>
<tr>
<td>May 2002</td>
<td>All five Social Worker positions are filled.</td>
</tr>
<tr>
<td>May 2002</td>
<td>New staff members attend a three-day training on the core Connections components.</td>
</tr>
<tr>
<td>June 2002</td>
<td>Employment Specialist is transferred to the jail to fulfill a Social Worker position and the position is never filled.</td>
</tr>
<tr>
<td>September 2002</td>
<td>Second staff retreat is held.</td>
</tr>
<tr>
<td>February 2003</td>
<td>Original Project Director leaves the program and the position is not backfilled.</td>
</tr>
<tr>
<td>March 2003</td>
<td>All program staff are located at one office building.</td>
</tr>
</tbody>
</table>

**Program Closure**

<table>
<thead>
<tr>
<th>Date</th>
<th>Implementation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2002</td>
<td>Implementation of TCM billing for eligible Connections clients.</td>
</tr>
<tr>
<td>February 2003</td>
<td>Client randomization is completed.</td>
</tr>
<tr>
<td>April 2003</td>
<td>Two DPOs are removed from the team to assist with Connections TCM billing.</td>
</tr>
<tr>
<td></td>
<td>Content of Connections team meetings changes to TCM billing issues.</td>
</tr>
<tr>
<td>June 2003</td>
<td>Teams are reduced from five to two.</td>
</tr>
<tr>
<td>December 2003</td>
<td>Service provision ends.</td>
</tr>
</tbody>
</table>

SOURCE: SANDAG
Staffing

One full-time staff person from the San Diego County Sheriff’s Department and one from the San Diego County Probation Department were dedicated to the implementation of this project. From the time they were hired in September 1999, the Project Director and the Supervising Probation Officer worked in close collaboration to build the necessary infrastructure for the program. This included selecting and hiring staff, developing training curricula, securing necessary resources, eliciting buy-in from key community members, as well as identifying community resources for mentally ill offenders. In addition, the Sheriff’s Department Chief Clinical Social Worker was instrumental in organizing the client identification and intake process and providing on-going clinical supervision of the social work staff. He was also the only management staff member who remained with the program from beginning to end, thereby providing necessary continuity.

Project staff for the Connections program included five Social Workers, hired through the San Diego County Sheriff’s Department, five Deputy Probation Officers (DPOs), and five Correctional Deputy Probation Officers (CDPOs). These individuals worked collaboratively in five teams of three. Additional staff included two Consulting Psychiatrists (reduced to one in 2002), an Employment Specialist, a Probation Aide, and a Word Processor.

By February 2000, the Supervising Probation Officer had identified eligible candidates to fill all of the DPO and CDPO positions. However, there was considerable difficulty in recruiting and selecting qualified individuals to fill the Social Worker positions, which delayed the formation of all five teams until April 2000. By that same month, all additional staff had been hired, and despite some staff turnover since then, almost all of the positions remained filled until March 2003 when the program started to phase out. One on-going staffing challenge involved filling one of the Social Worker positions. This position remained vacant and the responsibilities of this individual were fulfilled by the Employment Specialist and Social Workers from other teams until May 2002.

In June 2001, staff voted to change their work schedule from ten days per pay period to nine days. Because teams were subsequently off three days in a row every other week, adjustments in scheduling were made to ensure that staff availability was maintained around the clock. Another staff-related change included implementing a program policy to rotate team members every four months. The first rotation occurred in September 2000 and involved the DPOs transferring from one team to another. In addition to allowing people to work with different individuals and experience different caseloads, the transfer also permitted the Supervising Probation Officer the opportunity to provide closer supervision of staff previously stationed at a separate location. The second team switch occurred in January 2001, with one CDPO and one Social Worker switching teams. The switching of teams continued through December 2001 until the end of the program. To support the clients during these transitions, the rotating Social Workers met to review each other’s cases and made joint visits to the clients to introduce the new Social Worker.

Staff changes during the period of July through December 2001 included hiring a new Supervising Probation Officer, two CDPOs, a Social Worker, an Employment Specialist, and a Word Processor. The majority of these changes were due to promotions and the natural employment cycle of Probation, which encourages employees to rotate assignments within the Department. The number
of changes increased between January and June 2002, primarily due to numerous retirements and subsequent promotions at Probation, following a change in the Department’s retirement plan. In sum, the retiring Supervising Probation Officer was replaced, three new DPOs assumed the duties of the three that were promoted, one new CDPO replaced the promoted one, and two new Social Workers were hired, one filling the long standing vacancy and the other replacing a transferring Connections Social Worker. In addition, in June 2002 the Employment Specialist transferred to the jail setting to fill the temporary vacancy of a Social Worker out on family leave and the Word Processor was also replaced. Management was able to anticipate and quickly fill all these vacancies. To facilitate these transitions, in May 2002 new staff members attended a three-day training, which covered the core components of Connections. There were fewer staff changes between July and December 2002. Two new CDPOs were hired to fill the positions of those officers who had been promoted during this time period. One of these CDPOs had been with the program since its inception. The Employment Specialist also continued to work in the detention facilities and therefore was unable to provide specialized employment services to clients.

During the last eleven months of the program, between February and December 2003, there were significant staff changes and restructuring of the teams. This was due to the ending of the grant and no foreseeable means to sustain the program at its current level. One of the more significant changes occurred at the end of February 2003, with the departure of the Project Director, who was instrumental in the implementation and development of the program. Her position was never filled and the Clinical Social Worker and Supervising Probation Officer assumed her duties. However, because of the budget crisis, these two staff members also assumed more responsibility for other projects in each of their departments. During March 2003, one Social Worker was reassigned to the detention facilities and the Employment Specialist, who had been filling in where Social Workers were missing, was assigned to a team as the new Social Worker. During the period of March to June 2003, the Social Workers gradually decreased from five to two. In addition, in April 2003 two DPOs were pulled away from their cases to focus on an issue regarding the Targeted Case Management (TCM) billing that Connections had implemented to help sustain the program beyond the grant. To ensure that the remaining Connections clients involved in the research study received the same model of intervention, two teams that had three staff members each (e.g., CDPO, DPO, and Social Worker) were assigned all of the study cases.

### Training

In April 2000, team members began an intensive training program that involved seven specific areas that are described below. This training regimen was also required of additional staff who joined the project. The goal of this training was to ensure that project staff had the necessary skills to work collaboratively in the application of the ACT model to the population of mentally ill offenders.

**General Issues:** These training sessions were targeted at educating Social Workers about the Probation Department and educating Probation Officers about social work, and were supplemented by classes on collaborative casework, community resources, and the Connections program.

**Safety Issues:** Team members attended sessions on first aid/CPR, field officer safety, working with the radio, safe driving, and ride-along supervision. In addition, Probation Officers learned about arrest, search and seizure, and OC spray. In September 2001, the new Supervising Probation Officer reviewed and revised the field safety procedures to more accurately reflect the uniqueness of the
tasks required of the Connections Probation Officers. These policies were reviewed again in November 2002.

Clinical Issues: In addition to attending sessions on the ACT model, staff learned about characteristics of the mentally ill offender, medications, working with families, and substance abuse monitoring. Training was also conducted on the DSM-IV (Diagnostic & Statistical Manual of Mental Health Disorders, which is used to categorize individuals with mental illness and as a foundation for treatment decisions), the Psychiatric Emergency Response Team (PERT, which is a local team of law enforcement officers/deputies and a licensed mental health clinician that responds to crisis situations to evaluate, assess, and refer individuals to appropriate treatment and care in the community), how to use mental status examinations, and the program approach of the Village (a contractor of the Los Angeles County Mental Health Association that works with chronic and persistent mentally ill offenders using the ACT model).

Assessment and Research Documentation: Sessions in this area included data collection/research, use of the Probation computer system for documentation, the Level of Supervision Inventory (LSI), and program documentation.

Tours and Field Trips: Probation Department staff and Social Workers toured the San Diego Psychiatric Hospital, the psychiatric floor at the San Diego Central Detention Facility, and the psychiatric area at Las Colinas, the local women’s detention facility. Field visits were also completed at a crisis center, a clubhouse (a drop-in social model program with loose structure and support that provides life amenities such as showers and a kitchenette), a day program, a board and care facility, a shelter, a long-term care/locked facility, and the California Rehabilitation Center.

General Reading: Members from each team were expected to document their familiarity with a variety of reference materials, including the DSM-IV, the Physicians’ Desk Reference, the penal code, and a local resource guide. Required reading also included the Connections grant, a book and articles on the ACT model, a book on motivational interviewing, articles on family needs, the strength model of case management and critical time interventions, and a safe driving booklet.

Other Activities: Active learning experiences were emphasized and included completing a ride-along with a Probation Officer, conducting an LSI interview, listening to tapes on schizophrenia and supported housing (housing that is subsidized financially by a managing agency and has mental health support services available to the residents), and attending court hearings.

Supplemental Training: The prevalence of substance abuse among members of the target population introduced the need for additional training. To adjust to the large number of clients with co-occurring diagnoses in the program, management staff provided training on co-occurring disorders to team members, obtained information from experts in the field, and emphasized building relationships with the local substance abuse treatment community. This experience revealed the need to have a strong substance abuse component in the case management model and also emphasized the challenge of working with a dual-diagnosed individual.

Other types of supplemental training were also provided on a monthly basis to staff members to address specific and timely issues. These trainings, conducted by experts in the field, were intended to support the staff members’ understanding of the clients and assist them in linking clients to resources in the community. Training topics since February 2001 included case management,
supportive housing, PERT, the Medi-Cal system, the borderline personality, collaboration, the LSI, Proposition 36, Child Protective Services, Mental Health Systems dual-diagnosis programs, universal precautions (safety procedures to avoid the spread of disease), United Behavior Health Systems (UBH) computer system, long-term care resources, motivational interviewing, and the new staff orientation training. In addition, staff had the opportunity to attend the semi-annual BOC meeting in October 2002 in San Diego and learned more about other sites and practices. That same month, management staff attended and presented on Connections at the Mental Health Association’s Meeting of the Minds Conference.

Targeted Case Management: In anticipation of the completion of the grant, management staff engaged in several activities to identify new funding sources. The primary endeavor occurred in November 2002, with the implementation of TCM billing for eligible Connections clients. TCM allowed Connections to bill Medi-Cal for case management services provided to eligible clients. However, this effort required significant staff time and training that negatively affected the content of the team meetings and diminished client contact. Connections staff were joined by Probation staff from other units that were also billing for TCM, and each of the meetings shifted the focus to TCM training and billing and not the Connections program. As such, there were no additional trainings during the last nine months of the program. Some staff also observed that this emphasis on billing redirected the attention of those Probation staff who had not had the opportunity to receive thorough training away from the model and toward the more traditional ways of Probation supervision.

**Coordination**

Due to the interdisciplinary nature of the teams and the level of coordination necessary to provide services to up to 150 clients at any given time, constant communication was essential. With team members located at two separate locations, this was especially challenging. A goal planning retreat and celebration of work-related accomplishments in November 2000 led to the restructuring of team meetings with the intent to more effectively and efficiently support the dissemination of information, the review of cases, and clinical feedback to teams. Specifically, in addition to case plan review meetings, all-team meetings were held monthly, with the focus on training activities and administrative and clinical issues. Separate meetings for Probation Department staff and the Social Workers were held on a monthly basis and an optional weekly notification meeting was added during the first half of 2001 to allow teams timely access to management staff when urgent issues arose involving clients.

During the first half of 2001, a three-day training workshop on collaboration was held that offered staff an opportunity to voice concerns regarding team dynamics. To encourage candid dialogue regarding the program, time was set aside during the training for staff to meet with the facilitator alone. As a result, management learned that staff members were more concerned with the lack of resources available for clients than with team relations. Toward the end of 2001, the evolution of the teams entered a final stage of development. The Project Director reported that the teams had become more cohesive and had reached a greater level of understanding of each other’s professional roles and responsibilities. With the change in staff, a second team building retreat was held in September 2002. Again, the intent was to support and strengthen the team members’ relationships and the team model.
As noted earlier, between January and December 2003, these coordination efforts decreased. There were no more program-related trainings, team building events, or staff development activities. The primary reason for this was the ending of grant funds. However, all of the staff were relocated to one building in March 2003, which was conducive to better staff coordination.

**CLIENT ELIGIBILITY AND IDENTIFICATION**

Individuals were eligible for the Connections program if they were currently in jail, under probation supervision (intensive or mid-level), and had a DSM-IV Axis I Psychiatric Diagnosis (295.10 to 298.9, 300.3, and 311) and a Global Assessment of Function (GAF) Axis V score equal to or less than 50. The DSM-IV evaluates an individual’s behavior according to five dimensions or axes. The first three assess the individual’s present condition and include particular maladaptive symptoms or clinical psychiatric syndromes (Axis I), any long-standing personality problems (Axis II), and any medical or physical disorders (Axis III). Categories that can be included in Axes I and II include organic mental disorders (disorders involving malfunctioning of brain tissue and other brain pathology), substance-use disorders, disorders of psychological or sociocultural origin (e.g., anxiety and personality disorders), and other disorders usually arising during childhood or adolescence. GAF scores can vary from 1 (when an individual is in persistent danger of severely hurting themselves or others) to 100 (superior functioning in a wide range of activities). A GAF of 50 or less is categorized as having serious symptoms or any serious impairment in social, occupational, or school functioning.

Criteria that excluded a client from the program included:

- no probation conditions requiring counseling or treatment;
- currently active to State Parole or Federal Probation or Parole (subject to supervisor’s screening and override);
- not a county resident or permitted to reside out of county;
- an Immigration and Naturalization Service (INS) hold;
- active felony warrants and/or holds from other jurisdictions;
- history of excessive violence;
- needing supervision by another program (e.g., sex offender or gang unit), as determined by the Probation Director; and
- “execution” of State Prison suspended (subject to supervisor’s screening and override).

In February 2001, the criterion of being a United States citizen was removed.
A six-phase process was used to identify and screen potential clients for the Connections program. First, all individuals who were booked into one of the local detention facilities (Central, Las Colinas, and Vista detention facilities) were given an initial health screening. Those individuals who indicated prior or current mental health problems were given a brief mental health assessment using an instrument called the Detention Outpatient Screening, or DOPS. Those inmates who required a more extensive assessment were then referred to a facility psychiatrist. This assessment was assigned immediately if the individual was in crisis, with urgent referrals seen within 48 hours, and non-urgent within one to two weeks.

Once the assessment was completed, staff from the Medical Services Division of the jail faxed referral information for individuals with an appropriate psychiatric diagnosis (Axis I primary diagnosis and GAF 50 or lower) to the Probation Aide on a daily basis. She in turn shared this information with the Probation Department Connections Supervisor who conducted an in-depth screening of the potential client, which included contact with the inmate's current or investigating Probation Officer. In September 2001, the Probation Aide assumed this screening function. While being on probation was an eligibility criterion, an individual was considered for participation if she was in the investigative phase prior to sentencing and there was a strong possibility of being placed on probation.

When Probation verified an inmate as eligible, an intake was assigned to a Social Worker within 48 hours. Prior to the beginning of the interview, the client completed a standard informed consent that explained the purpose of the study and how the information would be collected and used. If, after the intake was completed, an individual was still determined to be eligible, the Project Director forwarded the information requesting randomization to the Probation Aide who was responsible for randomizing clients to either Connections or the control group. Specifically, prepared sealed envelopes with consecutive identifying numbers were opened in turn. These envelopes were prepared by SANDAG to ensure randomness. Inside each envelope was a form that was faxed to the Program Director, as well as the researchers, designating the inmate as either a member of the treatment or comparison group. To ensure the integrity of the randomization process, the Project Director faxed the referral information so that it was date and time stamped. This fax was attached to the randomization sheet as documentation that no bias was introduced into this process and an individual did not become a member of one group, rather than another, for any reason other than chance.

Probation determined that program participation was the required level of supervision and as such, was involuntary from the point of view of the client. The only situation in which an individual could choose not to be included was if she was not yet on probation (i.e., in the investigative phase of sentencing) and this lack of interest was expressed prior to completing the intake instrument.
Clients randomized to Connections were assigned to one of five service coordinating teams based on their zip code of residence and team caseload size (homeless inmates were assigned to the team with the smallest case load). Each team accepted clients from Central San Diego and four of the five also worked with clients in one additional area of the County (South Bay, East, North Inland, and North Coastal). Each team was comprised of a Social Worker, a DPO, and a CDPO and could serve a maximum of 30 clients at any one time. In addition to the three-member team, each client had access to the Employment Specialist. As explained earlier, this access was limited when the Employment Specialist was needed to fill the role of Social Worker.

Clients in the Connections program received services for 9 to 12 months after release from jail. The intensity of services was expected to decrease during this period as a function of the client becoming more stable and being linked to community resources. Individual service plans were designed collaboratively with the clients, families, and significant others to ensure that all aspects of the program were client-centered. The phases of treatment are described below.

Pre-Release: Prior to the client’s release from the detention facility, team members met with him/her for preliminary service planning, to plan for immediate housing, and to obtain signatures on consent forms. While not mandatory, program staff indicated that having the opportunity to conduct four to six pre-release visits was ideal to maximize client engagement.

Engagement and Assessment: For the first month post-release, team members had daily contact with the client and the LSI was completed. For the two months thereafter, contact was weekly. Goals during this phase included identifying stable housing options, reviewing probation conditions, planning services, having the client meet with the Employment Specialist, meeting with family members, providing transportation assistance, establishing a representative payee (if appropriate), conducting substance abuse testing\(^1\), drafting a financial plan, providing medication management, and linking the client with community resources, including mental health and substance abuse treatment, and medical resources.

Support and Monitoring: For the second three-month period, contact was continued on a weekly basis. During this phase, emphasis was 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: During the third three-month phase, contact with the client was also on a weekly basis and involved planning for on-going support from outside agencies and post-program mental health support, and providing continued vocational development, money management, and support and monitoring of services initiated in the previous phase.

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\(^1\) Drug testing was based on court orders and while not required of every client, approximately 90 percent of individuals had this as a condition of probation.
Discharge versus Continuation of Services: After nine months, a collaborative decision was made regarding the readiness of the client for discharge. If the team felt that the client was not ready, the services in the previous phases were continued. If discharge was deemed appropriate, the client was transitioned to a new Probation Officer (outside of the Connections program) and the agencies involved in the care of the client were notified of discharge.

## Challenges to Service Provision

### Systemic Barriers

Administrative barriers were an unexpected challenge to service delivery for Connections staff and clients. Commencing with program implementation, team members reported frustration with several key mental health and government systems when attempting to link their clients to needed services. For example, staff noted the large amount of time and effort it took to obtain medication for clients and link them with a mental health provider in the community. Staff also encountered challenges, such as waiting lists and impersonal services, when trying to maneuver through large bureaucratic systems.

Addressing these larger systemic issues became a priority for management staff, as linking clients to community services was a critical piece in the Connections service delivery model. Management staff was active in attempting to expand the capacity of services for their dual-diagnosed clients and improving their access to mental health services. In particular, meetings were held with administrators of the Emergency Psychiatric Unit and Mental Health Systems Inc., (a non-profit agency providing mental health services throughout the county) and presentations on Connections were made to the San Diego Dual-Diagnosis Committee, GAINS, and Meeting of the Minds Conferences in October 2002, Interagency Conference on the Development of Mental Health Court, and Downtown Partnership (a non-profit business advocacy group). In addition, the Project Director was a member of two countywide task forces, one to improve the overall treatment and coordination of dual-diagnosed services in San Diego and another that focused on mental illness and homelessness.

Additional efforts to overcome systemic barriers to service provision included the on-going relationship building between the Connections teams and community service agencies, as well as educating these agencies on the criminal justice system. To strengthen these partnering relationships, a policy was implemented in the first half of 2001 to send a thank-you note to agencies and/or individuals when they had helped a client. The teams and management staff continued with their outreach by providing presentations on the program and inviting agencies to present at team meetings to explain the best way to access their services. In addition, teams had to address the misconception by the community that the local justice system had more authority and mental health resources in local jails than actually existed. To address this, the teams clarified the difference between local detention or probation (maximum of a year) and state detention (greater than a year) or parole. The community held the belief that arresting a client would result in a long-term detention that would include mental health services. However, an arrest often meant the mentally ill offender would be detained locally, resulting in a disruption of any progress made to obtain treatment and resources in the community. The teams had to educate the community agencies that the best long term solution did not involve reincarceration.
As result of all these team efforts, great gains were made in building community partnerships during 2001, which included securing case management and housing for clients who had exited the program through a pilot project called REACH and augmenting the Connections resource list with individuals and agencies that had been helpful in linking clients to services. In addition, the teams had a greater knowledge of the useful resources in the community and had established solid relationships with various providers in the community. Not only did this improve access to services for clients, the community agencies also came to rely on the case management support the teams provided the clients while they participated in their program. Although not an initial objective, Connections’ attention to the needs of mentally ill offenders had an indirect outcome of challenging the existing system of care to better address the needs of this population.

During the period between January and June 2002, management staff initiated planning meetings with San Diego County’s Community Mental Health (CMH) staff administrators to more effectively partner with their outpatient mental health clinics to obtain uninterrupted psychiatric care for Connections clients. Meetings were held with outpatient clinic staff to educate them about the Connections program and its clients and to coordinate continuity of care. These meetings were an attempt to help CMH staff view Connections clients as mentally ill citizens, rather than criminals. Agreement was reached on a plan to guarantee outpatient evaluation and medication appointments within 30-days of a client’s release from jail. According to the agreement, Connections staff completed the outpatient program’s clinical history and evaluation records while the client was in jail. The outpatient staff was then able to administer a more abbreviated clinical evaluation at the time of the initial appointment, thereby eliminating significant duplication and redundancy for the clients. This procedure, coupled with the 30-day supply of medication provided by the Sheriff’s Department, provided for much improved continuity of care and stability for the clients. The protocol was implemented in April 2002 and was utilized and monitored by management from Connections and CMH through the end of the program.

During the same six-month period, efforts were made to secure more treatment beds for dual-diagnosed clients and to enhance Probation Officer’s court reports. Specifically, management staff entered into a contract with Serenity House, a recovery home for women in the North County, to buy beds for their clients. Unfortunately, because of funding issues only a few beds could be purchased. However, the experience was positive and staff stressed the importance of having immediate availability of such services when working with this population. Also during this time period, the Connections program supervisors provided additional training and direction to staff so that the Probation Officer’s court reports were more comprehensive and integrated significant mental health summary information. This provided the court with a more holistic picture of the client and his/her needs.

Co-occurring Disorders

Another challenge that became evident in the early phases of implementation was the large number of individuals grappling with a co-occurring disorder. This created a challenge, as many staff members were not prepared for the complexity of issues associated with working with individuals who had a mental health, as well as a substance abuse disorder. To address this problem, management staff provided frequent and in-depth training (as noted above) on the issues of substance use and co-occurring disorders. These trainings informed the staff as to what to expect and how to best deal with issues that often arise with this population.
Comparison Group Clients

For clients randomized to the comparison group, “treatment-as-usual” was concentrated in the jail setting, with the degree and intensity of services dependent on the inmate’s ability to participate and seek services, as well as the limited number of jail mental health staff. To encourage participation in services offered in jail, a letter was sent to these individuals after randomization informing them of the outcome of the intake process and reminding them that they had access to a Social Worker in jail if they were interested in receiving services or other assistance.

Psychiatric and social work services were available to these clients while in jail. While detained, an inmate could receive mental health services that included counseling with a Social Worker, assessment by a jail Psychiatrist, as well as medication management. Prior to release, discharge planning occurred, which entailed the inmate meeting with a Social Worker to obtain referrals to outside community agencies and mental health clinics. Referrals and linkages were provided for inmates who met the criteria for county case management and who requested such services.

Comparison group clients were under supervision in other Probation units. Compliance with court ordered conditions requiring treatment was monitored and lack of compliance was reported to the court. The level of supervision for comparison clients was either intensive (2 visits per month) or mid-level (minimal contact with Probation Officer). The majority of the comparison group was sent to mid-level supervision. A probationer was provided with referral information and it was his/her responsibility to follow-up with the agency in the community. The comparison clients had access to the same community and public resources as the Connections clients.

SUMMARY

Mentally ill offenders randomized into Connections received intensive case management from a MTD that included a DPO, CDPO, and a Social Worker. Services started while a client was still in custody and continued for up to a year after release. During the first four years of the program, staff members were provided thorough and on-going training that included the probation system, mental illness, co-occurring disorders, and safety provisions. Several staff development activities existed, such as monthly meetings, retreats, and supervision meetings to help strengthen the teams’ cohesiveness. Staff quickly encountered several obstacles when trying to access services for their clients. Efforts were made to mitigate these systemic issues and help streamline some of the services. Individuals randomized into the comparison group received treatment-as-usual, which consisted of either intensive or mid-level probation supervision.
CHAPTER 3
EVALUATION METHODOLOGY

INTRODUCTION

A mandatory aspect of the Connections project was the evaluation effort, conducted by the San Diego Association of Governments (SANDAG), to determine if the program was implemented as designed and to measure if the expected outcomes were realized. The current chapter describes the two components of the research design: the process evaluation documenting how implementation occurred and what challenges were faced; and the impact evaluation assessing if the implementation of the Assertive Case Treatment (ACT) model was effective in reducing recidivism and increasing functioning among the mentally ill jail population. In addition, data collected during the intake process are presented describing eligible clients prior to their receipt of services.

PROCESS EVALUATION

Background and Process

The goal of Connections was to utilize service coordinating teams to help mentally ill offenders integrate successfully into the community by focusing on teaching new skills so they would not re-offend. To determine if Connections was implemented as planned, a process evaluation was conducted. A variety of different methods were used to collect the qualitative data necessary to document program implementation and modifications. These included attending team meetings and trainings, reviewing program documentation, documenting service provision and client behavior, surveying program staff, surveying program participants at exit, and conducting case studies.

Statement of Hypotheses

Hypothesis 1: Connections will target mentally ill individuals with extensive needs and criminal histories.

Specific Research Questions

- How many individuals were screened and eligible for the program?
- What was the level of client need?
- What was the mental health status of clients?
- What was the level of criminal history of clients?
Data Sources

Project staff maintained statistics on the number of referrals made to the program, as well as the outcome of the intake process and reasons why an individual was deemed ineligible for the program. These statistics were shared with the evaluators and summarized as part of the evaluation component.

In addition, data were collected from a standardized intake instrument and from the Sheriff’s Department computer database. The intake instrument, which was designed specifically for this project, was administered to individuals eligible for Connections services (i.e., those eventually randomized to either the treatment or comparison group). The intake interview, which was conducted by a Social Worker prior to release from the facility, included questions pertaining to the client’s employment, mental health, and alcohol and drug use history. Criminal history, including information about jail bookings, the level and type of charges at booking, and case outcomes were collected from Sheriff’s Department records. These data were compiled for three years prior to the current booking that led to consideration for program participation and through the six-month follow-up period for individuals in both Connections and the comparison group.

Analyses

Descriptive and inferential statistics were used to analyze these data. Frequencies and cross-tabulations, as well as measures of central tendency and chi-square analyses are presented.

Hypothesis 2: Connections team members will be committed to the program model and satisfied with project implementation and management.

Specific Research Questions

- How did the Connections staff feel about the multi-disciplinary, collaborative team model?
- What did staff see as the greatest strengths and weaknesses of Connections?
- How did Connections staff feel about program implementation and management?

Data Source

As part of the process evaluation, Connections staff members were surveyed twice over the course of the project. The intent of these surveys was to gather qualitative information on staff members’ perceptions of the implementation and management of Connections, the interdisciplinary program model, possible areas of improvement, and staff experience with mentally ill offenders. The first survey was distributed and completed during April 2001 and the second survey was completed in June 2002.
Analysis

Responses to the staff survey were aggregated and frequencies are presented.

Sample Description

A total of 15 surveys were completed in 2001, which included surveys from each of the staff from the five teams and the Employment Specialist. In 2002, 13 surveys were completed, including 3 Probation Officers, 5 Correctional Deputy Probation Officers, 4 Social Workers, and an Employment Specialist. Only four of these staff had participated in the first survey. At the time of the first survey completion, the average length of employment with the program was just under one year and slightly longer (14 months) for staff who completed the second survey. More than half (57%) of those in the first survey and two-thirds (67%) in the second survey had worked with mentally ill offenders prior to joining the project. One of the most appealing aspects of joining the project, according to respondents of both surveys, was the opportunity to work with the target population. Other common reasons for wanting to work with Connections were for professional growth, the innovative treatment model, and the associated challenges of being a part of a new program.

Hypothesis 3: Connections clients will receive intensive case management services as they integrate back into the community.

Specific Research Questions

- What were the types and frequency of services provided to participants?
- How many clients completed the program and how long were they served?

Data Sources

A treatment tracking form was designed to capture the amount of services (in minutes) provided to Connections clients on a monthly basis. Specifically, program staff documented the amount of time spent on case management brokerage, individual mental health services (i.e., assessment, plan development, evaluation, and individual counseling), collateral services, crisis intervention, medication support, employment assistance, job coaching, and assistance with educational goals. In addition, team members tracked the number of pre-release jail contacts and the number of days the client spent in an in-patient facility. These data were provided to evaluation staff on a monthly basis and entered into the statistical program package SPSS for summarization and analysis.

Data on services received by the comparison group were not as easily available. Research staff collected the same type of data by accessing the Probation Department’s automated field contact system (CANARI). However, these data were not as reliable or valid for various reasons, including fewer mandatory contacts between the Probation Officer and the probationer (once a month), no face-to-face contacts required for mid-level supervision (which many comparison clients received or were transferred to), loss of contact with the probationer, and broader descriptive categories for types of contact. To mitigate these data challenges, researchers collected information from the actual probation files on a sample of the comparison group cases. The files offered no additional information compared to the CANARI system. Because of the problems with reliability and validity
of these data, only data on “Probation Contacts” were included in the analysis. As such, it is possible that the services received by the comparison group are underreported.

To accurately account for all of the services Connections clients and those in the comparison group received, data were also collected from the United Behavioral Health (UBH) database. This system is used by all county contracted and Medi-Cal service providers in San Diego County to document the type and amount of services provided using a standard set of codes. If clients in either group received publicly funded services during the program period or in the six-month follow-up period, it was documented.

Analysis

These data were aggregated over time for each client and measures of central tendency, standard deviation, and frequencies are presented. Comparisons between the two groups were made using t-tests and chi-squares.

Hypothesis 4: Connections clients will be satisfied with the services they received.

Specific Research Questions

• How did clients feel about their participation?
• How did clients feel about changes in their lives?

Data Source

Clients were asked to complete a satisfaction survey upon exiting the program. The purpose of the survey was to obtain feedback from participants about their experience with Connections and staff. A Connections team member, on or near the last visit, gave the client (when available) the survey and waited while s/he completed the form. The client then put the survey in a sealed envelope and returned it to the staff member who mailed it to SANDAG. Names or identification numbers were not included on the survey and staff informed the client that the information provided would remain confidential and would not be seen by staff.

Analysis

The analysis of these data is purely descriptive, using frequency distributions.

Sample Description

A total of 153 surveys, from 151 clients and 2 family members/ friends, were completed for inclusion in this report.
IMPACT EVALUATION

Background and Process

To determine if the ACT model was more effective than the standard level of service, an experimental design was used. Specifically, 449 (originally it was 450, but one comparison client was non-sampled after randomization was complete) eligible clients were randomly assigned to either participate in the Connections program or to receive “treatment-as-usual.” This randomization process was implemented on June 5, 2000, and the last individual was randomized on February 24, 2003. Random assignment to conditions is important because it ensured that the two groups were equivalent on any dimension from the outset and all eligible candidates had an equal chance of being assigned to either group. If any differences between the two groups were later documented, and the only difference between the two groups was the type of services received, then it could be concluded that it was the treatment and not initial differences (e.g., age, mental history, etc.) that was the cause.

Statement of Hypotheses

The primary goal of the Connections program was to reduce the rate of reoffending by the target group through the provision of continuous and coordinated mental health treatment and intensive case management services.

Hypothesis 5: Connections clients will be integrated into the community and less likely to recidivate after program participation.

Specific Research Questions

- Were Connections clients less likely to be booked into jail?
- Were Connections clients less likely to be convicted of a new offense?
- Were Connections clients less likely to use alcohol and other drugs?
- Did Connections clients have more resources available to them?
- Were Connections clients more likely to report emotional satisfaction?

Data Sources

Since the first project meeting in October 1999, program staff and the evaluation team worked jointly in determining the most valid and reliable ways to collect the data required as part of the cross-site evaluation, as well as information that was of local interest. Because there was more contact with Connections clients, it was inevitable that a greater amount of information was available for them than for the comparison group. Whenever possible, identical data collection strategies were used and as many data sources were utilized as possible for each group. For research purposes, the length of “program participation” for the comparison group was defined as 12.
months following release from jail, at which time the follow-up period began. In addition to the collection of interview data from the intake process and criminal activity information from the Sheriff’s Department records, other instruments included the Level of Supervision Inventory (LSI) and an exit/follow-up instrument.

The LSI, a Probation Department tool, is an objective, quantifiable, 54-item risk/need classification instrument that is composed of ten subscales that contain both “static” (e.g., criminal history) and “dynamic” (e.g., alcohol/drug problems) risk factors. The static risk factors have been demonstrated to be predictive of reoffending and the dynamic factors provide direction to the Probation Officer for focusing the intervention or change process. A decreased LSI score indicates a lower risk of recidivism. The Probation Department administers the LSI to all probationers on intensive supervision as a monitoring tool. A probationer who receives a score of 20 or lower would be considered for transfer to mid-level supervision. The LSI is administered as a semi-structured motivational interview by a Probation Officer who also utilizes supplemental information from official records and other sources to calculate a low, medium, or high risk score. This instrument was administered to Connections treatment clients within 45 days of discharge from the detention facility, at six-months after program intake, and again at program exit.

An exit and follow-up instrument, similar to the intake form, was designed to capture BOC common data elements and other outcome variables of interest. The exit instrument was administered by members of the project team to Connections clients at program exit. Five to eight months after program completion, a Connections Social Worker attempted to contact each client and conduct the six-month follow-up interview either on the phone or in person.

**Analysis**

These data were analyzed using frequencies and measures of central tendency, as well as inferential statistics including t-tests, sign tests, and chi-squares. Statistically significant results are reported at the significance level of $p < .05$ or higher for all tests.
Sample Description

Eligible clients were almost evenly distributed between genders. As Figure 3.1 shows, 55 percent of the Connections clients were male, as were 63 percent of those in the comparison group. Females were overrepresented in both groups, in comparison to the jail population as a whole. That is, according to a one-month census of all inmates booked into San Diego County detention facilities on July 2003, 81 percent were male and only 19 percent were female. Two individuals (1%) in the comparison group were transsexual (categorized as other).

NOTE: Cases with missing information are not included.
SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003
Eligible clients represented a variety of ethnic backgrounds. Fifty-six percent (56%) of the Connections group and 57 percent of the comparison group were White, as Figure 3.2 illustrates. In addition, individuals identifying their primary race or ethnicity as Black represented 27 percent of the Connections clients and 22 percent of the comparison group. Others identified themselves as primarily Hispanic, Asian, or having multiple ethnic backgrounds. In addition, 91 individuals identified themselves as having a secondary ethnicity. Most frequently this was a multiple or “other” ethnicity (19 for both Connections clients and the comparison group), followed by Hispanic (7 in Connections and 14 in the comparison group), White (7 in Connections and 8 in the comparison group), Asian (8 in Connections and 6 in the comparison group), and Black (2 in Connections and 1 in the comparison group) (not shown).

![Figure 3.2](image)

**Figure 3.2**

CLIENT PRIMARY ETHNICITY

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Connections (n=225)</th>
<th>Comparison (n=223)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>56%</td>
<td>57%</td>
</tr>
<tr>
<td>Black</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Asian</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Spanish</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Another</td>
<td>6%</td>
<td>9%</td>
</tr>
</tbody>
</table>

NOTE: Percentages may not equal 100 due to rounding.
SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003

English was the language of choice for 96 percent of the Connections clients, as well as the comparison group. Five of the Connections clients and four individuals in the comparison group, preferred to speak an Asian dialect, one Connections client and three of the comparison group members primarily spoke Spanish, and two individuals in Connections and one in the comparison group preferred to speak another language. No one was prohibited from receiving Connections services because of a language barrier (not shown).
The average age at intake was significantly higher for Connections clients at 36.2 years (SD = 10.6) and 34.2 (SD = 9.7) for the comparison group (t (449) = 2.066, p < .05) (not shown).

The majority of eligible clients were single. Slightly more than half of the Connections clients (54%) and those in the comparison group (56%) had never been married (Figure 3.3). Others reported that they were currently divorced, separated, married, or widowed.

**Figure 3.3**

CLIENT MARITAL STATUS

![Bar chart showing marital status](chart)

- **Connections (n=225)**
  - Never Married: 54%
  - Divorced: 21%
  - Separated: 11%
  - Married: 11%
  - Widowed: 4%

- **Comparison (n=223)**
  - Never Married: 56%
  - Divorced: 20%
  - Separated: 13%
  - Married: 9%
  - Widowed: 3%

NOTES: Cases with missing information are not included. Percentages may not equal 100 due to rounding.

SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003

The majority of eligible clients did not have any dependents. One in five (21%) of Connections clients and one-quarter (25%) of those in the comparison group reported having minor children dependent on them for food and/or housing (not shown).

Most clients had not graduated from high school. On average, the Connections clients had completed 11.8 years (SD = 1.9) of formal education and those in the comparison group had completed an average of 11.9 years (SD = 2.0) (not shown).
To determine if the Connections program was implemented as designed and if the expected outcomes were realized, both process and impact evaluations were conducted. This chapter presented an outline of the research methodology, including a description of the methods used to address the research questions and the associated statistical tests. The research included conducting surveys and interviews, doing case studies, documenting services received, and tracking criminal history. The majority of clients were single, had no dependents, had not graduated high school, and identified as White. With the exception of age, individuals randomized to Connections and the comparison group were equivalent on all characteristics at intake.
CHAPTER 4
PROCESS EVALUATION RESULTS
CHAPTER 4
PROCESS EVALUATION RESULTS

INTRODUCTION

The current chapter includes information pertaining to the process evaluation, which addresses the four research hypotheses discussed in Chapter 3. Client level of need, prior criminal history, substance use and mental health status, as well as overall quality of life prior to entering Connections are presented. Client post-impressions of the program are also documented. In addition, the input that Connections staff members who provided on the implementation and the strengths and the weaknesses of the program are discussed. Data are presented from program records, client intake instruments, criminal records, and staff and client surveys.

PROGRAM RECORDS

How Many Individuals Were Screened and Eligible for the Program?

Between June 1, 2000 and February 28, 2003, program staff received 4,786 referrals for individuals potentially eligible for program participation (not shown). Of those cases that completed the screening process, 463 or 10 percent were determined to be eligible, 190 were pending sentence, and 4,133 (90%) were not. As Table 4.1 shows, the most common reasons for ineligibility were being released from custody prior to intake\(^1\) (46%), being sentenced to state prison (17%), not being placed on formal probation after sentencing (15%), and not meeting clinical eligibility criteria (13%). Other reasons included having a legal “hold” by another law enforcement agency, being on parole, and not being a United States citizen (through January 2001).

Table 4.1
REASONS FOR CLIENT INELIGIBILITY

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Released prior to intake</td>
<td>46%</td>
</tr>
<tr>
<td>Sentenced to state prison</td>
<td>17%</td>
</tr>
<tr>
<td>Not placed on formal probation</td>
<td>15%</td>
</tr>
<tr>
<td>Not clinically eligible</td>
<td>13%</td>
</tr>
<tr>
<td>Other reasons</td>
<td>4%</td>
</tr>
<tr>
<td>Assigned to another program</td>
<td>3%</td>
</tr>
<tr>
<td>Unavailable for supervision</td>
<td>2%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>4,133</strong></td>
</tr>
</tbody>
</table>

SOURCE: SANDAG; Connections Program Records, June 2000 – February 2003

\(^1\) According to program staff, this percent is inflated because jail staff was initially providing referrals on all inmates, regardless of incarceration status (whether the inmate was still in jail or released), so this program categorization also includes inappropriate referrals.
Randomization of clients for the project evaluation began on June 5, 2000. Between that time and February 24, 2003, 449 individuals completed the intake process, with 225\(^2\) randomized to Connections and 224\(^3\) randomized to the comparison group. Unless otherwise noted, the two groups were comparable.

**INTAKE INFORMATION AND SHERIFF’S DEPARTMENT DATABASE**

Information from client intakes was available for 225 individuals in Connections and 223 individuals in the comparison group. Data on criminal history were available for 225 individuals in Connections and all 224 in the comparison group.

**What Was the Level of Client Need?**

**Employment History**

Individuals in both groups were underemployed. Just prior to arrest, 61 percent of the Connections clients and 58 percent in the comparison group were not employed and were not looking for work (Figure 4.1). In addition, 27 percent of the Connections clients were employed (38 full-time, 17 part-time, 1 full-time sheltered, and 5 part-time in a sheltered environment), as were 29 percent in the comparison group (39 full-time, 21 part-time, 1 full-time sheltered, and 3 part-time sheltered). Others reported that they were looking for work or identified themselves into other categories (i.e., student, retired, homemaker). When asked if they thought they would have a job when they were released from jail, only 19 percent of the Connections clients and 22 percent in the comparison group thought that they would (not shown).

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\(^2\) Two hundred fifty-seven (257) were actually randomized to Connections, but 32 were later determined to be ineligible. Specifically, 10 were sentenced to state prison, 5 were not granted probation, 4 were randomized inappropriately by a staff person, 3 each moved out of county or were admitted to another program, 2 each had a release date outside of study time period or demonstrated excessive violence, and 1 each was on hold in another county, was deported, or was misdiagnosed at intake.

\(^3\) Two hundred thirty-eight (238) were actually randomized to the comparison group, but 14 were later determined to be ineligible: 5 were not placed on probation, 3 went to prison, 2 each were ordered from probation to the court or randomized inappropriately by a staff person, and 1 case each was dismissed or had a release date out of the study time period.
When asked about their prior employment status, 49 percent of the Connections clients and 46 percent of the comparison group reported that they had not worked at all in the past 12 months. Of those who had worked, the number of jobs held ranged from 1 to 12 for Connections clients and 1 to 10 for those in the comparison group, with 1 job being the most common for both groups (not shown).
All of the individuals, regardless of whether they had been employed in the last 12 months, were asked to describe their most recent employment position and the responses were coded into one of the seven Hollingshead categories: higher executive, business manager/owner, administrative, clerical and sales, skilled manual, semi-skilled, or unskilled. As Figure 4.2 shows, the majority of individuals in both groups (81% Connections and 84% comparison group) reported working in either a semi-skilled (e.g., machine operator), unskilled (e.g., janitor, construction help), or clerical/sales position. The remaining individuals reported they were most recently employed in a skilled manual (e.g., plumber, welder), an administrative, or managerial position.

Figure 4.2
CLIENT MOST RECENT EMPLOYMENT POSITION

![Bar chart showing employment positions for Connections and Comparison groups.]

NOTE: Cases with missing information are not included. Percentages may not equal 100 due to rounding.

SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003
Income Level and Financial Status

A number of individuals who completed the intake process revealed that they lacked adequate income in the 30 days prior to their arrest to meet basic needs, including food, clothing, housing, transportation, and other social needs (e.g., recreational activities), demonstrating the high level of need of this population. For example, 41 percent of the Connections clients and 38 percent of the comparison group felt that they were unable to meet their basic food needs prior to their arrest. Similarly, approximately half of Connections clients (51%, 53%, and 49%) and nearly half in the comparison group (48%, 49%, and 48%) were unable to fund their clothing, housing, or transportation needs (Figure 4.3).

Figure 4.3
CLIENT INABILITY TO MEET BASIC NEEDS

NOTES: Cases with missing information are not included. Percentages are based on multiple responses.
SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003

In the 12 months prior to their arrests, over half of the Connections clients and the comparison group received some type of financial assistance (57% of Connections clients and 58% of comparison group). In addition, 44 percent of Connections clients and 47 percent of the comparison group were receiving some type of public financial assistance immediately prior to this arrest. Of the Connections clients who had been receiving assistance prior to intake, 71 percent were receiving Social Security Income (SSI), 13 percent Social Security Disability Insurance (SSDI), 6 percent unemployment compensation, 4 percent each welfare or CalWORKS, 3 percent each pension benefits or Veterans’ Administration (VA) support, and 2 percent other sources of income. Of those in the comparison group receiving assistance, 66 percent were receiving SSI, 15 percent SSDI, 6 percent unemployment compensation, 5 percent VA support, 4 percent each welfare or CalWORKS,
3 percent other sources, and 2 percent a pension. These differences were not statistically significant (not shown).

The two groups were also similar in terms of health insurance status. Specifically, 59 percent of Connections clients had insurance, compared to 57 percent of those who were randomized to the comparison group. When asked what type of insurance they had, approximately three-quarters (77% each) of both groups reported their insurance was paid for by state government and 13 percent of Connections clients and 11 percent of those in the comparison group were insured through their employer (not shown).

**Client Living Situation**

As Figure 4.4 shows, over half of both groups reported residing in a house or apartment (56% Connections and 57% comparison group) and approximately one-third identified themselves as being homeless (i.e., no identifiable residence) immediately prior to the current arrest (32% Connections and 35% comparison group). Other living situations reported by individuals in both groups included supported housing (which includes living in a house or apartment with daily support and supervision) and group housing situations (e.g., board and care, skilled nursing facility, and other residential facilities). When individuals who were living in a house or apartment (both independently and with support) were asked how many people (including themselves) lived in the household, the mean was 3.2 (SD = 2.0) for Connections clients and 3.4 (SD = 2.0) for the comparison group (not shown).

![Figure 4.4: Client Living Situation](image)

**NOTE:** Cases with missing information are not included.
**SOURCE:** SANDAG; Connections Intake Instrument, June 2000 – February 2003

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4 Program staff believed this percentage was low and that clients tended to underreport on this variable.
On average, Connections clients reported living at their current residence for 58.8 months ($SD = 129.4$) months and the comparison group did so for 43.9 months ($SD = 133.3$). Sixty-one percent (61%) of the Connections clients and 64 percent of the comparison group thought that they would have a residence to go to when they were released from jail (not shown).

**Alcohol and Other Drug Use**

According to program staff, a significant proportion of individuals booked into jail exhibited behavior indicative of a psychiatric disorder that may actually have been the result of their use of alcohol and other drugs. In addition, a high percentage of those who were appropriately identified as being mentally ill were also dual-diagnosed individuals with a history of alcohol and/or other drug abuse and dependence. This latter pattern, which is visible in the following self-reported information, presented unique challenges in regard to service plan development.

**Alcohol Use**

Fifty-six percent (56%) of the Connections clients and 62 percent of the comparison group reported they had used alcohol in the 12 months prior to their arrest. For 114 Connections clients who had used alcohol in the past 30 days, the average number of days of use was 11.9 ($SD = 13.5$). For 123 comparison group individuals with reported use, the average was 13.7 days ($SD = 16.1$) (not shown).

Of those individuals with use in the past year (127 in Connections and 137 in the comparison group), 30 percent of Connections clients and 36 percent of the comparison group felt they needed or were dependent on alcohol. In addition, 47 percent and 48 percent, respectively, reported they had tried to quit or curtail their use in the past year. Of those 125 individuals (59 in Connections and 66 in the comparison group) who tried to reduce their drinking, over three-quarters (76%) of the Connections clients reported the ability to do so, as did 77 percent of those in the comparison group (not shown).

Over one-quarter of individuals in both groups (27% Connections and 28% comparison group) reported receiving alcohol treatment or detox in the past. Ten individuals in the Connections group and 12 in the comparison group were actually receiving treatment when they were arrested. Approximately one-fifth (19%) of the Connections clients and one-quarter (26%) of the comparison group reported feeling they needed treatment for alcohol at the time of intake (not shown).

**Drug Use**

As Figure 4.5 shows, a number of clients in both groups reported using one or more illicit substances during the past 12 months. The most common drug used by Connections clients was marijuana (50%), followed by methamphetamine (46%). The comparison group reported using both these drugs almost equally (41% marijuana and 40% methamphetamine). Twenty-five percent (25%) of the Connections clients and 31 percent of the comparison group reported that they had not used any type of illegal drug in the past 12 months (not shown).
As part of the national Arrestee Drug Abuse Monitoring (ADAM) program, adult arrestees in San Diego are interviewed about their current and past drug use. This information provides an opportunity to assess the drug use experience and trends of a relatively high-risk population subgroup. In comparison to other arrestees in San Diego, these clients had a similar use pattern for all the listed drugs except for crack, which was twice as high. In comparison, only 13 percent of arrestees interviewed in 2003 for the ADAM study reported using crack in the past 12 months (SANDAG, unpublished data).

Forty-eight percent (48%) of the Connections clients reported feeling dependent on drugs, as did 42 percent of the individuals in the comparison group. Specifically, 55 percent overall felt dependent on methamphetamine (56% in Connections and 54% in the comparison group), 35 percent on marijuana (37% and 32%, respectively), 15 percent on crack (14% and 17%, respectively), 14 percent on heroin (13% and 15%, respectively), and 5 percent on cocaine (4% and 6%, respectively) (not shown).

Fifty-seven percent (57%) of the Connections group and 47 percent of the comparison group reported trying to cut down on their drug use in the past 12 months; this was a significant difference ($\chi^2 (1) = 3.934$, $p < .05$). Eighty-three percent (83%) of the Connections clients felt they were successful in doing so, as did 79 percent of the comparison group respondents (not shown).
Forty-six percent (46%) of the Connections clients and 38 percent in the comparison group reported that they had previously received treatment or detox for drug abuse. Forty-three (43) of these individuals (28 in Connections and 15 in the comparison group) were receiving treatment at the time of their arrest. Significantly more of the Connections clients (48%) expressed a current need for treatment compared to the comparison group (36%) ($\chi^2 (1) = 6.035, p < .01$) (not shown).

**What Was the Mental Health Status of Clients?**

**Psychiatric Diagnoses**

As Figure 4.6 shows, 43 percent of the Connections clients were diagnosed by the jail Psychiatrist with schizophrenia (e.g., paranoid type, affective disorder, and undifferentiated type) as their primary diagnosis, as were 46 percent of the comparison group. In addition, 32 percent and 31 percent were diagnosed with some form of depression, slightly less than one-quarter (23% and 22%, respectively) with a bi-polar disorder, and 2 percent and 1 percent with some other type of disorder (e.g., adjustment disorder for anxiety, post-traumatic stress disorder). When looking at both groups combined, there were significant differences between gender and diagnoses ($\chi^2(4) = 52.631, p < .001$). Overall, women more often had a primary diagnosis of some form of depression (48% for women compared to 20% for men) and men were more likely to have a diagnosis of schizophrenia (54% versus 30%) or bi-polar disorder (26% versus 18%). These differences were consistent between the Connection clients and the comparison group (not shown).

![Figure 4.6 CLIENT PRIMARY PSYCHIATRIC DIAGNOSIS](image)

NOTES: Cases with missing information not included. Percentages may not equal 100 due to rounding.

SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003
In addition, the majority of individuals had a secondary diagnosis (61% of Connections and 67% of comparison group). Over half of the individuals in both groups had a secondary diagnosis of substance abuse or dependence. Specifically, 54 percent of those in Connections and 52 percent of the comparison group had a diagnosis for alcohol or drug (e.g., opioid, amphetamine, polysubstance, or cocaine) dependence or abuse. Both of these were slightly higher than clients’ self-report on their dependency on alcohol or drugs. Other individuals had a secondary diagnosis of depression, schizophrenia, bi-polar disorder, generalized anxiety disorder, or a personality disorder (antisocial or sexual masochism) (not shown).

The average GAF scores for the two groups were also similar, with clients eventually randomized to Connections having an average score of 42.0 (SD = 9.14) compared to 41.0 (SD = 8.5) for those in the other group. Sixteen percent (16%) of the Connections group and 14 percent of those in the comparison group were identified as a suicide risk at the time of booking into the jail (not shown).

Social Worker Observations

At the end of the intake survey, Social Workers were asked whether substance abuse, a developmental disorder, or a physical health disorder affected the mental health of the client. This determination was made based on the information obtained during the survey, both from the client and through personal observation. As Figure 4.7 illustrates, in the opinion of program staff, substance abuse had a negative effect on an individual’s mental health status for more clients in both groups, compared to health disorders or developmental disabilities.

Figure 4.7
SOCIAL WORKER RATINGS OF EFFECTS ON MENTAL HEALTH STATUS

<table>
<thead>
<tr>
<th></th>
<th>Connections (n=205-222)</th>
<th>Comparison (n=204-218)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse</td>
<td>54%</td>
<td>58%</td>
</tr>
<tr>
<td>Health Disorder</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>3%</td>
<td>5%</td>
</tr>
</tbody>
</table>

NOTE: Cases with missing information are not included.
SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003
Case Manager/Conservatorship

Few individuals in both groups had someone looking after their well-being. Twenty-seven percent (27%) of individuals in the Connections group and 25 percent in the comparison group reported that they had someone who looked out for their well-being on a regular basis during the last 12 months. For individuals in both groups, this role was most frequently filled by a case manager or family member. Four individuals in Connections reported having a conservatorship, as did six individuals in the comparison group. In addition, 13 percent of Connections clients compared to 10 percent of the comparison group had a representative payee at intake (not shown).

Previous Mental Health Treatment

Sixty-four percent (64%) of the Connections clients and 67 percent in the comparison group reported that they had received some type of mental health treatment in the 12 months prior to their arrest (not shown). For both groups, this most often took the form of medication management (90% and 91%, respectively) (Figure 4.8). In addition, a little more than half of Connections clients (54%) and 42 percent of those in the comparison group reported receiving counseling. “Other” types of services include the regional center (e.g., services for the developmentally disabled) and clubhouse services (e.g., socialization services).

Figure 4.8
PREVIOUS MENTAL HEALTH TREATMENT

NOTES: Cases with missing information are not included. Percentages are based on multiple responses.
SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003
Overall, 63 percent of Connections clients and 66 percent of the comparison group reported they had been prescribed psychiatric medication in the previous 12 months. A psychiatrist was the person who most often prescribed this medication (97% for the Connections group and 89% for the comparison group). Of the individuals prescribed medication, only 57 percent of Connections clients and 54 percent of the comparison group reported they were taking their medication as prescribed prior to this arrest. When probed as to why they weren’t taking it, the most common reasons included having lost it or ran out (36%), the side effects were unpleasant (30%), they didn’t think it was helping (11%), it interfered with their drug use (11%), they were too depressed to take it (9%), or some other reason (6%). Despite this fact, approximately three-quarters of both groups (71% Connections and 72% comparison group) expressed the desire to continue treatment upon release with the individual who prescribed this medication (not shown).

**Emotional Satisfaction**

Using a seven-point scale, potential clients were asked to rate how things were going, in general, between themselves and their families immediately prior to their arrest. Nearly half of both groups (45% of the Connections clients and 44% of the comparison group) felt negatively about their relationships and over one-third (35%) of each group noted a positive rating (Figure 4.9).

**Figure 4.9**

CLIENT RATING OF QUALITY OF RELATIONSHIP WITH FAMILY

<table>
<thead>
<tr>
<th></th>
<th>Connections (n=225)</th>
<th>Comparison (n=221)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>35%</td>
<td>20%</td>
</tr>
<tr>
<td>Mixed</td>
<td>45%</td>
<td>20%</td>
</tr>
<tr>
<td>Negative</td>
<td>20%</td>
<td>5%</td>
</tr>
</tbody>
</table>

NOTES: Cases with missing information are not included. Percentages may not equal 100 due to rounding.

SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003

5 The rating categories included terrible, unhappy, mostly dissatisfied, mixed, mostly satisfied, pleased, and delighted. The three highest and three lowest were collapsed and categorized as “positive” and “negative.”
Using the same rating scale, potential clients were also asked to make three ratings regarding their living situation prior to arrest: how they felt about it in general, the amount of privacy they had at this location, as well as the prospect of returning and living there for a long period of time. Figure 4.10 presents the percentage of respondents who gave negative ratings. Overall, around half (from 44% to 54%) of individuals in both groups selected a negative rating for each of these characteristics of their prior living situation. For example, 45 percent of Connections clients felt negatively about the amount of privacy they had, as did 48 percent of the comparison group. Although one-third reported being homeless at intake, over half of the individuals in each group (54% and 51%, respectively) felt negatively about the prospect of returning to their prior living situation after release.

![Figure 4.10: Client Negative Rating of Living Situation](image)

**Figure 4.10**

**CLIENT NEGATIVE RATING OF LIVING SITUATION**

<table>
<thead>
<tr>
<th>Connections (n=221-225)</th>
<th>Comparison (n=221-223)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Arrangements</td>
<td>47% 45% 54%</td>
</tr>
<tr>
<td>Privacy</td>
<td>44% 48% 51%</td>
</tr>
<tr>
<td>Prospect of Returning</td>
<td></td>
</tr>
</tbody>
</table>

*NOTES: Cases with missing information are not included.*

*SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003*
Individuals in both groups were also likely to report doing poorly in terms of their emotional well-being. Again, using the same rating scale, approximately two-thirds of those surveyed (66% of the Connections clients and 62% of the comparison group) reported that they felt negatively about their emotional well-being immediately prior to this arrest (Figure 4.11). Of the remainder, 17 and 18 percent, respectively, had mixed feelings, and 17 and 20 percent, respectively, had positive feelings.

**Figure 4.11**

**CLIENT RATING OF EMOTIONAL WELL-BEING**

<table>
<thead>
<tr>
<th></th>
<th>Connections (n=223)</th>
<th>Comparison (n=223)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>66%</td>
<td>62%</td>
</tr>
<tr>
<td>Mixed</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Positive</td>
<td>17%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Note: Cases with missing information are not included.

Source: SANDAG; Connections Intake Instrument, June 2000 – February 2003
The last question requiring use of the seven-point rating scale pertained to how the clients felt about their lives in general immediately prior to this arrest. As Figure 4.12 shows, more than half of the Connections group (62%) and the comparison group (57%) reported feeling terrible, unhappy, or mostly dissatisfied (collapsed to “negative”) and only around one-quarter felt positive.

Figure 4.12
CLIENT RATING OF LIFE IN GENERAL

<table>
<thead>
<tr>
<th></th>
<th>Connections (n=225)</th>
<th>Comparison (n=223)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>62%</td>
<td>57%</td>
</tr>
<tr>
<td>Mixed</td>
<td>15%</td>
<td>19%</td>
</tr>
<tr>
<td>Positive</td>
<td>23%</td>
<td>24%</td>
</tr>
</tbody>
</table>

NOTES: Cases with missing information are not included. Percentages may not equal 100 due to rounding.
SOURCE: SANDAG; Connections Intake Instrument, June 2000 – February 2003

What Was the Level of Criminal History of Clients?

The majority of eligible clients had a criminal history prior to the instant offense. Eighty-eight percent (88%) of Connections clients and 91 percent of the comparison group self-reported that the current arrest was not their first. The average age at first arrest was 24.4 years (SD = 10.7) for Connections clients and 23.5 years (SD = 10.26) for the comparison group, with the average age at first conviction 27.6 (SD = 10.1) and 27.0 (SD = 9.8), respectively (not shown).

Additionally, for the majority of individuals in both groups, their current booking was not their first in San Diego County. That is, only 16 percent of the Connections clients and the comparison group had not been booked in San Diego County in the three years prior to their booking for the instant offense. The average number of separate jail bookings over the three years was 3.0 (SD = 2.8) for Connections and 3.1 (SD = 3.39) for the comparison group. On average, Connections clients had spent 67.7 days (SD = 86.6) in jail during the past three years prior (not counting time spent for the instant offense and not necessarily consecutively). Members of the comparison group had spent an
average of 72.4 days ($SD = 105.2$) incarcerated for prior offenses in the previous three years (not shown).

As Figure 4.13 shows, both groups had similar levels of charges for which they were booked. Individuals in each group were more likely to be booked for a felony level charge for the instant offense (73% and 67%, respectively) than a misdemeanor charge (9% and 12%, respectively) or a further processing (17% and 20%, respectively). A further processing charge is a booking on a previous conviction, which usually is a violation of a probation condition.

**Figure 4.13**
LEVEL OF MOST SERIOUS INSTANT OFFENSE BOOKING CHARGE

<table>
<thead>
<tr>
<th></th>
<th>Connections (n=225)</th>
<th>Comparison (n=224)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felony</td>
<td>73%</td>
<td>67%</td>
</tr>
<tr>
<td>Misdemeanor</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Further Processing</td>
<td>17%</td>
<td>20%</td>
</tr>
</tbody>
</table>

NOTE: Percentages may not equal 100 due to rounding.

SOURCE: SANDAG; Connections Criminal History Tracking, June 2000 – February 2003
As Figure 4.14 shows, both groups were also similar in terms of the types of crimes individuals were booked for, with about one-fifth and one-third booked for a violent, property, drug offense, or further processing offense.

**Figure 4.14**
TYPE OF MOST SERIOUS INSTANT OFFENSE BOOKING CHARGE

<table>
<thead>
<tr>
<th>Type of Offense</th>
<th>Connections (n=225)</th>
<th>Comparison (n=224)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Property</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Drug</td>
<td>13%</td>
<td>17%</td>
</tr>
<tr>
<td>Other</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Further Processing</td>
<td>21%</td>
<td>20%</td>
</tr>
</tbody>
</table>

SOURCE: SANDAG; Connections Criminal History Tracking, June 2000 – February 2003
Both groups were similar in the charge level and offense types of convictions they sustained for the instant offense. Of those individuals that had a sustained conviction for the instant offense, they most often received a felony conviction (86% Connections and 88% comparison group) for a property (37% and 41%, respectively) or drug (27% and 21%, respectively) offense. The remaining individuals were charged for some other type of offense (18% Connections and 17% comparison group). Twenty-seven percent (27%) of Connections clients and 38 percent of the comparison group did not have a conviction associated with their instant offense booking (not shown).

**STAFF SURVEY**

**How Did the Connections Staff Feel About the Multi-Disciplinary, Collaborative Team Model?**

The teaming of Probation Officers with Social Workers was a crucial component of the Connections program model. As with all partnerships, the process required attention to team development and a paradigm shift in the provision of services to mentally ill offenders. These efforts were reflected in staff opinions, which became more accepting over time, on the effectiveness and usefulness of the interdisciplinary model. Initially, nearly half of the staff thought the model was “very effective” and half felt it was “somewhat effective” in providing services to the target population. These percentages increased to 77 percent and 23 percent respectively, in the second round of staff surveys, reflecting stronger staff support of the model. In both surveys, staff cited the different perspectives and roles each member brought with them (67% and 85%) and the sharing of ideas as a strength of the model. This increased in the second round of surveys, as staff more often recognized the team’s benefit to the clients (46% versus 20%) as valuable. One staff member commented, “Clients enjoy working with more than one person. Everyone on the team has something to offer. It is nice to have so much knowledge with you.” Additionally, some staff noted that the team atmosphere was supportive, provided a means to prevent burnout by dispersing the work, and was an opportunity to pool resources.

The issues of communication and balancing different perspectives were most often seen as challenges in working as an interdisciplinary team at the beginning of the program. However, only two staff members noted communication as an issue in the second survey, with a larger percentage (77%) concerned about the differing perspectives between the Social Workers and Probation Officers. Similarly, staff in the second survey was more concerned about team members’ unwillingness to compromise for the greater goals of the team. Staff was asked in the second survey to reflect on any changes in the team dynamics over time. Of the seven who felt that there had been some changes, five felt that the staff changes had been disruptive to the teams and three thought there had been an increase in understanding of each other’s role.

The project teams collaborated with community-based agencies and other governmental agencies, such as the Social Security Administration or County Mental Health, to access services for their clients. The staff reported encountering some challenges when working with these entities. Locating enough services for their clients was staff’s greatest challenge when working with community-based agencies. This included dealing with long waiting lists, lack of funds on the part of the client, and the inadequate number of treatment beds, especially for the dual-diagnosed. This was valuable feedback, given that the linkage with community resources is a critical component of
the ACT model and the overall success of the program. Although not as frequently, staff did note the low quality of services and lack of cooperation as issues, at times, when working with the community-based agencies. Dealing with cumbersome bureaucracies, which included long waiting lists, rigid standards, paperwork, and impersonal individuals were the most often cited problems when working with governmental agencies.

| What Did Staff See as the Greatest Strengths and Weaknesses of Connections? |

Staff recognized the interdisciplinary team as the primary strength of Connections, both for combining two different disciplines and by increasing the availability of staff to clients. One staff member, when describing a strength of the program, wrote, “The team approach - clients derive strength and some degree of comfort from knowing that a group of people is interested in their lives and is willing to assist them in being more successful in meeting their goals.” Closely related to this was the value placed on the availability of wrap-around services, which provided flexibility and access to resources for the client. The expertise of the Connections staff, although mentioned in the first survey, was more often cited as an asset by the staff in the second survey. The goals to assist this population and reduce recidivism were viewed as additional strengths of the program. The support of management was noted equally in both surveys as a positive aspect of the program. Suggestions for improving the program included changing some aspects of the model, such as increasing the length of program participation or lowering the client-to-staff ratio. Some staff also felt that it would be less disruptive if the individuals on teams remained the same.

When asked in the second survey how effective Connections was in working with the mentally ill offenders, all staff members thought it to be either “very” or “somewhat” effective. Dealing with the issues associated with addiction, as well as a lack of resources, was viewed as the greatest challenges in working with this population. Although not mentioned as frequently, medication compliance and the instability associated with mental illness were also challenging for the staff. Despite these challenges, staff felt that the greatest asset a successful client can possess is the desire and willingness to change. Accessing the resources available to them through the community and the government, not engaging in criminal behavior, and taking their medication were also cited as characteristics of clients who succeed. The interventions that staff identified as being most helpful with this population were the case management services and the relationship between the staff and the clients. A few staff also noted the importance of being able to transport the client to appointments, providing wrap-around funds, and supporting their mental health treatment as valuable interventions.

Although the team model was seen as very valuable, dealing with the inherent issues associated with working in a team environment was most often reported as a challenge to be addressed in the first survey. Specific challenges included adjusting to the different professional perspectives of Probation staff and Social Workers, dealing with different personalities, and operating out of different offices. This was less of a concern in the second survey with only 15 percent, compared to 57 percent of staff, citing it as a weakness. Staff in the second survey was more concerned with the program criteria, specifically, increasing the length of program participation and the lack of funds to sustain the program past the grant period. A few staff members in the first survey suggested having more focused selection criteria to include clients who were more motivated and had fewer substance abuse issues. Management issues, such as long meetings and lack of trust, as well as
dissatisfaction with the split location of the teams, were also less of an issue for staff in the second round of surveys. When asked about the value of the research being conducted for Connections, nearly all of the staff thought it was either “very” (71%) or “somewhat” (21%) valuable.

**How Did Connections Staff Feel About Program Implementation and Management?**

Overall, staff members who responded to the first survey were satisfied with the implementation and management of Connections, with an equal number feeling that it was either “very” or “somewhat” effective. The most common suggestion for improvement centered on the dynamics of the partnership between Probation and the Sheriff’s Department. Specific suggestions were to increase the understanding of each other’s perspective and have more inclusion and equity of all members. Additional training on mental illness at the beginning for the Probation Officers, more cars, and a single office location were other suggestions for improvement.

In the second round of surveys, 85 percent of staff thought the program was being managed “very” effectively. Overall, the majority of staff felt that they had been provided with the necessary resources to do their jobs effectively. Of the few individuals who noted a need for additional resources, the resources were more external than internal to the program. Specifically, they requested more housing for clients and additional treatment services. The opinions of the staff reflected the efforts by management staff to support the team model in a manner that offered them the greatest opportunity to meet the needs of their clients.

There was a slight difference between the surveys in how the staff felt about the training they had received. Staff members felt that they had “completely” (53% and 46%, respectively) or “somewhat” (27% and 38%, respectively) received sufficient training to prepare them for their work. Suggestions for additional training included receiving more information on mental health and substance abuse treatment, team dynamics, communication, the criminal justice system, and the ACT model. There was also a suggestion to repeat some of the previous trainings.

**TREATMENT TRACKING**

**What Were the Types and Frequency of Services Provided to Participants?**

Connections clients received a greater amount of treatment services post-release from jail for the instant offense compared to those randomized to the comparison group. As Table 4.2 shows, Connections clients received significantly more assessments ($\chi^2(1) = 148.055$, $p < .001$), case management ($\chi^2(1) = 277.173$, $p < .001$), medication support ($\chi^2(1) = 36.563$, $p < .001$), individual counseling ($\chi^2(1) = 142.773$, $p < .001$), crisis intervention ($\chi^2(1) = 39.442$, $p < .001$), probation contacts ($\chi^2(1) = 13.099$, $p < .001$), collateral services ($\chi^2(1) = 62.140$, $p < .001$), and vocational services ($\chi^2(1) = 84.419$, $p < .001$), than the comparison group. In addition, nearly all of the Connections clients had contact with a Probation Officer (96%), 80 percent received pre-release planning, and 98 percent had life skills training. Although the Connections teams attempted to meet with clients several times prior to release, this was not possible if the client was released from jail soon after
randomization into conditions. On average those Connections clients received an average 159 minutes (SD =14.6) or close to 3 hours of pre-release contact.

However, when clients left the program there were fewer differences between the two groups in the amount of services received. Only those clients that successfully completed Connections had received more services than the comparison group in the six-month follow-up period. Specifically, they more often had received individual counseling (36% compared to 17%) or medication support (57% compared to 39%) than comparison group individuals ($\chi^2(1)= 10.171, p < .001$ and $\chi^2(1)= 6.813, p < .01$) (not shown). Successful Connections clients also had significantly fewer psychological evaluations in the six-month follow-up period (8% Connections vs. 18% comparison group) ($\chi^2(1) = 3.838, p < .05$). One possible explanation for this decrease is the need for on-going support to assist the mentally ill in accessing treatment.
## Table 4.2
### TREATMENT SERVICES RECEIVED PRE-RELEASE AND POST-RELEASE FROM JAIL

<table>
<thead>
<tr>
<th></th>
<th>Pre-Release</th>
<th>Post-Release</th>
<th>Pre-Release</th>
<th>Post-Release</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Connections</td>
<td>Comparison</td>
<td>Connections</td>
<td>Comparison</td>
</tr>
<tr>
<td>Case Management$^{1,4}$</td>
<td>1%</td>
<td>3%</td>
<td>99%</td>
<td>22%</td>
</tr>
<tr>
<td>Collateral Services$^{1,4,6}$</td>
<td>30%</td>
<td>40%</td>
<td>99%</td>
<td>37%</td>
</tr>
<tr>
<td>Probation Officer Contacts$^{3,5}$</td>
<td>n/a</td>
<td>n/a</td>
<td>96%</td>
<td>86%</td>
</tr>
<tr>
<td>Assessment$^{1,4}$</td>
<td>2%</td>
<td>1%</td>
<td>98%</td>
<td>46%</td>
</tr>
<tr>
<td>Individual Counseling$^{1,4}$</td>
<td>21%</td>
<td>25%</td>
<td>90%</td>
<td>35%</td>
</tr>
<tr>
<td>Medication Support Services$^{3,4}$</td>
<td>65%</td>
<td>72%</td>
<td>89%</td>
<td>64%</td>
</tr>
<tr>
<td>Life Skills Training$^3$</td>
<td>n/a</td>
<td>n/a</td>
<td>70%</td>
<td>n/a</td>
</tr>
<tr>
<td>Crisis Intervention/Stabilization$^{1,4}$</td>
<td>5%</td>
<td>5%</td>
<td>67%</td>
<td>37%</td>
</tr>
<tr>
<td>Residential Substance Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment$^3$</td>
<td>n/a</td>
<td>n/a</td>
<td>41%</td>
<td>n/a</td>
</tr>
<tr>
<td>Psychological Evaluation$^2$</td>
<td>8%</td>
<td>4%</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>Vocational Assistance$^{1,4}$</td>
<td>0%</td>
<td>0%</td>
<td>32%</td>
<td>0%</td>
</tr>
<tr>
<td>Group Counseling$^2$</td>
<td>16%</td>
<td>17%</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Acute Inpatient Services$^2$</td>
<td>7%</td>
<td>7%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Mental Health/Hospital Inpatient$^2$</td>
<td>n/a</td>
<td>n/a</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Crisis House$^2$</td>
<td>0%</td>
<td>0%</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Job Coaching$^3$</td>
<td>n/a</td>
<td>n/a</td>
<td>4%</td>
<td>n/a</td>
</tr>
<tr>
<td>IMD Facility$^2$</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Socialization$^2$</td>
<td>0%</td>
<td>&lt;1%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Pre-Release Planning$^3$</td>
<td>80%</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>TOTAL</td>
<td>225</td>
<td>224</td>
<td>225</td>
<td>224</td>
</tr>
</tbody>
</table>

**SOURCE:** SANDAG; Connections Treatment Documentation, June 2000 – December 2003

$^1$ Information collected from the UBH system and Connections staff tracking forms.

$^2$ Information collected from the UBH system.

$^3$ Information collected from Connections staff tracking forms.

$^4$ Connections clients significantly more likely to receive this service during the post-release period.

$^5$ Information collected from Probation CANARI database.

$^6$ Comparison group significantly more likely to receive this service during the pre-period.

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### How Many Clients Completed the Program and How Long Were They Served?

The last client randomization into Connections occurred in February 2003, with a start date in March 2003. All of the 225 study clients were exited from the program by December 31, 2003. On average, these individuals were in the program for approximately eleven months (336.12 days, SD = 64.3) after their release from jail (not shown). However, the time in the program does not accurately reflect the duration of services, as clients remained in the program even when incarcerated or missing for a period of time. The intent was to allow as much opportunity for the client to re-engage in the program. For example, clients who successfully completed the program...
were in the program an average of 353.10 days ($SD = 37.8$), compared to the 312.46 days ($SD = 83.7$) for clients who did not complete the program ($t(223) = 10.883, p < .001$). However, in many cases, the unsuccessful client was AWOL for most of that time, but the program kept the case open in case she returned.

Over half (58%) of Connections clients who exited had successfully completed the program, 16 percent chose to leave or went AWOL from the program, 16 percent were either sentenced to prison, committed a new offense or had a new incarceration (e.g. probation violation), 7 percent continued to have unacceptable behavior, and 3 percent each were sent to a special program, died, or were removed by the court (Table 4.3).

Table 4.3
CONNECTIONS CLIENT EXIT STATUS

<table>
<thead>
<tr>
<th>Exit Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successfully completed program</td>
<td>58%</td>
</tr>
<tr>
<td>Chose to leave the program (AWOL)</td>
<td>16%</td>
</tr>
<tr>
<td>Sentenced to prison, new incarceration, or new offense</td>
<td>16%</td>
</tr>
<tr>
<td>Unacceptable behavior</td>
<td>7%</td>
</tr>
<tr>
<td>Entered a special program, died, or removed by court</td>
<td>3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>225</td>
</tr>
</tbody>
</table>


Factors Predictive of Success

Upon closer examination, there were a few factors associated with successfully completing the Connections program. Table 4.4 shows the client characteristics that were predictive of success. Specifically, unsuccessful clients were twice as likely to be homeless and had more contact with the criminal justice system prior to their arrest than successful clients (Table 4.4).

Table 4.4
CLIENT CHARACTERISTICS SIGNIFICANTLY RELATED TO SUCCESS IN CONNECTIONS

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Successful (%)</th>
<th>Unsuccessful (%)</th>
<th>Significant Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless at Intake</td>
<td>26</td>
<td>40</td>
<td>$\chi^2(1) = 4.623, p &lt; .05$</td>
</tr>
<tr>
<td>Number of Prior Bookings</td>
<td>2.64</td>
<td>3.40</td>
<td>$t(224) = -2.024, p &lt; .05$</td>
</tr>
<tr>
<td>Number of Prior Convictions</td>
<td>2.02</td>
<td>2.41</td>
<td>$t(224) = -2.114, p &lt; .05$</td>
</tr>
</tbody>
</table>

SOURCES: SANDAG; Connections Criminal History Tracking, June 2000 – December 2003; Connections Intake Instrument, June 2000 – February 2003
CLIENT SURVEY

How Did Clients Feel About Their Participation?

One hundred fifty-one clients completed a client survey upon exit. Overall, clients reported having a positive and helpful experience in Connections. The overwhelming majority of clients were either “very” (79%) or “somewhat” (14%) satisfied with the services they received. The consistent attention and concern from the team, as well as the team members themselves were most often cited as the “best” part of the program. Referring to what s/he liked best, one client stated, “the fact that this program let Probation see me as a human. The staff...they care!” Likewise, the support and assistance received from the teams was also appreciated by the clients. As one client said when reflecting on the program, “they made me get a job [which made me productive again]. I felt like they were my counselors and I could talk to them about everything.” Some clients noted that Connections had helped them to change their behavior for the better and others were impressed by the team’s knowledge of resources and mental health issues. As one client simply put it, "They were always on time and there when you needed them. Thank you."

Nearly three-quarters (71%) of the clients did not have any suggestions for improving the program and those recommendations that were provided were varied. The most often cited recommendations for program improvement were to have the program duration be longer and to provide additional assistance. Other suggestions included more contact with the team and more program information. A few clients also requested more resources, such as bus passes or food certificates (not shown).

How Did Clients Feel About Changes in Their Lives?

Clients were asked to use a four-point scale to rate their level of improvement from “a lot” to “not at all” in four areas: employment, family, housing, and emotional well-being (Figure 4.17). The greatest level of improvement was in clients well-being (70%), followed by their housing situation (62%), and their relationship with family members (57%). The least amount of change occurred in the area of employment (36%). One possible explanation for this is that many of the Connections clients depend on SSI, rather than employment, for their primary source of income. In addition, there was a decrease in the amount of vocational services received with the absence of the Employment Specialist since June 2002. As such, this question was not applicable for approximately 20 percent of the clients and for those who did respond, 34 percent reported no change at all.
Information in this chapter was compiled from program records, intake, exit and follow-up interviews, a staff and client surveys, and UBH and criminal records. Similar to other research findings, many of the mentally ill offenders in this study were unemployed, lacked adequate income to meet their basic needs, had a history of alcohol and other drug abuse, had received mental health treatment previously, and had a lengthy involvement with the criminal justice system. Consistent with expectations, the Connections group received a greater variety and amount of services than those in the comparison group. Specifically, Connections clients received significantly more assessments, case management, medication support, individual counseling, crisis intervention, and vocational and collateral services than the comparison group after release from jail for the instant offense. Staff members were pleased with Connections and praised the program model and the innovative approach to working with this population. The suggestions for improvement centered on inherent issues associated with creating a new program and partnerships to provide services. Results from the client survey showed that clients were appreciative of the assistance, personal support, and attention they received, and that the majority felt that they had made positive changes in the quality of their lives as a result of being a part of the program.
CHAPTER 5
CASE STUDIES

INTRODUCTION

As part of the process evaluation, two cases studies were conducted. Case study clients were selected prior to their meeting the Connections team or completing any assessments or evaluation forms. Based on availability, a member of the evaluation team was paired with a Connections team and attended team meetings at various points throughout the client’s program participation, from initial intake through the exit interview. The evaluation member became part of the team and established a relationship with the Connections staff and the client. The researcher documented each team visit, reviewed the assessments, program forms, and team case notes. She also debriefed with team members after visits and asked the client informal questions about his/her experience throughout the process. This participant observation style offered a more in depth, qualitative perspective on the program process and the relationship between the team and the client. It also shed light on some of the systemic issues and the unique challenges of working with mentally ill offenders.

CASE STUDY NUMBER ONE: M.S. X

Client History

Ms. X was a 48-year old African-American woman, with a lengthy history of interaction with the criminal justice system. Her criminal history spanned 30 years, which included a juvenile record. She had been arrested 23 times as an adult, with most of her arrests for drug offenses, theft, or prostitution. Her instant offense was for petty theft with a prior and involved her stealing a bottle of alcohol from a neighborhood liquor store. She was arrested later that week, when she returned to the store and the owner pointed her out to police officers who happened to be in the store on a different matter.

There was less documentation of Ms. X’s mental health history compared to her criminal history. Her qualifying diagnosis for Connections was Post Traumatic Stress Disorder, with a secondary diagnosis of polysubstance abuse dependence. Prior to entering Connections, Ms. X had very limited exposure to mental health providers in San Diego County and reported receiving no mental health treatment 12 months prior to her arrest. While in jail, Ms. X was prescribed several different types of medication and complained of severe depression. She disclosed a history of suicide attempts, with the most recent one occurring six months prior to her arrest. She reported hearing voices that told her to attempt to kill herself and she had tried to do so in the past by slashing her wrist and overdosing on street drugs.

Similar to many of the Connections clients, Ms. X had an extensive substance abuse history. Although she did not identify a drug of choice, she had a history of using crack cocaine, heroin, and marijuana, as well as drinking alcohol. Ms. X was actively using drugs prior to her arrest and reported feeling dependent on crack. Not only had her use led to problems with the law, it also had
been disruptive to her family and personal life. Ms. X’s social system revolved around her drug use. There was substance abuse in her family and possibly some history of mental health issues with one of her brothers and her father. Ms. X reported that both her brother and father were seriously impaired by their use of drugs. At the time of program intake she currently did not have any contact with them. In addition, she had been diagnosed with hepatitis.

Ms. X had two children, an adult daughter (who had one child and was pregnant at the time of the first visit) and a 17-year old son who lived with his father in San Diego. Her mother, stepfather, daughter, grandchild, niece, and nephew also live in San Diego. She also had four brothers. Her mother lived in a well maintained, lower middle class neighborhood, predominated by single family residents. Her mother had lived in the same house for 25 years and worked at a local school district. Ms. X’s brother and his children were living with her mother.

Prior to her arrest, Ms. X was homeless and reported not having enough income to meet her basic needs. She also reported feeling terrible about her well-being and life in general. Ms. X did not have a solid work history and had little to no job skills. She was unemployed at the time of arrest and not looking for work. Ms. X did not graduate from high school, but did possess a GED.

### Phase One: Pre-Release (July through August 2000)

**Description**

Prior to the client’s release from the detention facility, team members meet with him/her for preliminary services planning, to plan for immediate housing, and to obtain signatures on consent forms. To maximize client engagement, the optimal number of pre-release visits is four to six.

**Key Characteristics/Activities**

During the three pre-release visits with Ms. X, the team put into action a key component of the program, which is to establish a relationship with the client and communicate their goal to support her in altering those behaviors that led her to being incarcerated. The team introduced themselves, provided an overview of the program, and asked Ms. X to sign the necessary consent and release of information forms. At the first visit, Ms. X was under the influence of psychotropic medication and was drowsy and a little dazed. She was seeing the jail psychiatrist once a week and was taking four different types of medications. Her affect improved over the course of the three visits, becoming more lucid and coherent. Her trust and interaction with the team also increased during this time.

The Deputy Probation Officer (DPO) and Correctional Deputy Probation Officer (CDPO) had a different role and style than the social worker. This was evident by their interview approach and the type of questions they asked. The DPOs questions were more direct and fact based, and the Social Worker's questions were more circuitous, explanatory, and directed towards Ms. X’s feelings and emotional state. For example, the Social Worker asked Ms. X how she was sleeping, how was her depression, and administered a mental health evaluation tool by framing the questions in a conversational style, rather than reading the questions from the form. The DPO reviewed the conditions of probation, the expectations of Ms. X, and asked probing questions when inconsistencies became apparent in her story. Despite these differences, the team presented a cohesive approach that was non-confrontational, supportive, encouraging, and client-driven.
The underlying message was to aid Ms. X in achieving her goals by working collaboratively with her, not for her.

Over the course of the pre-release visits, the team learned about Ms. X’s past, her communication style, how forthcoming she was with information, and how motivated she was to participate. She also had the opportunity to become more familiar with the team and what to expect from them. At first, Ms. X was surprised by the attention the team was showing her. She stated that it was a different approach from her past experiences with Probation. She was taken aback by how much contact she would have with the team after release and that they would be coming to her home, rather than her reporting to an office. She expressed a concern about the team being too involved in her life.

During these visits, Ms. X was a bit reserved with the information she was willing to share and did not answer all the questions directly. She had a tendency to be more forthcoming about her mental health history, than her substance abuse history. She also had a tendency to disengage in the conversation about one half hour into the meeting.

Ms. X and the Social Worker completed her service plan during the third visit. The plan addressed five goals – living arrangements, social, educational, health, and legal. She was not very interested in setting goals and once she did she had a hard time identifying obstacles that would keep her from achieving them, even though she had never been able to meet them in the past. These initial goals were small, with very simple and clear steps to accomplish them. For example, one of the health goals was to take her medication at the same time everyday. Other goals included: having her children pick her up and drive her to her mother’s home upon release, apply for SSI, attend Narcotics Anonymous (NA) and Alcohol Anonymous (AA) meetings, maintain daily contact with the team, follow the conditions of probation, enroll in at least two classes at City College, make an appointment for a hepatitis test, and take her medication as prescribed.

In addition to meeting with Ms. X, the team spoke with her mother ahead of time and met with her at her home. This visit served several functions, including offering the team an opportunity to see where Ms. X would be living upon release, explaining the program to her mother, and obtaining collateral information about Ms. X. Ms. X’s mother made it very clear that Ms. X would have to follow her rules, stay off drugs, and take her medication if she wanted to live there. Her questions suggested that she was not familiar with Ms. X’s mental health condition, asking if it would be safe to have her there around the grandchildren and what effect the medication would have on Ms. X. The Social Worker took the time to explain Ms. X’s condition and explained that the team would be working very closely with Ms. X to help her stay on track with her goals.

Challenges/Barriers

Overall Ms. X seemed interested in getting help from the team; however, she was not very aware of the issues that contributed to her being incarcerated or understanding how to address them. Additional challenges for Ms. X that became apparent during these initial meetings included a history of not taking her medication, lifetime history of substance abuse, low education level, lengthy involvement in the criminal justice system, and lack of income, coupled with no self-sustaining work history.
Phase Two: Engagement and Assessment (September through November 2000)

Description

During phase two, the team maintained daily contact with a client during the first month post-release, tapering down to weekly contacts for the two months thereafter. Goals during this phase included identifying stable housing options, reviewing probation conditions, planning services, having the client meet with the Employment Specialist, meeting with family members, providing transportation assistance, establishing a financial plan, providing medication management, and linking the client with community resources, including mental health services, substance abuse treatment, and medical resources.

Key Characteristics/Activities

Upon release, Ms. X first resided with her mother and then moved in with her daughter and granddaughters. During the first few weeks after her release Ms. X slipped back into her old patterns. She did not fill her prescription and used cocaine, marijuana, and alcohol. The team kept in daily contact with her and quickly recognized the deterioration in her behavior and confronted her. Within days, the team intervened on several levels. They first went and picked up her medication and delivered it to Ms. X. The team then instructed Ms. X to enroll in an outpatient drug program and to make an appointment at her local county mental health clinic. The team followed up with each request to ensure Ms. X completed them. Within three weeks of her release she had an appointment at the above agencies and one with a medical clinic to address her hepatitis diagnosis.

During this period, Ms. X had two positive drug tests. However, instead of violating her probation, the Probation Officer worked to get her into treatment. Ms. X never denied the use, nor did she resist following through with the team’s instructions. Once given clear direction and the assistance to follow it, Ms. X completed the tasks and started to get some of her needs met. The DPO noted that prior to this experience of working with a mental health specialist, he might have interpreted Ms. X’s behavior as defiant, rather than as a symptom of her depression. During these visits Ms. X seemed impatient and did not want to interact very long with members of the team. She was not forthcoming with information and the team usually initiated the conversation. Two assessments were completed at this time, the Level of Service Inventory (LSI) and the Adult Substance Use Survey (ASUS).

After a period of two months, there were obvious outward changes with Ms. X. Although her affect was still low, she was paying more attention to her appearance and was more comfortable during the interactions with the team. She seemed to have become familiar with the routine and the members of the team. Part of this routine included regular drug tests, delivery of the monthly bus pass, and transporting her to appointments. In turn, the team was becoming more familiar with Ms. X. so much so, that when her demeanor seemed lethargic they inquired about her medication and discovered that the doctor had recently changed it. In response, the Social Worker went with Ms. X to her next appointment and discussed changing the medication to help minimize some of the side effects Ms. X was obviously experiencing.
Ms. X’s personal life was also stabilizing. She continued to live amicably with her daughter and granddaughters. Her daughter was the sole source of income, working full-time and paying for the household items and food. Ms. X was attending her outpatient drug program once a week, she kept her appointments with her Psychiatrist, and was taking her medication as prescribed. Ms. X and the team agreed that she was not able to work and submitted an application for Social Security Insurance (SSI). Her application was rejected and they assisted her with the appeal. Ms. X also expressed interest in taking classes at a local community college. In response, the team had her meet with the Connections Employment Specialist regarding educational opportunities.

Challenges/Barriers

Ms. X faced several challenges during this phase of treatment. Her lack of experience with substance abuse treatment, not taking her medication, and lack of self-direction put her at risk upon release. Although the team took immediate and appropriate action to redirect this spiral, these issues remained challenges that both Ms. X and the team would have to continue to grapple with while she remained in the program. Ms. X’s denial of SSI, which resulted in a lack of income, was an additional barrier to overcome.

Phase Three: Support and Monitoring (December 2000 through February 2001)

Description

The team continued weekly contact during the second three months. During this phase the emphasis was placed on crisis prevention and intervention, long-term goals and planning, substance abuse testing on a monthly basis, continued vocational interests, money management, and continued support and monitoring of services initiated earlier.

Key Characteristics/Activities

During this period, Ms. X made strides to accomplish many of her initial goals. She continued attending her drug treatment outpatient program and graduated in December. Also, with the assistance from the team's social worker, Ms. X was linked to a therapist at the same mental health clinic where she was seeing her Psychiatrist. Ms. X was unsuccessful in her SSI appeal process and the team connected her with a lawyer to assist her with the next appeal. Ms. X continued to live with her daughter in an apartment that was well-maintained and located in a secure complex. Ms. X did not have her own room and slept on the couch. She helped with the children, but was not responsible for their day care. She also cooked for the family.

During this phase, the team experienced a change in the DPO. As part of the Connections policy, every four months different teams rotated certain personnel. Ms. X seemed to adjust to the new DPO with little disruption to her connection with the team.

As part of this phase of treatment, the Social Worker met with Ms. X to revise her service plan. Ms. X’s living and social goals revolved around her relationship with her daughter. She set the goal of finding a larger apartment with her daughter, so she could have her own room and stated she wanted to work on improving her relationship with her daughter. Related to this, was her goal to
continue pursuing the appeal process for SSI. She also carried over the goal to register and sign-up for classes at the community college. Underlying all of these was Ms. X’s on-going goal to take the prescribed medication for her mental health needs and hepatitis.

The team played an active role in attempting to support Ms. X’s interest in taking classes. Despite verbalizing this desire several times, it was not until the team transported her and walked her through the registration process that Ms. X was able to address this goal. It was clear, both from her comments and her request for assistance, that without the aid of the team Ms. X would not have been able to maneuver through that system. The team met her at the community college, attempted to have her sign-up for classes through Disabled Students Services, and assisted her in applying for financial aid. Despite this assistance and her effort, in the end Ms. X was not able to follow through with the classes. The task proved to be more than she could handle.

Ms. X did experience a couple of set backs during this period. One had to do with a larger system issue of the lack of adequate mental health services for this population. During this period, Ms. X’s therapist left the clinic and the clinic did not reassign another one to her. Both the DPO and the Social Worker commented on how frustrating, time consuming, and difficult it had been to access a therapist through the County Mental Health system. They couldn’t imagine a client navigating this system on their own. The second set back was that Ms. X started drinking again. Although she graduated from the treatment program, she stopped attending recovery meetings altogether. Soon after this she started to drink alcohol, and in February she was arrested for driving under the influence and without a license. The team quickly responded and requested that she start going to her meetings again, which she did.

Challenges/Barriers

Further challenges arose during this phase. In particular, the lack of consistent and accessible mental health treatment proved to be an overwhelming challenge for the team and Ms. X. Despite their efforts and her willingness to participate, Ms. X could not obtain a mental health therapist. This was a crucial mental health resource and factor in meeting her overall goals. In addition, the rejection of her SSI appeals was becoming a more daunting challenge. Coupled with these larger system issues were Ms. X’s recovery program and her lack of initiative to seek treatment and support on her own.

Phase Four: Transfer of Care (March through August 2001)

Description

The fourth phase varied from three to six months, depending on the client’s needs. Contact remained on a weekly basis and involved planning for on-going support from outside agencies and post-program mental health support, and providing continued vocational development, money management, and support and monitoring of services initiated in the previous phases.

Key Characteristics/Activities

Overall, this phase was a time of stabilization for Ms. X. She made progress in every area of her life, as identified in the service plan. Although the team maintained weekly contact, the type of contact shifted mostly to phone contact rather than personal visits. Following the DUI, Ms. X started
attending 12-Step meetings that were held in her apartment complex. She also attended a dual-diagnosis group at her mental health clinic and started volunteering at a neighborhood church once a week to fulfill her community service requirements. Ms. X was also ordered to attend MADD groups that were over 20 miles from her home. The team assisted her by transporting her to these groups.

Ms. X maintained her appointments with her Psychiatrist and took her medication regularly. She also maintained her sobriety and had no positive drug tests. Although the team offered to assist her again with taking classes at the community college, Ms. X never followed through with this.

There was another change in the structure of the team during the month of May, with the loss of the Social Worker. This position remained vacant through the duration of Ms. X’s involvement in the program. One impact of this change was the loss of some key information. The DPO and CDPO were not as familiar with Ms. X’s mental health treatment or her SSI appeal process. In addition, no service plan was completed during this time period.

Challenges/Barriers

Despite these accomplishments, Ms. X still was without a therapist and had yet to obtain SSI. The lack of income made it impossible to make changes in her living situation. Although she was living amicably with her daughter, she still did not have her own room.

Phase Five: Discharge (August 2001)

Description

After a period of 9 to 12 months, the client was transferred to a new Probation Officer, a discharge plan was created and the agencies involved in the care of the client were notified of the discharge.

Key Characteristics/Activities

Three months prior to Ms. X’s discharge, the team met with her to discuss program completion and resolve any remaining goals that she wanted to accomplish while in the program. At that time Ms. X did not have any additional goals.

At the time of discharge, Ms. X was sober, had been taking her medication for 12 months, had established a daily routine, and had found enjoyment in her meetings and her volunteer activity. She had also signed up for general relief on her own and now had a small income. At the last meeting, Ms. X stated that this time out of jail was much different than the first time and she really didn’t want to use drugs. Unlike her first meetings with the team, Ms. X seemed attached to them, expressing her gratitude for their help and stating that she would miss them. It was obvious that she had come to trust and like the DPO and CDPO. While in the program, Ms. X had made improvements in her living arrangements, emotional state, substance use, basic needs, and family relations.

As part of the discharge process, the DPO administered the exit LSI and a Social Worker completed a discharge service plan and the exit form. According to the LSI, Ms. X’s risk for recidivism decreased
from a greater than 90 percent chance of rearrest at intake to a 44 percent chance at exit. The discharge plan was completed at the second to last visit between Ms. X and a Social Worker. Many of her goals were to continue with what she had started while in the program. These goals included: completing probation, filing another appeal for SSI, maintaining a positive relationship with her daughter, obtaining her own apartment if she gets SSI, maintaining her sobriety and contact with her Psychiatrist, volunteering at her church, walking for exercise, and maintaining friendships with law abiding persons. Ms. X was discharged successfully from the Connections program on August 29, 2001.

Challenges/Barriers

Although Ms. X had made great strides and accomplished many of her goals, the team did state that Ms. X could have benefited from longer involvement in the program. She had yet to secure a long-term source of income, was still living with her daughter and grandchildren, had not been reassigned a therapist, and had just recently started to build a social support system. Her case was transferred to a mid-level status, which would mean little or no contact with a Probation Officer. This lack of connection with an individual or agency that could help guide and support Ms. X would be a substantial challenge for her. In addition, Ms. X departed Connections with a loosely structured recovery program, consisting of NA meetings and no sponsor.

Summary

Ms. X entered Connections with numerous issues that put her at-risk for recidivism, homelessness, suicide, and disenfranchisement. With a lengthy history of substance abuse and involvement in the criminal justice system, as well as little attention to her mental health needs, Ms. X had to overcome substantial obstacles in order to improve the quality of her life. Hesitant at first of the intense involvement of the Connections team in her life, over the course of the year Ms. X came to trust and depend on their support. Building upon her desires and wishes, the team partnered with Ms. X to accomplish several of her program goals.

Her time in the program was not without setbacks and it was not until the last few months that Ms. X started to stabilize and allow the new behaviors and routines to take root. At the time of program exit, Ms. X had experienced the effects that different choices could make in her life. She reported a higher level of satisfaction with her living situation, emotional well-being, and her overall feeling about life in general. Her mental health was stable and she had several months of sobriety behind her. Overall, she was in a much better place at the end of her involvement with the program.

The outstanding question that remains with the departure of the Connections team from her life is how she will do without the consistency of someone to look out for her well-being. Several challenges still exist for Ms. X. to address. These include her lack of an income, navigating a complex and onerous mental health and Social Security system on her own, less than a year of sobriety, a history of non-compliance with her prescribed medication, a new and small social system, and a fairly short time of stabilization versus a lifetime of use and chaos. During her time in Connections, Ms. X demonstrated successfully that, with assistance, she had the desire and capacity to change.
CASE STUDY NUMBER TWO: M R. X

Client History

Mr X was a 63 year old African-American man diagnosed as chronic paranoid schizophrenia in 1992. He reported that the symptoms started after his wife’s death from a crack overdose in 1986. While incarcerated Mr. X was taking psychotropic medication and expressed a desire to continue to do so upon his release. Mr. X had some history of receiving outpatient treatment for his mental health needs and was briefly hospitalized in 1954 for auditory hallucinations. At intake, Mr. X had a GAF score of 35. In addition to his mental health needs, Mr. X had several severe physical health issues, including asthma, incontinence, and a hyperextended hip. At his first couple of visits with the Connections team, while in jail, he was severely out of breath from the walk from his cell to the interview room.

In addition to his mental health issues, Mr. X had a drug history that dated back to when he was a teenager. He reported that he first used heroin at the age of 16 and continued to do so for 20 years. Mr. X stopped when he ran out of usable veins. Although heroin was his drug of choice, Mr. X also used powder cocaine and crack. Mr. X reported using drugs prior to his arrest and that his instant offense was for possession and transportation of narcotics. Mr. X was middleman for a drug sale on the street in downtown San Diego. Despite his past and current drug history, Mr. X did not express any desire for drug treatment.

Mr. X had a lengthy criminal history, reporting that he was first arrested at the age of 14 and convicted at the age of 19. He had a total of six felony and three misdemeanor convictions. Most of the charges were for concealing or possessing a weapon, auto theft, and drug possession. Most of the offenses occurred in Detroit or New York. Mr. X served time in both jail and prison and had a history of compliance with his conditions of Probation.

At the time of his arrest, Mr. X had a LSI score of 38. He was homeless and reported being “mostly dissatisfied” with his emotional well-being and life in general upon intake. Prior to his arrest, he was receiving SSI, but reported that he did not have enough income to address his basic needs. Mr. X had been living in San Diego for over a year, and prior to that he was in San Francisco, but he considered Detroit his home base.

Mr. X’s family resided in Detroit. He had contact with his mother and his father died in 1999. Mr. X had two brothers and two sisters. He also had two children by two different women. The children were aged 28 and 7 years old and he did not have contact with them. Mr. X had been married several times and was currently a widow when he entered the Connections program.

Phase One: Pre-Release (February through March 2002)

Key Characteristics/Activities

The Connections team had the opportunity to visit Mr. X four times prior to his release. In addition, to establishing a relationship with Mr. X and describing each of the team member’s roles, the team completed the initial needs assessment and required consent forms. Consistent with the motivational interviewing style of the program, the information needed for the assessment was
acquired over the course of the four visits, through a conversational style. The content of their questions were directed at his entire well being, and his criminal history remained in the past. The conversations were focused on the future and not falling into the same old patterns.

Mr. X's Connections team consisted of a DPO, CDPO, and a Social Worker. The overall tone of the interview was similar to other such Connections interviews, which communicated a message of support and the importance of the team and Mr. X's working together to achieve his goals. Although each member had their specific role and tasks, the DPO and the Social Worker on this team had similar styles, with the DPO possessing more of a social worker approach. The team gathered information on Mr. X's housing, medical, and treatment needs and spent the time in between visits searching for resources.

Mr. X's affect with the team did not change much during these visits. He seemed to become more comfortable with the team, but was still reserved, skirted sensitive questions, and was not forthcoming with information. When assessing his needs, Mr. X denied any need to get drug treatment and did not see any problem with returning to the downtown area, despite the team's concern about him returning to the neighborhood where he had used drugs and was arrested. Despite their concerns the team created a case plan that followed Mr. X's wishes, but were cognizant of the risk and planned to pay attention to them. They also required that he attend NA meetings, despite his denial of drugs being an issue. Also included in his case plan was the location of a residence near downtown, connection to a community clinic to assess his immediate physical needs, obtaining a transit identification card, and applying to reinstate his SSI.

The team discovered that Mr. X's physical needs, specifically his limited mobility and incontinence, were an obstacle in finding him a residential placement. After contacting several board and cares the team contacted the County Senior Homeless services to help locate some housing. They were able to locate temporary housing at a downtown single room occupancy (SRO) hotel that catered to senior citizens. The hotel was located only a couple of blocks from where Mr. X was arrested for the instant offense. However, it was conveniently located next to the Senior Community Center that Mr. X enjoyed visiting, his medical home, and a coffee house that had a daily NA meeting.

On the last pre-release visit, the team agreed to pick Mr. X up on the day of his release and escort him on several errands to get him situated in the community. The first stop would be to the Senior Community Center to link him to a county Social Worker. The team had made arrangements with jail personnel to have Mr. X released at a later time to facilitate a smooth transition. However, when the team showed up at 10:00 a.m. on the morning of his release, they were informed that the jail released him at 3:00 am. Fortunately, the team received a phone call from a Social Worker from the County's Senior Homeless Team out stationed at the Senior Community Center, who they had previously spoken with when making pre-release plans, notifying them that Mr. X had made his way to the Center. The team met him outside of the Center and despite being released early Mr. X did not seem upset. Mr. X demonstrated his street savvy by riding the trolley in the early morning hours until the Center opened. Mr. X looked his age and was disheveled wearing the soiled clothes he was arrested in. The team drove him to fill his prescription and get something to eat prior to their scheduled meeting with the Center's Social Worker.

At the meeting, it was revealed that Mr. X had been previously banned from the Center because of his involvement with drugs. The only reason the Center would allow him back was because he was working with Connections. In addition, Mr. X's housing was made available through the County's
Senior Homeless Team and he would be required to meet regularly with the Social Worker and follow a case plan. The team asked to assist in helping Mr. X meet the requirements of his case plan.

Following the meeting, the team walked over to the hotel to help Mr. X settle in. The Center provided him with a supply of linens and toiletries. Mr. X had a room that was approximately 6’ x 8’ and had a small refrigerator and microwave. He would be able to get breakfast and lunch at the Center. After dropping his stuff off at the hotel, the team walked with Mr. X to the Downtown Community Family Health Center, which was only three blocks from the hotel and signed him up for a 1:00 p.m. doctor’s appointment. At that time the team left Mr. X to run additional errands for him, including the purchase of new clothes. They also made arrangements to pick him up the next day and drive him to the Social Security office.

**Challenges/Barriers**

Mr. X was receptive to receiving assistance from the team and seemed very familiar with working within systems and with outside help. Mr. X’s apathetic behavior communicated that he was less interested in changing and content with having others do things for him. The greatest challenge at this phase was Mr. X’s past drug use and his lack of motivation to address it. The team discussed their concern that he would not be participating in any structured drug treatment and Mr. X would be living and socializing in the neighborhood where he actively used and sold drugs. The team was aware of Mr. X’s apathy in changing his behavior, but would wait to see if his approach proved to be unsuccessful.

**Phase Two: Engagement and Assessment (March through April 2002)**

**Key Characteristics/Activities**

Shortly after Mr. X’s release from jail, Mr. X’s physical conditions became a larger issue. The team discovered that Mr. X was both Hepatitis B and C positive and was having a hard time keeping his balance. Finding him more permanent housing in a board and care proved to be impossible with his incontinence and past criminal history. The team also noticed that Mr. X was not taking his psychotropic medication as prescribed. His explanation was that the doctor said he only had to take them if he heard voices. Besides this mishap, Mr. X established a routine of going to the Center in the early afternoons and attending the local NA meeting.

During the first six weeks after his release from jail, an LSI was administered to Mr. X and a service plan was created. The service plan was created by the team, who then reviewed it with Mr. X and asked him if he had any changes or input. The plan was also shared with the Center Nurse Psychiatrist who was working with Mr. X. Despite the team’s effort to engage Mr. X in the process, he was passive and provided little input. The service plan included adding Mr. X to the waiting list for HUD housing, continuing his mental health treatment at the Center, increasing his SSI check to compensate for his lack of cooking facilities, and trying to get him a wheelchair to help with his mobility.
Challenges/Barriers

In addition to the challenges associated with Mr. X’s poor health, his greatest challenge remained his unwillingness to be an active participant in his treatment. Although he was friendly and non-disruptive, Mr. X showed no initiative to change his behaviors. This remained the greatest challenge during his time in Connections.

Phase Three through Five: Support, Monitoring, and Discharge (May 2002 through November 2002)

As is explained below, because of Mr. X’s non-compliance, lack of participation and rearrest, there was little to no distinction between phases three through five. Most of phase three was spent trying to assess why Mr. X was deteriorating. During the month of May, the team started to notice changes in Mr. X’s behavior and suspected that he was using drugs again. He claimed to have had his check stolen, he had lost about 20 pounds, and appeared very racy and looking exhausted. He also started seeing a woman who was an old acquaintance and was known to be part of the local drug crowd downtown. Although Mr. X was drug tested regularly, the tests results were negative. However, because of the networking the team had done with Mr. X’s community resources, they found out that he was also missing his psychiatric appointments and that the Psychiatric Nurse suspected him of using prescription drugs. This prompted the team to submit a request to the lab to run different tests on Mr. X’s urine sample.

While waiting for the adjustments in the drug tests, Mr. X’s deterioration came to an apex in June when he was unable to pay his rent, because he said his check was stolen again and he was evicted from his hotel. The team made arrangements for him to stay in a local homeless shelter, one that Mr. X was familiar with. However, once the team received a positive urine test they rearrested Mr. X and the Probation Officer recommended that he be sent to prison because of his lack of initiative to change. The court decided to give him one more chance and placed him in a sober living apartment.

The team met with Mr. X weekly and then bi-weekly at his apartment and he continued to test negative for drug use. The sober living was located approximately 20 miles from downtown and this limited Mr. X’s contact with his old neighborhood. He spent his days watching television and interacting with the other residents. He attended the AA meetings at the apartment building, but went to as few meetings as possible. Mr. X never fully engaged with the team and seemed content to pass the days in the apartment. The team continued to monitor his progress until exit, but did not provide any additional interventions. At the exit interview, Mr. X thanked the team, but did not have much to say beyond that.
Summary

Upon entry into Connections, Mr. X had several issues that made his case particularly difficult. These included his extensive drug and criminal history, his health problems, his incontinence, and his age. Mr. X was diagnosed with schizophrenia at an unusually late age. This raised the issue of how much of Mr. X’s circumstance was a factor of his chronic drug use, rather than his mental illness.

During the first few months, the team provided intensive case management services to help situate Mr. X in the community. Working closely with the Senior Community Center, the team was able to ensure that Mr. X’s basic needs were met and that he was linked with a medical home. However, Mr. X was situated in the same neighborhood that he had been actively using and dealing drugs in prior to his arrest and he was not involved in any formal treatment program. This proved to be a problem for him, as he ended up socializing with old acquaintances, using drugs again, and eventually losing his housing.

Although Mr. X was categorized as “successfully completing” the program, he never actively engaged in the process. The Probation Officer’s decision to recommend prison for Mr. X when he relapsed was influenced more by his apathy, than the relapse itself. After this decision, the team's interactions with Mr. X were more supportive than motivational. Without his participation and willingness to address his drug use, there was not much the team could do for him. At exit, Mr. X was living in a stable environment, had enough funds to meet his basic needs, and was not using drugs. He also did not reoffend in the six months following his exit.
CHAPTER 6
IMPACT EVALUATION RESULTS
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IMPACT EVALUATION RESULTS

INTRODUCTION

The results from the impact evaluation are presented in this chapter. The research questions presented address the hypothesis that Connections clients would integrate into the community and be less likely to recidivate. This was measured by looking at new bookings and convictions, changes in at-risk behaviors, and increases in protective factors such as clients’ available resources and sense of well-being. Because little difference existed between Connections clients and the comparison group in regard to criminal history, additional analysis was conducted to determine if receiving the full dosage of treatment (e.g., successful clients) had an impact. As a result of this, clients who successfully completed Connections were compared to the comparison group to measure any differences in criminal history outcomes. This specific analysis was not completed for the risk and protective factors (i.e., alcohol use, client well-being) because significant differences were realized for all clients who received some level of service.

SHERIFF’S DEPARTMENT DATABASE

Data regarding criminal activity during program participation were available for 225 individuals in Connections and 224 in the comparison group. Because of State funding issues, it was necessary to end the program and the evaluation period earlier than anticipated. As such, there were 70 Connections clients and 59 comparison group individuals who did not complete their follow-up period and were excluded from the follow-up analysis.
Were Connections Clients Less Likely to be Booked into Jail?

Criminal history for both groups was gathered from the time an individual was released from jail to their date of exit, either from the program if they were a Connections client or one year from release if they were in the comparison group. Significantly more individuals in the comparison group were booked into jail during the period of “program participation” compared to those who were receiving Connections services ($\chi^2(1) = 5.062, p < .05$). Specifically, 35 percent of the individuals in the Connections group were booked into jail for a new offense while participating in the program, compared to 46 percent of those in the comparison group (not shown). In addition, those in the comparison group were in jail a significantly greater number of days, on average ($34.6, SD = 72.1$), compared to Connections clients ($20.2, SD = 46.1$) ($t (447) = -2.517, p < .01$) (not shown).

This difference was even greater when comparing those clients who successfully completed the program (e.g., received the full dosage of treatment) with the comparison group. Only 19 percent of the 131 clients who completed the program successfully were booked during program participation compared to nearly half of the comparison group (46%) ($\chi^2(1) = -3.882, p < .001$) (Figure 6.1). In addition, they spent significantly less days in jail ($8.7, SD = 33.1$) days in jail ($t (353) = -3.882 p < .001$) (not shown).

Figure 6.1
SUCCESSFUL CLIENTS AND COMPARISON GROUP INDIVIDUALS BOOKED INTO JAIL DURING PROGRAM PARTICIPATION

SOURCE: SANDAG; Connections Criminal History Tracking, June 2000 – December 2003

96
Slightly fewer Connections clients (21%) were booked into jail during the six-month follow-up period compared to the comparison group (26%) (not shown). However, there was a significant difference between the Connections clients who successfully completed the program and the comparison group ($\chi^2(1) = 5.878, p < .05$). As Figure 6.2 shows, while 26 percent of the comparison group was booked into jail, only 12 percent of successful Connections clients were booked.

Figure 6.2
SUCCESSFUL CLIENTS AND COMPARISON GROUP INDIVIDUALS BOOKED INTO JAIL DURING FOLLOW-UP

![Bar chart showing the percentage of successful Connections clients and comparison group individuals booked into jail.

SOURCE: SANDAG; Connections Criminal History Tracking, September 2001 – December 2003

The two groups also differed significantly in terms of the number of days they spent in jail during follow-up (2.1, $SD = 9.1$ days for the successful Connections clients compared to 19.3, $SD = 39.3$ for the comparison group) ($t(253) = -4.098, p < .001$) (not shown).
Were Connections Clients Less Likely to be Convicted of a New Offense?

There was little difference between number of individuals convicted of a new offense during program participation for Connections clients (16%) and the comparison group (21%) (not shown). However, there was a significant difference between Connections clients who successfully completed the program (8%) and the comparison group ($\chi^2(1) = 9.960, p < .01$) (not shown).

In addition, while only two percent (2 of 90) of the Connections clients who successfully completed the program were convicted of a new offense in the follow-up period, ten percent (16 of 165) of those in the comparison group were convicted ($\chi^2(1) = 3.886, p < .05$) (not shown).

Data collected from the Level of Supervision Inventory (LSI) for Connections clients also revealed positive changes over time with respect to their criminality. According to the scoring of this instrument, the lower the risk score, the less likely the client is to recidivate. As Figure 6.3 shows, there was a significant decrease in the average LSI score from 31.0 (SD = 7.2) at intake to 26.3 (SD = 8.4) at six-months, and to 22.9 (SD = 9.8) at program exit ($t(127) = 9.769, p < .001$ and $t(127) = 7.587, p < .001$).

Figure 6.3
CONNECTIONS AVERAGE CRIMINALITY RISK SCORE AT INTAKE, SIX MONTHS, AND EXIT

![Bar Chart](attachment:image.png)

TOTAL = 128

SOURCE: SANDAG; Probation Level of Supervision Inventory, June 2000 - December 2003
Interviews with clients at exit and at six-months following program completion revealed that Connections clients (whether successful or not) had improved in areas that research has shown to put the mentally ill at risk for recidivism. Specifically, clients possessed more protective factors such as financial security, access to resources, stable living environment, more positive sense of well-being, and better relations with family and friends. In addition, they had decreased their risky behaviors, such as alcohol and drug use and were more often engaged in treatment.

Analysis on changes that occurred after clients completed the program includes individuals who completed both an intake and exit interview. Similarly, follow-up analysis only includes those individuals who completed all three interviews. Figure 6.4 shows the number of matched cases that were used for the exit and follow-up analysis.

**Figure 6.4**

CLIENTS’ MATCHED INTAKE, EXIT, AND FOLLOW-UP INTERVIEWS

```
250
200
150
100
50
0

Intake Intake & Exit Intake, Exit, & F/U

224
158
77
```

SOURCES: SANDAG; Connections Intake, Exit, and Follow-up Instruments, June – December 2003

**Were Connections Clients Less Likely to Use Alcohol or Other Drugs?**

Connections clients were significantly less likely to report alcohol and other drug use at program exit and follow-up compared to at intake. Specifically, while more than half (54%) of the clients reported using alcohol in the past 30 days at intake, less than one-fifth (14%) did so at exit, as did 12 percent at six-month follow-up for those individuals who completed all three instruments (Sign Test, n = 158, 69 negative differences and n = 77, 33 negative differences, p <.001) (Figure 6.5). In
addition, while only 8 clients reported being in treatment for alcohol abuse at intake, 51 were in treatment at exit (Sign Test, n = 158, 38 positive differences, p < .001) (not shown).

Figure 6.5
CLIENT USE OF ALCOHOL AND OTHER DRUGS AT INTAKE, EXIT, AND FOLLOW-UP

Similarly, while 65 percent of the clients had used some type of drug in the 30 days prior to intake, only 9 percent reported using drugs in the 30 days prior to program exit (Sign Test, n = 158, 92 negative differences, p < .001). This was sustained six months after program exit (62% at intake and 9% at follow-up) for drugs (Sign Test, n = 77, 42 negative differences, p < .001). The number of individuals receiving treatment for drug abuse also increased, from 22 clients at program entry to 76 at program exit (Sign Test, n = 158, 42 positive differences, p < .001) (not shown).

Did Connections Clients Have More Resources Available to Them?

Results for the 158 Connections clients who exited the program and the 77 who also completed the six-month follow-up interview, revealed that these individuals were better off after participating in the program, compared to when they entered it. Areas of improvement included being more financially secure, more likely to have a stable residence, and better able to meet basic needs.

At program exit, a significantly greater proportion of Connections clients reported receiving some type of financial support (61%) compared to at program entry (46%) and at follow-up (62%) (for
those that completed all three interviews) (Sign Test, \( n = 158 \), 33 positive differences, \( p < .001 \) and \( n = 77 \), 6 positive differences, \( p < .05 \)) (Figure 6.6). This increase was most directly tied to a greater number of individuals receiving SSI (79 at exit compared to 54 at entry, and 39 at six-months, compared to 25 at intake). In addition, 64 percent had health insurance at program intake compared to 70 percent when they exited, as did 81 percent at six-months, up from 62 percent at intake (not shown).

Figure 6.6
CLIENT RECEIPT OF FINANCIAL ASSISTANCE AT INTAKE, EXIT, AND FOLLOW-UP

SOURCES: SANDAG; Connections Intake, Exit, and Follow-up Instruments, June 2000 – December 2003
As Figure 6.7 shows, Connections clients were also less likely to report that they lacked adequate resources to cover basic expenses at program exit compared to at entry. In other words, approximately three-quarters or more were able to adequately afford food, clothing, housing, and transportation and around two-thirds could afford to meet their social needs at time of program exit. Again, these were all significant increases from prior to the individual entering Connections (Sign Test, \( n = 158 \), 49 positive differences, 53 positive differences, 64 positive differences, 52 positive differences, 58 positive differences, \( p < .001 \)). These increases were also similar for those clients who completed the six-month follow-up interviews (not shown).

Figure 6.7
CLIENT ABILITY TO MEET BASIC NEEDS AT INTAKE AND EXIT

<table>
<thead>
<tr>
<th></th>
<th>Intake</th>
<th>Exit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>61%</td>
<td>86%</td>
</tr>
<tr>
<td>Clothing</td>
<td>51%</td>
<td>78%</td>
</tr>
<tr>
<td>Housing</td>
<td>49%</td>
<td>82%</td>
</tr>
<tr>
<td>Transportation</td>
<td>54%</td>
<td>82%</td>
</tr>
<tr>
<td>Social Needs</td>
<td>40%</td>
<td>68%</td>
</tr>
</tbody>
</table>

NOTE: Cases with missing information are not included.

SOURCES: SANDAG; Connections Intake and Exit Instruments, June 2000 – December 2003
Were Connections Clients More Likely to Report Emotional Satisfaction?

Connections clients expressed greater emotional satisfaction after program participation in terms of their relationship with their family, their own emotional well-being, as well as their life in general. As Figure 6.8 shows, there were significant increases in the percentage of participants making positive ratings in these areas, with over two-thirds reporting they were “mostly satisfied,” “positive,” or “delighted” (Sign Test, n =158, 66 positive differences, n = 156, 93 positive differences, and n = 158, 80 positive differences, p < .001). Again, these gains were still evident six-months after exiting the program (not shown).

![Figure 6.8](image_url)

CLIENTS MAKING POSITIVE RATINGS OF FAMILY RELATIONSHIPS, EMOTIONAL WELL-BEING, AND LIFE IN GENERAL AT INTAKE AND EXIT

NOTE: Cases with missing information are not included.

SOURCES: SANDAG; Connections Intake and Exit Instruments, June 2000 – December 2003
A larger proportion of clients also reported greater satisfaction with their living arrangements, which was also a significant improvement from intake to exit. As Figure 6.9 shows, 68 percent of clients reported feeling positively about their current living arrangements at exit (Sign Test, n = 158, 62 positive differences, p <.001) and 59 percent felt positive about the amount of privacy they had there (Sign Test, n = 158, 54 positive differences, p <.001). Clients also had made changes in their living situations. The number of clients who were homeless decreased from 27 percent at intake to 3 percent at program exit and more clients were living in a group facility at exit, increasing from 7 percent to 27 percent. In addition, eight percent of the clients were detained in a justice-related facility at exit. This trend was maintained in the follow-up period with only five percent reporting to be homeless (not shown).

Figure 6.9
CLIENTS MAKING POSITIVE RATINGS OF LIVING SITUATION CHARACTERISTICS AT INTAKE AND EXIT

SOURCES: SANDAG; Connections Intake and Exit Instruments, June 2000 – December 2003
The average GAF score also improved significantly over time (from 42.4, \( \text{SD} = 8.9 \) at intake to 53.7, \( \text{SD} = 11.8 \) at exit), demonstrating increased self-reliance on the part of participants (\( t(154) = -11.198, p < .001 \)). The average score change over time was 11.3 points. The score was slightly higher at the six-month follow-up period for those individuals who completed all three interviews, with an average score of 58.0 (\( \text{SD} = 13.0 \)) (\( t(62) = -8.842, p < .001 \)). As previously noted, a GAF score of 50 or less categorizes an individual as having “serious” symptoms or “serious” impairment in social, occupational, or school functioning. A score of 51 to 60 indicates an improvement in an individual’s level of functioning from “serious” impairment to “difficult” in the social, occupational, or school functioning. (not shown).

**Figure 6.10**

CLIENTS GAF SCORES AT INTAKE, EXIT, AND FOLLOW-UP

![GAF Scores Graph](image)

NOTE: Cases with missing information are not included.

SOURCES: SANDAG; Connections Intake, Exit, and Follow-up Instruments, June 2000 – December 2003

Upon exiting the program, significantly more Connections clients had someone to assist them than at program intake (47% versus 31% at intake) (Sign Test, \( n =157 \), 20 positive differences, \( p < .01 \)). There was little change between intake and exit in the percent of clients who had a representative payee 18 percent at intake, compared 16 percent at exit. However, at the six-month follow-up period more individuals had a representative payee (17 compared to 10), while the percent of individuals who had someone to assist them was the same (31% at six-months compared to 30% at intake) (not shown). This linkage with resources is an important factor for the mentally ill, as they need on-going support to remain stable in the community. However, except for the representative payee, these data suggest that it was difficult to sustain this support after exiting the program (not shown).
SUMMARY

The answers to the research questions for the impact evaluation support the hypotheses that Connections clients would be integrated into the community and less likely to recidivate after program participation. Connections clients were less likely to be booked into jail and to be convicted of a new offense, during program participation and at program exit, compared to individuals in the comparison group. They also spent less time in jail. When comparing those clients who successfully completed the Connections program with the comparison group, there were significant differences between the two groups for all of the criminal justice related outcomes. In addition, it seems that even partial intervention was beneficial to those Connections clients who did not complete the entire program.

Connections clients also improved their level of functioning in the community and decreased their risk for recidivism over time, as measured by positive changes on both the GAF and LSI assessment scores. In addition, clients receiving services through the ACT model were significantly less likely to use alcohol and other drugs and also reported significant improvement in their ability to meet their basic needs and in their overall quality of life. Fewer clients were homeless and more clients had linkages to someone in the community who could provide support.
CHAPTER 7
DISCUSSION

INTRODUCTION

This final chapter summarizes the findings and implications of the results for the Connections program. However, it is important to note that the future of Connections is not so much dependent on its outcomes, but rather on the availability of funds during tight budget times. In addition, lessons learned and recommendations for improvements and program replication are explored.

SUMMARY AND CONCLUSIONS

The Program

From the Summer of 1999 through the end of 2003, the San Diego County Probation and Sheriff’s Departments embarked on a partnership to try to improve the recidivism rate of local mentally ill offenders. The goal was to help this at-risk population improve their life skills, with the intention of closing their revolving door into the criminal justice system.

Modifying a research-based “best practices” ACT model, Connections provided intensive case management by a multi-disciplinary team (MDT) comprised of a Social Worker, Deputy Probation Officer (DPO), and a Correctional Deputy Probation Officer (CDPO). This was a new approach to working with the mentally ill offender for San Diego County and required a paradigm shift in how Probation and the Sheriff’s Departments dealt with this population. Much time and effort was spent educating each other about the two professions’ different perspectives and roles, with the goal of creating a team that could address the myriad of needs the clients had.

The Connections clients presented similar characteristics as other mentally ill offenders in the justice system. They entered the program with multiple needs, had very few resources available to them, were often struggling with a secondary diagnosis of substance dependence or abuse, were underemployed, had less than a high school education, and had a lengthy criminal history.

The teams quickly learned the difficulty of accessing services in the community. The staff members were often frustrated with the cumbersome bureaucracies of government agencies, such as Social Security Income (SSI) or just the sheer lack of resources available in the community for their clients. Connections staff and clients encountered the fragmented, burdensome, and difficult system that researchers have identified as one of the primary reasons the mentally ill reoffend. The system, despite its intentions, sets the mentally ill up for failure. To address this locally, Connections staff created effective partnerships with community agencies and provided on-going support to the agencies by providing consistent involvement with their clients. This helped facilitate access and long-term engagement to services for their clients. The teams also advocated for changes to expedite receipt of medicine and mental health care upon release, and supported their clients in connecting with local resources. Teams worked with clients for approximately eleven months to help them establish themselves in the community.
The Impact

Findings from both the process and impact evaluations showed that the program achieved its outcomes and met its intended goals. Connections clients reported a higher quality of life, with sufficient income to meet their basic needs such as housing, food, and clothing. They reported using less alcohol and drugs and exhibited a higher level of functioning. The program also 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.

These findings add to the existing research on the effectiveness of case management in reducing the recidivism of the mentally ill. Connections provided a modified version of the ACT model that proved to be successful with this population. Both the Probation and Sheriff’s Departments embarked on an experiment to change their systems via the Connections model and as such, they were able to improve the lives of the clients and reduce the number of mentally ill individuals returning to the criminal justice system.

WHAT WE FOUND THAT WORKS

Multi-Disciplinary Team: 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. The overwhelming majority of staff felt that this team approach was crucial to the program model. 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. Learning about behaviors associated with mental health diagnoses and having an immediate resource available proved valuable in both understanding and managing individuals with severe mental health issues. Conversely, the Social Workers were able to learn more about the legal system and criminogenic characteristics of their clients. Essential to the success of the MDTs was having program staff that were open to change and committed to the philosophy of the program model. Staff selection, screening, and oversight were necessary in creating an effective MDT. In addition, having clear expectations and support from management aided in creating continuity and cohesion within the teams, especially when there was change in staff.

Intensive Case Management: By providing intensive, consistent, and directed support, Connections created a continuum of care that this population doesn’t usually receive when seeking treatment. 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

“Clients enjoy working with more than one person. Everyone on the team has something to offer, it is nice to have so much knowledge with you.”
- Staff member on the best aspects of working with a Multi-Disciplinary Team.

“I had three people who cared about me and helped me make positive changes in my life. I learned how to take care of myself and to value my life.”
- Connections client on what s/he liked best about the program.
providing advocacy when needed. Again and again the clients praised the staff for keeping them on track, for always being there when needed, and for caring about them. This relationship, although not prescribed, was a valuable part of the client’s treatment and reintegration into the community. Case management provided a continuum of care by helping the client map out a plan and assisting him/her in navigating through some very cumbersome and complicated resource systems.

Partnering Effectively with the Community: The end goal of Connections was to link clients with services in their community, so when the client exited the program s/he would have a foundation of resources to draw upon. Three initial obstacles had to be overcome before this could occur. These included convincing providers to give clients a second chance (as many of them had been previously kicked out of programs), educating the community to see mentally ill offenders as citizens and not criminals, and creating a trust with service providers to facilitate access to the services.

Although there was an undeniable shortage of resources, staff members’ efforts to overcome these obstacles proved to be fruitful for their clients. In particular, non-profits and some county agencies shifted how they perceived the mentally ill and came to trust the Connections staff and rely on the support they provided to help them succeed in their own program, which in turn opened doors that would otherwise have remained closed. Connections started to affect how County Mental Health (CMH) worked with individuals released from jail and helped streamline the medication process. Overall, Connections provided a catalyst for change in how several community agencies approached and viewed the mentally ill.

Training: Bringing together two professions with different approaches and knowledge levels about the target population required a very thorough training curriculum at the beginning and later as new staff joined the program. In addition to a core set of topics, working with the population stimulated the need for on-going training. Throughout most of the program, the monthly meetings incorporated trainings in new areas, as well as refreshers. The trainings also functioned to maintain the program’s philosophy among the staff. Those staff who had received thorough training were most adept with working within the MDT structure and understanding the program philosophy.
WHAT DIDN’T WORK – LESSONS LEARNED

Lack of Resources in the Community: Despite Connections efforts to create system changes, the teams still faced numerous obstacles when trying to link their clients to services. Staff complained of long waiting lists, difficult bureaucratic systems, apathetic workers, and a sheer lack of available resources. Some of the most common challenges for the teams when seeking services for their clients included finding treatment services for clients with co-occurring disorders, securing stable and affordable housing, obtaining SSI benefits, and accessing consistent mental health treatment in the community. Understanding the systems was difficult for the staff and several noted that they did not see how their clients would be able to navigate it on their own. San Diego had to deal with the same obstacles that most other communities grapple with, including a well-intentioned community system that is fragmented, under funded and often ill-equipped to take care of their mentally ill citizens.

Changes in Team Personnel: As part of standard practice, Probation often has staff rotate positions every couple of years or, as was often the case with Connections, staff was promoted and assigned to a new duty. However, because of the intensive training, importance of building trust with the client, and the sometimes delicate nature of working within a team structure, these staff turnovers were disruptive. This was especially evident toward the end of the grant, when there was numerous staff changes due to the uncertainty of the funding and insufficient training for the new staff. Management staff took steps to mitigate this; however, any systemic changes that could decrease these transitions would be beneficial to the program.

Maintaining the Program Model Integrity: Similar to the disruption that staff turnover created, uncertainty of future funding was disruptive to the integrity of the program. This resulted in a shift in focus from developing the program to ending it. Without the core trainings on key program concepts and monthly team meetings that focused on the program, staff was not as equipped to maintain the rigor of the model. In addition, after the program started to mature, management staff became aware of the need to provide more intensive monitoring of staff and case files to ensure that the key components of the program were still being applied. Although not universal, this breakdown was visible in less stringent and immediate accountability of client behavior, inconsistent interpretation of the philosophy among team members, and fewer staff members understanding and implementing the core elements of the model.
Program Duration: There were mixed opinions about the appropriate length of time for the program. Initially, the program had anticipated clients leaving at nine months, with a possible extension to 12 months if necessary. However, most of the clients were not ready to separate from their teams at 12 months. Some contributing factors to this were the length of time needed to secure a client’s benefits, the necessity of gaining the client’s trust, relapse, increasing motivation of the client, and re-incarceration on a minor offense or probation violation. Rarely was an application to SSI accepted on its first submission, based on past experience clients were often distrustful of law enforcement, it was not uncommon for a client to have at least one relapse episode during the 12 months, and there were occasions when a client spent a third or more of their 12 months in jail. It was also common for clients to continue to maintain some contact with the team through occasional phone calls after they had exited the program. One suggestion was to have the program duration extend to 18 months, with less intensive services offered during the last six months. This would help with the transition and provide the opportunity to ensure that the client is soundly connected to other resources. Another suggestion was to utilize the court system more frequently in a supportive role to help motivate the client. This could tighten up the intervention and help teams to more effectively use the time available.

Utilization of Employment Specialist: Although originally designed to provide intensive employment development for clients, the position of the Employment Specialist was never fully utilized. Initially, the Employment Specialist was to intervene immediately with the client and assist him/her in obtaining some level of employment. However, the Employment Specialist more often provided guidance for education or social activities for the clients and eventually assumed the mental health position on teams when a Social Worker was unavailable. The Employment Specialist was never fully engaged in the client’s case plan and did not play an active role, as originally planned. As such, employment was not a primary goal for many of clients.

FUTURE PLANS FOR THE PROGRAM

Not surprising, the greatest impact on the future of Connections was the lack of funding for the project. Unfortunately, a substantial part of the last year of operation was disrupted due to the ending of the grant and no foreseeable future funding with the current budget climate. The disruption came in the form of staff needing to find new positions and Probation having to redirect some of their personnel and training to secure additional funds in the form of Target Case Management (TCM). Both the Probation and the Sheriff’s Departments were committed to Connections and providing services for this special population. In fact, the San Diego County Grand Jury filed a report with the County Board of Supervisors in July 2003 commending the success of the Connections program and the Sheriff’s efforts to work with mentally ill offenders.

The future of Connections as designed and implemented is unknown and the program as implemented no longer exists. The program’s success in improving the recidivism outcomes of the mentally ill only exacerbates the frustration of not being able to fund the project as designed. The
two key components of teaming Probation Officers and Social Workers and providing intensive case management is not possible at this time. However, both Probation and the Sheriff’s Departments remain committed to providing specialized services to this population. Probation has continued to use TCM to help sustain a specialized unit of two DPOs and two CDPOs. The new program is entitled Mentally Ill Offenders (MIO) and the two DPOs carry a reduced case load of 30 per Officer (a standard intensive supervision case load ranges from 40 to 60). Two Reserve Deputy Probation Officers are utilized to make contact while the individual is still in jail and they begin to establish a rapport. The probationer is kept in the unit approximately 14 to 18 months or until stable enough to transfer to mid-level supervision. Although, there is not a mental health professional on the teams, Probation does have access to a psychologist to consult with when needed. In addition, the current DPOs received intensive training while in Connections and are experienced in working with the mentally ill. The criteria for eligibility is similar to Connections, requiring an AXIS I diagnosis, a GAF of 50 or below, medication compliant, and a willingness to participate in the program.

The Sheriff’s Department continues to work on developing and maintaining partnerships with key agencies in the health and human service field. Specifically, they are working more closely with CMH by collaborating on grants, attending Community Provider meetings, and utilizing the streamlined referral system to CMH that was implemented as a result of Connections.

**RECOMMENDATIONS FOR OTHER COUNTIES CONSIDERING A SIMILAR PROGRAM**

**Establish a Formal Agreement Between the Involved County Partners**

The success of Connections was predicated on the commitment at the highest levels to collaborate in the development of the program. It is vital to have each of the partners at the table from the beginning and to clearly define what each other’s roles and expectations are. The leadership at the top will open doors at the ground level and facilitate the change. Without this support the program will not succeed. Although not part of the San Diego model, having CMH as a formal partner could help address some of the system barriers.

**Prioritize Staff Selection**

This model is not recommended for everyone and is dependent on the success of the staff working in a MDT environment and embracing a different intervention approach to the mentally ill offender. Furthermore, the success of case management is dependent on the relationship between the client and the case manager, emphasizing the importance of staff selection (McHugo, et al., 1998). Staff who possess the skill set to work cooperatively with others, are flexible and open to new ideas, and who have the patience and compassion to work with a challenging population should be selected. These are not positions for individuals who are looking to enhance their resume or make a lateral change. The Connections staff members that excelled were those who believed in the model and worked well in a team setting.
**Provide Intensive and On-Going Training and Monitoring**

With the merging of two different professional cultures, training is essential to bridge the gap. Each culture will need training on the others, including providing training on the Probation system, the courts, clients’ legal obligations, mental health, drug and alcohol issues, motivational interviewing, crisis intervention, case management, pharmacology, and other areas as the need arises. The mentally ill have an array of needs and require a certain sophistication on how to best facilitate their reintegration. In addition, management staff learned that teams need consistent monitoring to ensure the integrity of the program. Because of the different facets of the model and the dynamics of the team, routine quality assurance checks should be institutionalized. Likewise, training should also be standardized and required by each new staff member before they assume a case load.

**Nurture and Develop the MDTs**

Working within a team model is difficult and this is only intensified when combining staff with different professional philosophies. To build effective teams, time and attention must be given to developing these relationships. Utilize team building exercises, retreats, and individual meetings with teams by management to help support the teams.

**Reduce Case Loads**

An intensive case management model requires more client contacts and time spent with the probationers. It would be impossible to provide the intensity of service need for this population carrying a typical probation case load. Furthermore, more frequent contact allows the teams to identify potential risks for relapse and intervene prior to a crisis. Although this study did not test for the optimal staff-to-client ratio, the staff did acknowledge the lower case loads as vital in providing immediate and intensive support to this population.

**Anticipate Working With Co-Occurring Disorders**

Research has shown that the majority of mentally ill offenders suffer from a co-occurring disorder. Although this is not a new phenomenon, the mental health and alcohol and drug treatment communities have yet to effectively integrate systems to address the needs of this population. Working with these two systems to identify both outpatient and residential treatment services for this population will aid in the transition from jail to the community. At one point, Connections attempted to purchase beds for their clients, which would have been a valuable resource. Unfortunately, the shift in the budget prohibited this from occurring. The community appreciated having the case management support of the Connections team and viewed it as an enhancement to the services they were able to offer. Anticipate this need by designating funds to purchase treatment slots, and start meeting with the provider community at the beginning of the project to create collaborations.
Utilize the Court System

Having access to the leverage and authority of the court could be an asset in supporting clients in completing their case plans. Connections learned that the court could have been used more frequently in a supportive and not punitive role, to increase the accountability of their clients. Incorporating periodic review hearings before the court in the case plan could function as a motivator for clients. It could be a tool for the teams to help keep the client on task.

Include Wrap-around Funds in the Budget

Wrap-around funds are a natural complement to individualized case plans. The flexibility of the funds allows the staff to respond quickly to any crisis or to meet the unique needs of their clients. The funds also support the creation of a continuum of care by filling gaps in needed resources.

LIMITATIONS OF RESEARCH

While the current research project utilized an experimental design which serves as the strongest starting point, there are limitations with any research protocol which affects the reliability and validity of the results. These limitations are discussed below.

Self-Reported Outcomes: Many of the indicators measuring quality of life changes were dependent on the self-report from the clients. Self-report data are less reliable than standardized assessments. For example, the staff felt that clients often underreported their state of homelessness. Much of these self-reported data were unavailable in other forms and there was not an alternative data collection method. When possible, other sources were used to validate the clients' answers.

Missing Data: As described in the methodology section, more information was available for the Connections clients than the comparison group. Due to budget restrictions, exit and follow-up interviews were not conducted with the comparison group. In addition, because the treatment tracking data were collected from different sources and were not always available for those in the comparison group, the same variables were not always available for comparison. In addition, data were not available for those clients that staff were unable to locate at exit or at the six-month follow-up to complete an interview. As such, the post information does not fairly represent those clients who failed the program.

Local Criminal History: When originally designed, data were to be collected from the local Sheriff’s database. Toward the end of the grant, it was requested by the Board of Corrections (BOC) that data also be collected from the State system. This was not feasible in San Diego and criminal history was limited to arrests and bookings in local jails for both groups. Those clients that were arrested outside of the county, who were sent to prison, or who died were not accounted for and may have falsely been documented as not committing any new offenses. However, there was an equal chance of this underreporting to occur with each group. Therefore, the difference between the two groups is unlikely to be artificial.
RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations are offered to other researchers involved in similar evaluation research projects.

Increase the Length of Follow-up Data Collection: Although not feasible in this study, tracking the criminal history outcomes 12 and 18 months post-exit from the program would provide valuable information on the longitudinal effects of the program. When possible, conducting a random sample of client interviews during these same time intervals could inform program development and policy.

Work Closely with Program Staff to Ensure Proper Documentation: Building on past experience, the researchers were involved with the program from its inception. This provided the opportunity to inform the design of the data collection system and to speak to the need for the operational definitions of key concepts. This early involvement was also essential in documenting the implementation process. Since some of the data were collected by the staff, this partnership allowed the researchers to quickly intervene if data were being collected incorrectly and to answer any questions that arose. Finally, the researchers were able to provide immediate feedback on the evaluation process, which reinforced the value of the staff collecting thorough data.

Designate One Program Staff Person to Fulfill Data Responsibilities: Adequate documentation could not have occurred if a program staff person had not been dedicated to fulfill this responsibility. The Probation Aide in charge of collecting and tracking data from staff was essential to the success of the evaluation.

Allow for Start-Up Time: Allocating start-up time to permit staff to become familiar with the data collection instruments and to learn more about their new roles would be helpful. If possible, based on past projects, allow for a six month start-up time to make any adjustments and incorporate any changes.

RECOMMENDATIONS FOR THE FUTURE OF THE PROGRAM

At the time of writing this report there are no available funds to sustain Connections as implemented for this study. However, if future funds do become available the following are some suggestions for program improvements based on the evaluation.

Include Alcohol and Drug Specialist Position: Because of the number of Connections clients who had a co-occurring disorder and the challenge this posed for staff, having one staff position dedicated to addressing their needs and assisting the teams would be an enhancement to the MDTs.

Extend Duration of Program: The feedback from some staff and clients suggested that extending the program an additional six months would be beneficial to transitioning clients back into the community. Having this as an optional extension would accommodate the varying degrees of need for each client.
Secure Treatment Beds: The lack of treatment beds, or long waiting lists, calls into question the need for the program to subcontract treatment slots in the community to be reserved for program clients. This recommendation addresses one of the system issues that was prevalent throughout the period of the program.

Maintain Consistency of Staff: Because of the specialization of the model and the significant training given to each staff member, staff retention is important. If possible, adjust policies to allow for more continuity in staff assignments with a minimum staff commitment of two years to the assignment. This will help the MDTs mature and also provide more consistent treatment for the clients.

Standardize Quality Assurance Monitoring: To help ensure the integrity of the program model, institute a standardized system to review case files, provide training on the philosophy of the program, and evaluate staff’s understanding of the model.

Require Standardized Training of Staff: All staff should receive the same core training prior to joining the team and assuming a case load. New staff should go through the same rigorous training that the initial staff members receive. In addition, provide periodic refreshers on key issues related to this population.

Intensify Employment Services: Other ACT models have demonstrated success in securing employment for this population by providing intensive vocational services. If employment services are to be provided, they should be emphasized from the beginning of the program and given more attention by the team.
REFERENCES
REFERENCES


San Diego County Sheriff’s Department (2004). JIMS (Jail Information Management System) [Computer file]. San Diego, CA: Medical Services Division [Producer and Distributor].


