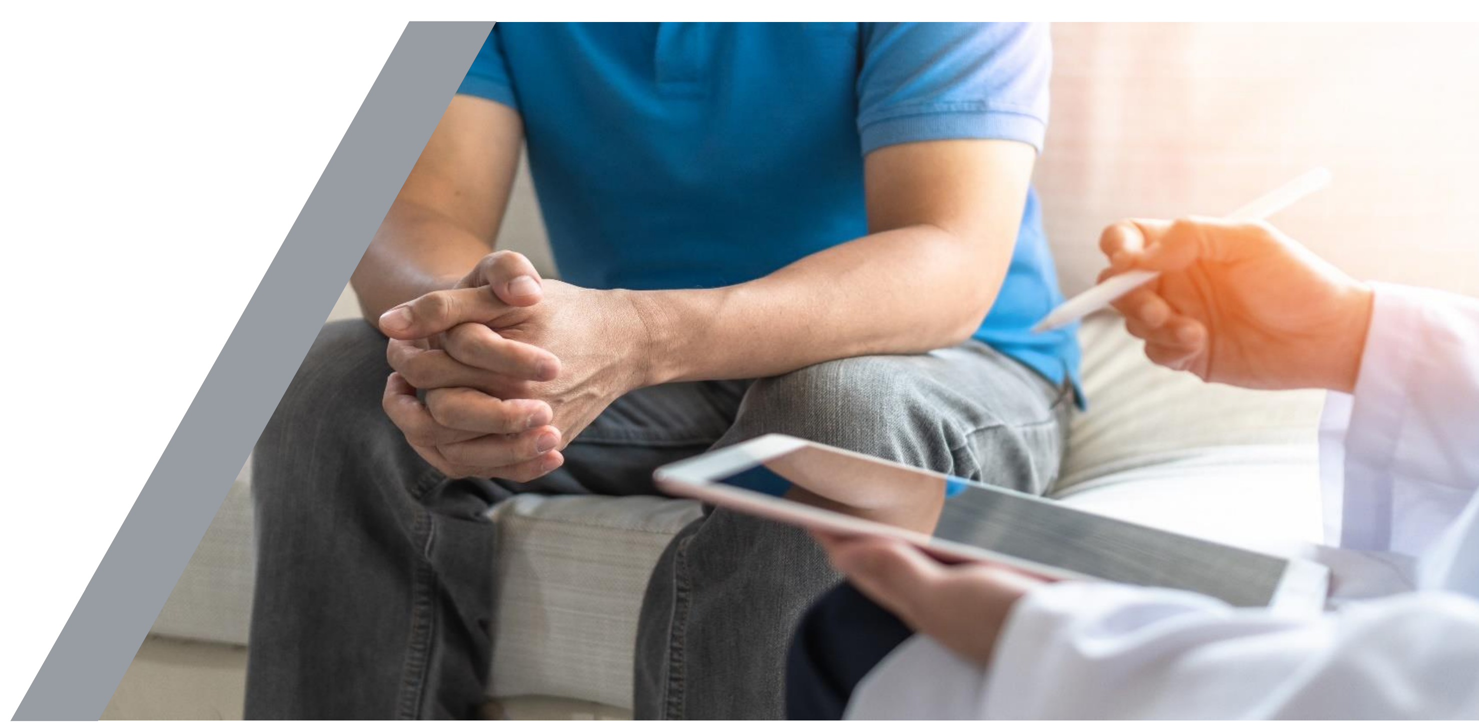
ESTABLISHING CONTINUITY OF CARE

A REPORT ON THE TERRY REILLY HEALTH SERVICES MENTALLY ILL OFFENDER COMMUNITY TRANSITION PROGRAM



Idaho Statistical Analysis Center
Planning, Grants, & Research
Idaho State Police

ESTABLISHING CONTINUITY OF CARE: A REPORT ON THE TERRY REILLY HEALTH SERVICES MENTALLY ILL OFFENDER COMMUNITY TRANSITION PROGRAM

Authors

Thomas Strauss, MPA
Danielle D. Swerin
Kourtnie Rodgers, MA

Idaho Statistical Analysis Center
Planning, Grants & Research
Idaho State Police

For More Information

Email: pgr@isp.idaho.gov
Website: www.isp.idaho.gov/pgr/sac/

Published: November 2022

This project was supported by Subgrant No. 20BJ1878 awarded by the state administering office for the Bureau of Justice Assistance, U.S. Department of Justice's Edward Byrne Memorial Justice Assistance Grant Program. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the state or the U.S. Department of Justice.

TABLE OF CONTENTS

Executive Summary 4
Background 6
- Mental Health and the Criminal Justice System 6
- Barriers to Successful Reentry 8
- Characteristics of Effective Reentry Programs for Offenders with Mental Health Conditions 9
- Terry Reilly, IDOC, and the MIO-CTP 11

Data Collection and Analysis Methods 12
- Data Collection 12
- Data Analysis and Study Limitations 12

Results 16
- Phase 1: Client Screening 16
- Phase 2: Pre-Release Contact 18
- Phase 3: Post-Release Services 20
- Discharge from Program 22

Conclusions and Policy Recommendations 24
Appendix A: References 26
Appendix B: Data Tables – Complete Cases 29
Appendix C: Data Tables – Client Demographics 33

EXECUTIVE SUMMARY

Beginning in the spring of 2017 and ending in the fall of 2020, Terry Reilly Health Services received funding through the Edward Byrne Memorial Justice Assistance Grant Program to implement the Mentally Ill Offender Community Transition Program (MIO-CTP) in the Boise/Garden City area with the goal of serving 170 formerly incarcerated people with mental health conditions per year and reducing the recidivism rate of their clients 10% relative to those who did not participate in the program. This evaluation report presents the results of data analysis conducted by the Idaho Statistical Analysis Center (ISAC) with program data collected by Terry Reilly staff.

Program Highlights

466 clients

Total clients served between 2017 and 2020

6 months

Average time in MIO-CTP per client

6 referrals

Average number of referrals to other services per client

- Between June 2017 and October 2020, Terry Reilly accepted 466 clients to the MIO-CTP.
- Only 23% of clients had a record of a mental health diagnosis prior entering the MIO-CTP.
- 59% of clients had a record of accessing services provided by Terry Reilly, the majority of which were case management sessions. On average, clients spent about six months in the program and received three hours of services.
- 94% of clients were referred to additional services not directly funded through the MIO-CTP, with the average client receiving six such referrals. Clients were referred to a wide range of services, including additional behavioral health, medical, and supportive services.
- 27% of clients were successfully discharged from the program. Most of those (24% of all clients) were transitioned to other programs or moved away from the Boise/Garden City area. 3% of all clients successfully completed the program. 48% of clients did not have a record of being discharged.

Key Recommendations

Evaluators should work with programs and stakeholders to improve data quality

Evaluators and programs should work together to develop client retention strategies

- Evaluation of the MIO-CTP was hindered by two main problems: data quality and client attrition.

- To combat the data quality issues with a complex program that is designed to have as many stakeholders as the MIO-CTP, the evaluator should take the lead on coordinating data collection efforts and work to ensure that all relevant data is collected, is accurate, and reflects the full scope of the program and outcomes that are being evaluated.

- Client attrition, or drop-out, is a common problem especially in criminal justice settings. In order to produce solid evaluation results, programs should strive for a retention rate of at least 80%. The MIO-CTP's retention rate (which was also affected by data quality issues) fell below that benchmark and contributed to ISAC's inability to make any conclusions about the program's effectiveness. Evaluators and program staff should be aware of this issue when planning an evaluation and work together to develop and implement strategies for keeping retention rates above 80%.

BACKGROUND

Mental Health and the Criminal Justice System

In 2015, more than 1.5 million individuals were housed in state and federal correctional facilities in the United States, with an additional 870,500 on parole (Carson & Anderson, 2016; Kaeble & Glaze, 2015). While practitioners and scholars alike have contemplated the impact of high incarceration rates, one important consequence is the greater number of prisoners being released into the community (Seiter & Kadela, 2003). Despite the justice system's goal of curbing criminal activity, nearly 62-66% of formerly incarcerated individuals reoffend within three years of being released, 71% recidivate within five years, and 82% within 10 years (Durose & Antenangeli, 2021; Antenangeli & Durose, 2021).

Although maintaining a prosocial lifestyle can be difficult for formerly incarcerated individuals, the effect may be more pronounced among specific populations, such as those with mental health conditions. Research by Baillargeon, Binswanger, Penn, Williams, and Murray (2009) indicates the number of previous incarcerations is higher among offenders with major psychiatric disorders including major depressive disorder, bipolar disorder, schizophrenia, and non-schizophrenic psychotic disorders. In addition to evidencing larger numbers of previous incarcerations, offenders with mental health diagnoses are also at an increased risk of recidivating sooner than those without (Cloyes, Wong, Latimer, & Abarca, 2010). Specifically, Cloyes and colleagues (2010) found that offenders with a serious mental illness (SMI) returned to prison an average of 358 days sooner than offenders without an SMI. However, it is possible that much of this effect is due to co-occurring SMI and substance abuse rather than the SMI on its own (Wilson, Draine, Barrenger, Hadley, & Evans, 2013). In fact, Wilson and colleagues (2014) suggest that jail inmates with an SMI alone resided in the community longer and had an equal risk of reincarceration. However, inmates with an SMI and a co-occurring substance abuse diagnosis demonstrated higher rates of reincarceration (Wilson et al., 2014).

Historical Factors

Considering the potentially heightened risk of recidivism among formerly incarcerated people with mental health conditions, further examination of this population is warranted. The overlap between mental health and criminal justice system involvement has not been a consistent phenomenon. The current status of this overlap is largely attributed to four factors: deinstitutionalization; modifications to civil commitment policies; inadequate or fractured services for individuals with mental health conditions; and the "war on drugs" (Baillargeon et al., 2009; Baillargeon, Hoge, & Penn, 2010; Brandt, 2012; Lurigio, Fallon, & Dincin, 2000). After World War II, policies favoring deinstitutionalization of those with mental health conditions sparked national favor based on concerns of patient abuse, the development of medication to treat mental health conditions, and funding for community-based treatment centers (Brandt, 2012). Patients were subsequently released from mental hospitals for intended placement in community-treatment centers. However, as state hospitals began to close down, the anticipated community facilities proved to be limited in number and unable to adequately serve the high patient demand (Brandt, 2012). As a result, many individuals were left in the community without access to adequate treatment or social services (Baillargeon et al., 2010).

Statutory reforms and case law in the 1960s and 1970s further contributed to the current overlap by restricting civil commitment to only the most dangerous and severely mentally ill individuals and enforcing determinate stays (Brandt, 2012; Baillargeon et al., 2010). Simultaneously, other individuals remained in the community with scarce and insufficient mental health services (Brandt, 2012). The shift

in correctional policy from rehabilitative to punitive further engulfed individuals with mental health conditions into the criminal justice system (Brandt, 2012; Baillargeon et al., 2010). As policies continued to emphasize strong enforcement of drug-related offenses, many individuals with co-occurring substance use and mental health disorders were processed through the criminal justice system rather than the mental health system (Brandt, 2012; Baillargeon et al., 2010). The cumulative effect of these factors is a "revolving door phenomenon in which many mentally ill people move continuously between homelessness and the criminal justice system" (Baillargeon et al., 2009, p. 103).

Current Trends

Although there is wide variation in current literature, it is evident that a substantial portion of the incarcerated population in the United States suffers from mental health conditions (Baillargeon et al., 2009; Mallik-Kane & Visher, 2008; James & Glaze, 2006; Cloyes et al., 2010). In 2005, the Bureau of Justice Statistics estimated that 56% of state prisoners and 45% of federal prisoners met the criteria for a mental health problem (James & Glaze, 2006). In 2016, 28% of federal prisoners and 32% of state prisoners reported taking prescription medications for a current mental health problem. Additionally, 17% of federal prisoners and 30% of state prisoners reported receiving counseling or therapy since being in prison (Maruschak, Bronson & Alper, 2021). Self-reported data from individuals two to three months after their release from prison further suggested that "19 percent of men and 45 percent of women reported having been diagnosed with a mental health condition" (Mallik-Kane & Visher, 2008, p. 33).

Not only do individuals with mental health conditions account for a disproportionate percentage of the prison population (James & Glaze, 2006), but they also exhibit high rates of substance abuse and are more likely to serve longer prison terms, experience homelessness, and report a history of abuse (Baillargeon, 2009; James & Glaze, 2006; Cloyes et al., 2010).

In Idaho, the Idaho Department of Correction (IDOC) and the Idaho Department of Health and Welfare (IDHW) are required to submit an annual report to the Idaho Legislature detailing the behavioral health needs of IDOC's population, the services accessed by those individuals, and any gaps in services that exist. According to the 2017 Annual Community Gap Analysis (the most recent analysis available when this project began), 11,418 offenders under IDOC supervision were evaluated for behavioral health needs via a GAIN assessment that occurred during their pre-sentence evaluations. Of those, more than half (56%) reported they had been diagnosed with a mental, emotional, or psychological problem, with more than half of those with diagnoses (56%) reporting that they were not currently receiving treatment for those disorders (notably, 4% reported they had never received any treatment). An equal number of those who had been previously diagnosed reported they needed help paying for treatment, and 19% reported that they needed help accessing medication for their conditions. Additionally, nearly half of those evaluated (47%) were estimated to experience high mental distress, and 40% were estimated to suffer from an SMI. Nearly half of those evaluated (48%) had a co-occurring substance abuse or dependence problem, and 4% were determined to be at high risk for suicide. Pairing this assessment data with treatment data from IDHW, the report conservatively estimates the number of offenders on probation or parole who were moderate-to-high risk for reoffending and needed treatment for an SMI but did not receive it in Fiscal Year 2016 was just under 2,000. The report also notes that the cost of providing services to those individuals would cost an estimated $5.7 million (based on the roughly $500,000 spent that year for the 164 offenders who did access services).

Barriers to Successful Reentry

One of the most immediately apparent barriers for offenders with mental health conditions is the "double stigma" associated with the labels of "ex-con" and "mental patient" (Hartwell, 2003; Draine, Wolff, Jacoby, Hartwell, & Duclos, 2005; Hoge, 2007). The combination of these labels can negatively impact one's ability to attain housing, employment, social support, and other factors that are essential to successful reentry. According to Baillargeon and colleagues (2010), "preliminary evidence suggests that the presence of SMI [serious mental illness] compounds the challenges of community reentry" by making it more difficult to attain housing, employment, and sufficient mental health services (p.367). Released prisoners with a mental health condition have higher rates of homelessness, are less likely to live with family members, and are more likely to reside with former prisoners and individuals who struggle with substance abuse than offenders without a mental health condition (Mallik-Kane & Visher, 2008; Hoge, 2007). Interviews with offenders with mental health conditions who have been released from incarceration further identifies housing as the most needed service upon release (30%) other than substance abuse treatment (76%; Hartwell, 2003). Additional qualitative interviews of individuals with mental health conditions who have been involved in the criminal justice system highlighted the impact of housing struggles on successful reentry (Pope, Smith, Wisdom, Easter, & Pollock, 2013). "In describing experiences where discharge led to periods of unstable housing, clients spoke about how unstable housing situations had a rippling effect that impacted other parts of their lives; clients reported using drugs again, failing to attend mental health services (even when mandated), and violating parole" (Pope et al., 2013, p. 451).

In addition to housing difficulties, offenders with mental health conditions also experience barriers to obtaining employment and sufficient mental health services (Mallik-Kane & Visher, 2008; Jacoby & Kozie-Peak, 1997; Lovell, Gagliardi, & Peterson, 2002; Baillargeon et al., 2010). In fact, these individuals report finding a job and supporting themselves financially as their most prevalent concerns (Jacoby & Kozie-Peak, 1997). Despite this identified need, released prisoners with a mental health condition are less likely to attain and maintain employment compared to other released prisoners (Mallik-Kane & Visher, 2008). Specifically, 53% of male prisoners and 35% of female prisoners without a mental health condition report having legal employment compared to 28% of men and 18% of women with a mental health condition (Mallik-Kane & Visher, 2008).

Limited access to mental health services further compounds obstacles to successful reentry. Research by Mallik-Kane and Visher (2008) suggests that just 50% of released prisoners receive mental health treatment immediately after prison and that 59% of men and 40% of women who received medication in prison continue using the medication eight to ten months after release (Mallik-Kane & Visher, 2008). This decline in medication use may be partially attributed to low rates of health insurance among participants (Mallik-Kane & Visher, 2008). Specifically, 30% of men and 40% of women report having health insurance two to three months after release (Mallik-Kane & Visher, 2008). Limited access to mental health services is supported by additional research with individuals with mental health conditions released from prison in Washington, which found that only 16% received mental health services for more than eight months after release (Lovell et al., 2002).

Another notable barrier is co-occurring substance abuse. Demonstrated across multiple studies, approximately 7 out of 10 prisoners with mental health conditions have co-occurring substance abuse concerns (Mallik-Kane & Visher, 2008; Cloyes et al., 2010; Hartwell, 2003; Wilson et al., 2014). In addition

to the obstacles already mentioned, they also often have a more extensive criminal history (Baillargeon, 2009; Castillo & Alarid, 2011), are three times more likely to report past physical or sexual abuse (James & Glaze, 2006), and receive less familial support (Mallik-Kane & Visher, 2008; Hoge, 2007) compared to released offenders without a mental health condition. The combination of these factors exacerbates the already difficult reentry process and subsequently increase their risk of reoffending. Considering the multitude of barriers faced by upon reentry, an examination of specialized and comprehensive services is critical in order to improve conditions for both offenders with mental health conditions and the community at large.

Characteristics of Effective Reentry Programs for Offenders with Mental Health Conditions

Reentry can be broadly defined as the transition from life in prison to life in the community (Seiter & Kadela, 2003; Miller & Miller, 2010; Travis, Solomon, & Waul, 2001). The most cited goal of reentry programs is to improve community safety by reducing recidivism and promoting prosocial lifestyles among released offenders (Draine et al., 2005; Travis, 2000; Lurigio et al., 2000). For offenders with mental health conditions specifically, preventing rehospitalization is an additional objective (Lurigio et al., 2000). According to Taxman, Young, Byrne, Holsinger, and Anspach (2002), reentry programs should operate in three interdependent phases: institutional, structured release, and community reintegration. Under this model, the offender is: (1) assessed and enrolled in programming during incarceration (institutional phase); (2) guided through the process of developing a feasible plan for reintegration prior to release (structured reentry); and (3) subsequently connected to community resources, treatment, and other positive social controls upon release (community reintegration; Taxman et al., 2002). Although all of these phases are important segments of the reentry process, much of the research on reentry initiatives highlights the latter two.

In regard to structured reentry, numerous researchers have identified transition planning as a key component of effective reentry programs (Miller & Miller, 2010; Hatcher, 2007). Such preparation may be even more critical for offenders who require ongoing mental health treatment (Farabee, Bennett, Garcia, Warda, & Yang, 2006; Arnold-Williams, Vail, & MacLean, 2008; Lurigio et al., 2000; Osher, Steadman, & Barr, 2003; Hoge, 2007). Based on the APIC model, a best practice approach developed by Osher and colleagues (2003), there are four key components of effective transition planning: assessment, planning, identification, and coordination. During the assessment and planning phases, inmates are screened for co-occurring disorders and offered comprehensive transition planning. Under this framework, transition planning involves the evaluation and prioritization of inmates' short- and long-term needs including, but not limited to, housing, medication, integrated treatment for both mental health and substance abuse, medical care, financial support, food, clothing, transportation, and childcare. Once the inmate's needs have been identified, appropriate community and correctional programs are selected to provide services following release. After identification, the inmates are also provided assistance with coordinating and implementing the transition plan. Case managers are strongly recommended during this final stage. This model also encourages community providers to do "inreach", which involves establishing rapport via face-to-face contact before the inmate is released. This process provides a level of predictability and may serve to improve the likelihood of follow through post-release (Osher et al., 2003). This approach is further supported by Farabee and colleagues (2006) who concluded that participants who received pre-release assessment were 49% more likely to attend at least one appointment at the Parole Outpatient Clinic (POC) post-release compared to those who did not receive a pre-release assessment.

In addition to transition planning, many effective reentry programs also emphasize community reintegration by providing services to meet the individual needs of offenders with mental health conditions upon release. One such program is the Mentally Ill Offender Community Transition Program (MIO-CTP) in Washington State (Arnold-Williams et al., 2008). The main program components are coordinated pre-release planning, housing and employment support, treatment for both mental health and substance abuse, and intensive post-release case management. Analyses of the effectiveness of the program reveal that those who participated in this comprehensive approach were less likely to commit a new felony than their counterparts who did not receive these services (29% and 42%, respectively; Arnold-Williams et al., 2008).

A supplementary program in Washington State, called the Dangerous Mentally Ill Offender Program, provides reentry services to individuals released from prison with a mental disorder who were deemed dangerous to themselves or others (Washington State Institute for Public Policy, 2009). Specifically, the program offers pre-release services and transition planning three to four months prior to release as well as a variety of post-release services including housing, medical care, mental health treatment, and substance abuse treatment for up to five years. Individuals who participated in the program were approximately 42% less likely to be reconvicted of a new felony, saving taxpayers an estimated $55,463 per participant (Washington State Institute for Public Policy, 2009).

The Mental Health Services Continuum Program (MHSCP) in California utilizes a similar approach to reentry programming (Farabee et al., 2006). Under this program, those who are eligible for parole and have mental health conditions receive a prerelease needs assessment, assistance with benefits and applications prior to release, and mental health treatment after release. Pre-release assessments and contact with post-release services were associated with longer stays in the community (8.4 days and 74.6 days, respectively). Additionally, more post-release contact with the Parole Outpatient Clinic was associated with a lesser likelihood of being reincarcerated. This is consistent with research by Taxman and colleagues (2002) suggesting that the duration of services is an important factor contributing to successful reentry. The combination of additional days in the community and reduced risk of reincarceration also converted to cost savings. In fact, one or more contacts with post-release services was associated with $4,890 cost savings per Enhanced Outpatient Program participant and $2,876 for each Correctional Clinical Case Management System participant (Farabee et al., 2006).

In addition to transition planning and wrap-around services, case management is another key component of effective reentry programs for offenders with mental health conditions. According to Ventura, Cassel, Jacoby, & Huang (1998), the two primary goals of case management are connecting individuals to community resources and reducing risk of recidivism. Using this definition, they conducted an analysis of 261 jail inmates diagnosed with a mental health disorder who received case management services during incarceration and post-release. Participants who received case management services evidenced lower rates of rearrest and a longer period of time in the community. Additionally, receipt of case management services during incarceration significantly increased follow-through post-release, thus further supporting the importance of an "inreach" framework (Ventura et al., 1998).

Current research highlights that successful reentry often encompasses a wide variety of services both inside and outside prison walls, including transition planning, "inreach", wrap-around services, and coordinated case management. In order to achieve the most cited goal of reentry - improving community safety by reducing recidivism – it is imperative that providers consider the unique barriers of offenders

with mental health conditions including housing, employment, mental health care, and co-occurring substance abuse. Additionally, these individuals are often disproportionately reliant on public assistance, which may take up to 90 days to be reinstated after release (Hoge, 2007; Mallik-Kane & Visher, 2008); therefore, assistance with reestablishing benefits is an important part of transition planning. The inclusion of these components in reentry programs, in full or in part, can serve to reduce recidivism and save monetary resources.

Terry Reilly, IDOC, and the MIO-CTP

Recognizing the need in the Boise area for a program that would better serve individuals with mental health conditions who were reentering the community after a prison term, Terry Reilly Health Services (Terry Reilly) was awarded funding through Idaho's Edward Byrne Memorial Justice Assistance Grant (Byrne JAG) Program[1] to implement the MIO-CTP locally. The goal of the program was to improve access to behavioral health services for qualifying individuals being released from state prison into the Boise/Garden City area, and to reduce recidivism rates among this population.

In early 2017, Terry Reilly launched the MIO-CTP in partnership with reentry and probation/parole staff at the Idaho Department of Correction (IDOC). Coordinating with IDOC allowed Terry Reilly the opportunity to fully implement both the pre- and post-release aspects of the program. Pre-release services offered by Terry Reilly included identification and assessment of potential clients within three months of their expected release from prison, and for those selected for participation in the program, the creation of individualized treatment plans. Post-release services included a set of comprehensive wraparound services coordinated by Terry Reilly based on the individualized plans created prior to the client's release from prison. Examples of post-release services could include case management, counseling or therapy, physical health (i.e., medical or dental) services, or substance abuse treatment.

Terry Reilly's MIO-CTP program was active and funded through the Byrne JAG program from 2017 to 2020. The remainder of this report presents analysis of data collected by Terry Reilly during those three years, focusing on the characteristics, services received, and outcomes of clients who were selected into the program.

[1] The Edward Byrne Memorial Justice Assistance Grant (Byrne JAG) Program is a federal formula grant program that provides funding to states and local governments for programs in seven broad areas of the criminal justice system. The Terry Reilly MIO-CTP program was funded through a Byrne JAG sub-award administered by the Idaho State Police's Planning, Grants & Research Department (the State Administering Agency for Idaho's Byrne JAG funds) under the "Mental Health Programs and Services" program area and the "Improving Mental Health Services" priority area.

DATA COLLECTION AND ANALYSIS METHODS

Data Collection

The Idaho Statistical Analysis Center (ISAC) provided technical assistance with data collection to Terry Reilly throughout the life of the MIO-CTP. Working with program staff at Terry Reilly, ISAC developed a Client Tracker which took the form of an Excel spreadsheet that included client data on program intake decisions, client demographics, pre- and post-release services provided, and client outcomes. The spreadsheet also contained an automated component to aid Terry Reilly with their quarterly reporting requirements under the Byrne JAG grant. Terry Reilly entered data into this spreadsheet between 2017 and 2020, thus making the full three years of program data for 505 potential and active clients available for this evaluation study.

Data Analysis and Study Limitations

Data Analysis

Analysis of MIO-CTP data took two forms. First, all available data for each program "phase"[2] was analyzed in an effort to understand the full scope of programmatic activities conducted by Terry Reilly and services provided to clients. As noted above, a requirement of receiving Byrne JAG funding is the development of goals and objectives for the program and the reporting of data related to those goals and objectives on a quarterly basis. Terry Reilly developed and submitted a set of goals and objectives for the MIO-CTP to the Planning, Grants & Research Department (PGR)[3] of the Idaho State Police. ISAC used the data collected for this evaluation to determine Terry Reilly's level of success in meeting those goals over the life of the program.[4]

Second, clients were tracked throughout their time in the program as outlined in Figure 1 (see page 13). This method more closely aligns with traditional outcome evaluations. Although problems posed by data quality and client attrition (described below) limited ISAC's ability to draw any conclusions about the effectiveness of the MIO-CTP, these analyses simultaneously describe the experiences of those who could be tracked through the program from start to finish and illustrate the extent of the data quality problem, which allowed ISAC to develop recommendations for collecting data from grant-funded programs.

Data Quality and Client Attrition

Data quality and client attrition from the program present two challenges in evaluating a program such as the MIO-CTP.

In an effort to protect client privacy, ISAC relied on Terry Reilly program staff to collect and enter data into the Client Tracker and, upon final transmission of the data to ISAC, replace client names with their Idaho Department of Correction (IDOC) identification number. While ISAC did provide technical assistance to Terry Reilly throughout the three-year data collection period, ISAC recognizes that Terry Reilly program staff were not trained researchers, but behavioral health practitioners whose primary focus was on providing quality services to their clients. Relying on someone who is not a data analyst or researcher by trade to collect program data can introduce data quality problems into the evaluation design, the two

---

[2] Phases are defined as client screening (Phase 1), pre-release contact (Phase 2), and post-release services (Phase 3).

[3] PGR administers Byrne JAG funds for the State of Idaho. See Footnote 1 on page 11 for more information.

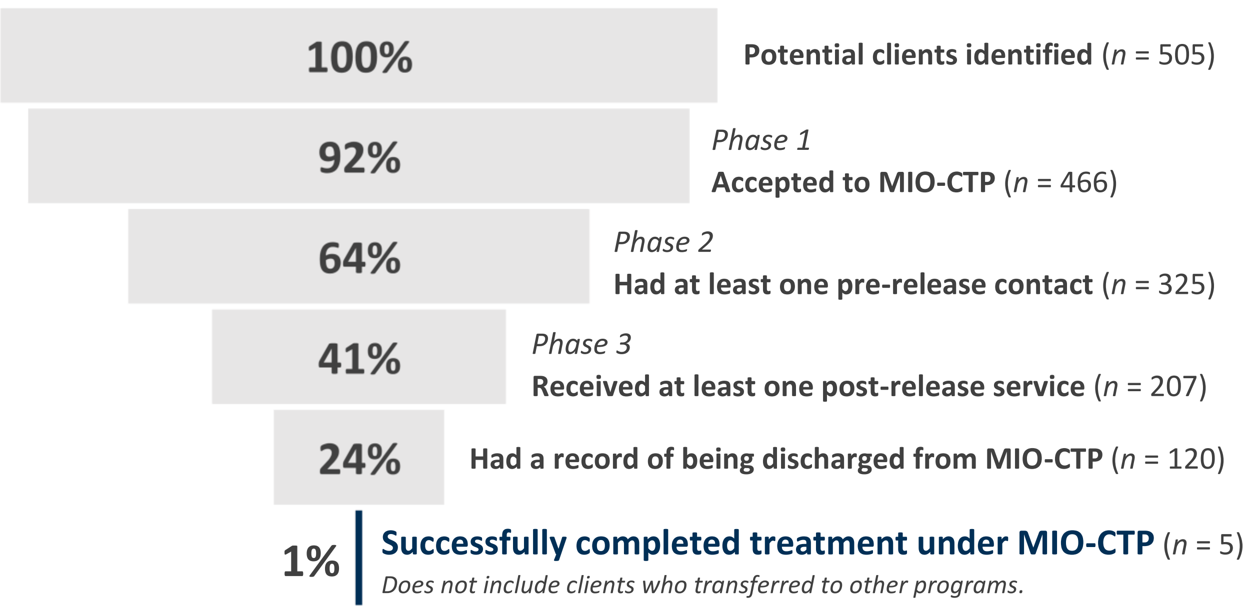
[4] Although Terry Reilly reported data related to their goals and objectives to PGR on a quarterly basis, this evaluation analyzes that data on a longer time scale as a measure of long-term program success, rather than success on a quarter-to-quarter basis.

most common problems being a higher prevalence of incomplete or missing data and the entry of inaccurate data. While ISAC made every effort to correct mistakes or fill gaps in the data when they were discovered, it is unknown how many of these data quality problems went undiscovered.

The second evaluation challenge is related to client attrition. Individuals being released from prison who have mental health needs are encouraged to seek services to address those needs. The MIO-CTP was one of the options available, thus making participation voluntary instead of mandatory. A substantial number of potential clients declined to participate in the program altogether or began a course of behavioral health treatment through the MIO-CTP but withdrew from the program prior to completion. Additionally, Terry Reilly only provided services to those who were being released to the Boise/Garden City area; those who were released to other parts of the state or moved away from the service area while they were participating in the MIO-CTP were subsequently deemed ineligible for the program and data collection on those individuals ceased.

In evaluating the extent to which these two problems affected ISAC's ability to follow clients all the way through the MIO-CTP, four points of client attrition were identified. Figure 1 identifies these points and the percentage of potential MIO-CTP clients who were able to be tracked through each step. Those who could not be tracked to the next step were considered to have "exited"[5] the program at that point.

Figure 1.
Of the 505 clients who were identified as potential MIO-CTP clients, ***1% successfully completed*** *the entire program.*



[5] The term "exited" is used here to describe how both attrition and missing/incomplete data was handled. In the context of evaluating data quality, a client was deemed to have "exited" the program if they did not have a record in the next step of the program as outlined in Figure 1, even if they did have records in later steps.

Study Limitations

The two challenges described above place significant limitations on ISAC's ability to draw solid conclusions about client outcomes and the effectiveness of Terry Reilly's MIO-CTP. Ideally, a program evaluation such as this one would be able to follow all participants through to the end of the program. Any loss of visibility into participants' experiences, whether due to missing data or program drop-outs, weakens the ability of evaluators to draw solid conclusions about the program's effectiveness. Because it is often unknown why participants dropped out, researchers cannot determine (or subsequently account for) those specific reasons in their analyses. This introduces potential "attrition bias" into the study (Bankhead, Aronson & Nunan, 2017). Those who dropped out of the program may have been fundamentally more likely to drop out than those who stayed with the program, meaning that any differences in outcomes between those two groups is not actually due to any aspect of the program itself, but to some other unknown characteristic shared by most or all of those who dropped out.

In most programmatic settings, attrition is inevitable. Mason (1999) identified a completion rate of at least 80% as sufficient to mitigate the effects of attrition bias. The evaluation at hand is weakened by having a completion rate well below that benchmark. Only 1% of those accepted into the MIO-CTP (5 of 466) were identified in Terry Reilly's program data as having successfully completed the program.[6] This can have devastating impacts on any conclusions drawn from the program data, as demonstrated in an evaluation of a community-based offender behavior intervention program in the UK (Hatcher et al., 2012). That study, which suffered from a completion rate of 38%, found that when simply comparing those who were selected into the program against a similar group of offenders who were not program participants, the program had no impact on recidivism. However, upon closer examination, the research team found significant differences between those who completed the program, entered but did not complete the program, and never entered the program. Specifically, those who completed the program were significantly less likely to reoffend than those who were not program participants, while those who entered but did not complete the program were significantly *more* likely to reoffend (indicating that starting and not finishing the program could actually be harmful to the participant).

Although Terry Reilly's MIO-CTP experienced an extremely high level of attrition, one option for working around that limitation is to conduct a complete case analysis (Bankhead, Aronson & Numan, 2017), which consists of only analyzing data for participants who did complete the entire program. This approach allows for mitigation of attrition bias by eliminating those who dropped out of the program early from all analyses. However, reducing the number of cases in the analyses can lead to other problems. For this evaluation study, those who were included in ISAC's complete case analysis were categorized as indicated in Figure 2 (see page 15). The size disparities between groups made statistical comparisons between groups unreliable. [7]

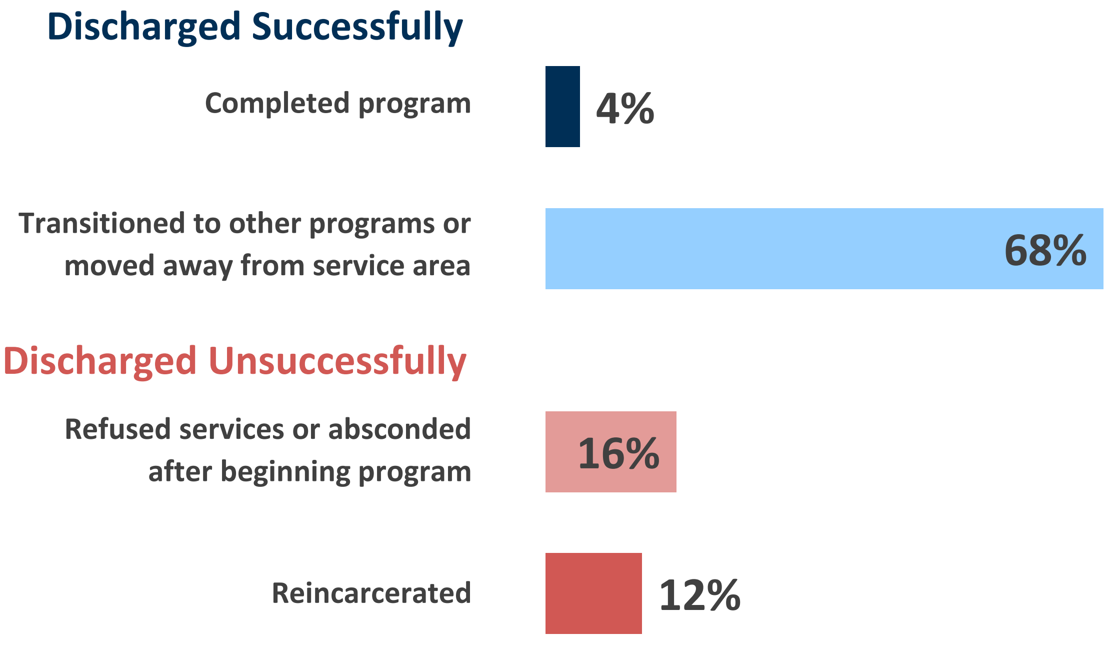
The final main limitation on this study is in ISAC's ability to evaluate client outcomes (i.e., recidivism). Terry Reilly did not collect follow-up data on clients at any point after leaving the MIO-CTP, and ISAC did

[6] That percentage rises to 18% when including those who transferred to other programs (81 people were identified as having successfully transitioned to another program), still significantly below the 80% target.

[7] Successful discharges outnumbered unsuccessful discharges nearly 3-to-1, and those who transitioned to other programs alone outnumbered all others by more than 2-to-1. These disparities in group size drastically reduce statistical power, limiting the ability to accurately draw conclusions about the effect of a client's experience in the program on that client.

not receive any identifiable client information from Terry Reilly. These flaws in the research design eliminate ISAC's ability to include recidivism as an indicator of program success in this report, even though recidivism reduction was an explicitly stated goal of the program.[8]

Figure 2.
Uneven discharge group sizes in the complete case analysis negated ISAC's ability to make comparisons between groups.



As a result of these limitations, this report only summarizes client experiences directly reported by Terry Reilly. The "Results" section of this report presents descriptive statistics at each phase of the program (see Figure 1 on page 13). While the results of these analyses can be viewed as indicators of program activities conducted by Terry Reilly that were funded by their Byrne JAG grant, ISAC did not attempt to reach any conclusions about program effectiveness or client outcomes based on their performance in the MIO-CTP. Readers should use extreme caution when interpreting the statistics presented in this report.

[8] In their Byrne JAG funding application, Terry Reilly included as a goal a 10% reduction in the recidivism rate of moderate- and high-risk mentally ill offenders re-entering the service area.

RESULTS

This section presents results from analysis of Terry Reilly's MIO-CTP program data by program phase[9], starting with client screening and ending with program discharge. Due to issues with data quality[10], this section is best viewed as a report on program *outputs* (i.e., services provided) rather than client *outcomes*. For example, ISAC lost visibility on some clients as they moved from one phase to the next, only to have some of those clients "reappear" in later phases. Specific points where data quality affected ISAC's analysis are noted where applicable. For readers who are interested in a more traditional approach to program evaluation, Appendix B presents data on clients who ISAC was able to track all the way through the program from start to finish. Those results are presented separately due to the program's extremely high level of client attrition.

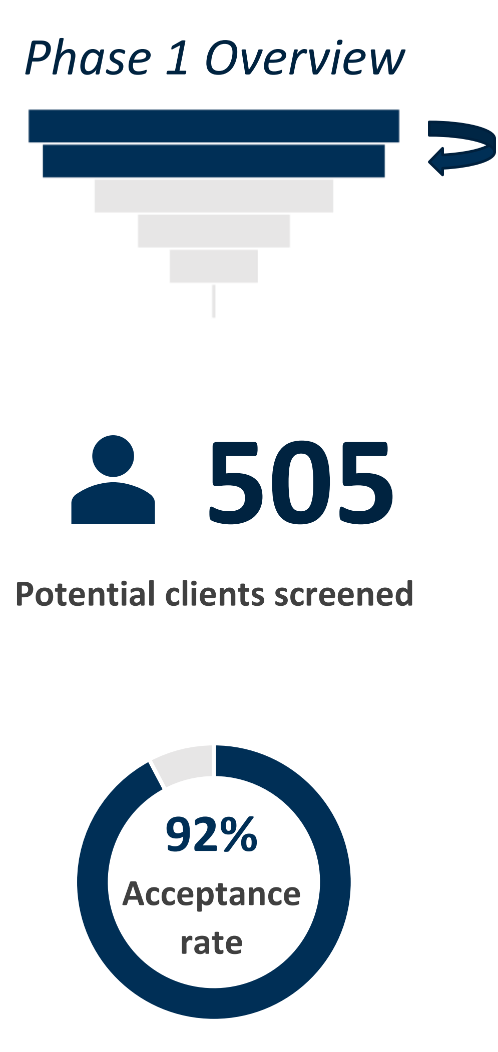
Phase 1: Client Screening

Between June 2017 and October 2020, Terry Reilly screened 505 individuals for potential participation in the MIO-CTP. Identification of individuals who may qualify for the program was conducted collaboratively by Terry Reilly and IDOC case managers. To qualify for selection into the MIO-CTP, individuals needed to meet three requirements:

1. Must currently be receiving services through IDOC Correctional Mental Health Services (CMHS),
2. Must have an expected prison release date that is less than three months away, and
3. Must be expected to live in either Boise or Garden City after release.

Of the 505 clients screened, 466 were accepted into the MIO-CTP, an acceptance rate of 92%. Figure 3 (page 17) illustrates the reasons for which the remaining 8% of potential clients were screened out of the program.

One of Terry Reilly's goals for the MIO-CTP was to serve 170 clients per year. In their Byrne JAG funding application from 2016, Terry Reilly notes that based on figures from IDOC reports on the behavioral health needs of their population, taking on 170 clients per year would cover roughly 17% of the formerly incarcerated population released to the Boise/Garden City area each year that have a high need for behavioral health services. Figure 4 (page 17) shows the number of new clients accepted to the MIO-CTP by year. The only year Terry Reilly accepted at least



[9] Phases are defined as client screening (Phase 1), pre-release contact (Phase 2), and post-release services (Phase 3).
[10] See the "Data Collection and Analysis Methods" section for a more detailed discussion on data quality and ISAC's analysis techniques.

170 new clients was in 2018, the first full year of implementation and one of two years in which they were accepting clients during the entire year.[11]

Figure 3.

Of the 505 potential clients screened, ***92% were accepted to the MIO-CTP****. The most common reason for not being accepted was* ***not meeting all three program requirements****.*

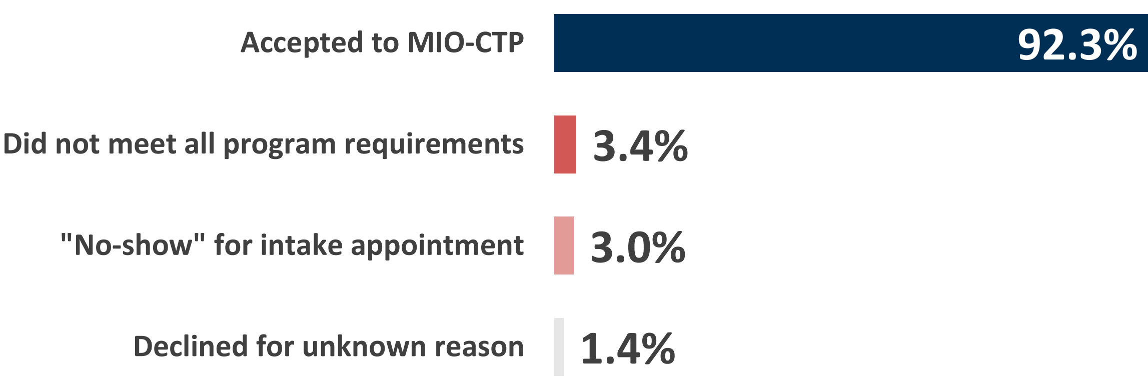
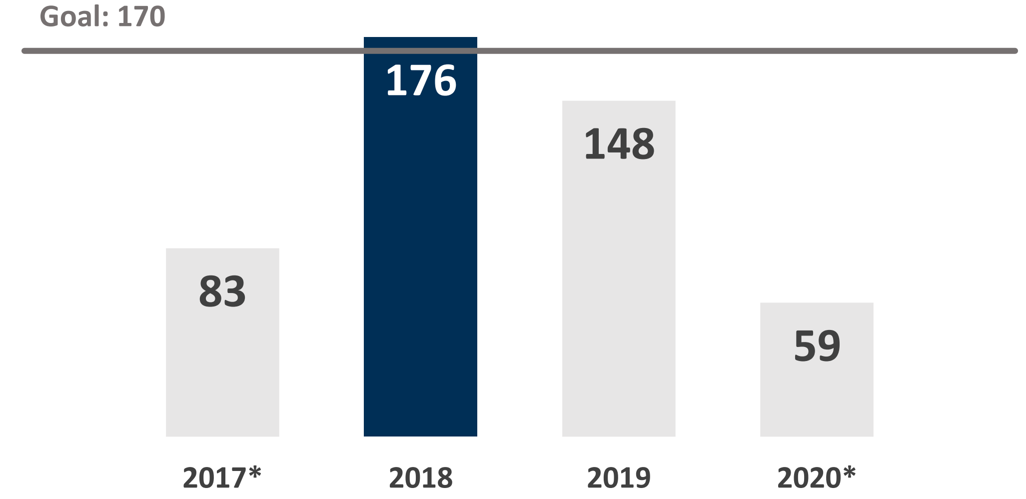


Figure 4.

The MIO-CTP ***accepted at least 170 new clients*** *once (2018).*



**NOTE: Terry Reilly began screening potential clients in June 2017. Program activities ceased in October 2020.*

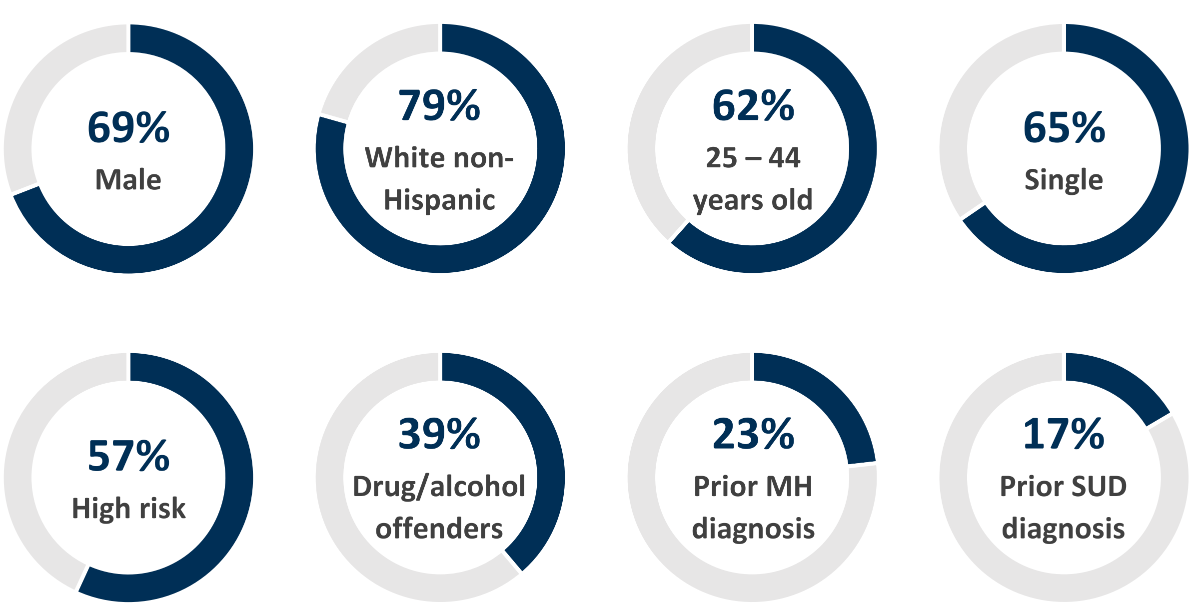
[11] Numbers of clients accepted into the MIO-CTP during 2017 and 2020 represent calendar years in which the program was only active for part of the year. Terry Reilly began screening clients in June 2017 and ceased program activities in October 2020.

Client Characteristics

Terry Reilly collected demographic, health, and criminal history data for the 466 clients accepted to the MIO-CTP. Common characteristics of program participants are shown in Figure 5.[12] Overall, MIO-CTP clients tended to be male, white, and not Hispanic/Latino, although females were overrepresented among program participants.[13] Most clients were between 25 and 44 years old, and most had never been married. The majority of clients were released to parole, were at high risk of reoffending[14], and the most common case type for which they were incarcerated was drug- or alcohol-related offenses. Notably, only 23% of clients had a record of a mental health diagnosis prior to entering the MIO-CTP, and the majority of those also had a co-occurring substance use disorder. However, more than two-thirds of MIO-CTP clients were classified as CMHS-2 clients when they were accepted into the MIO-CTP.[15]

Figure 5.

Selected characteristics of MIO-CTP clients.



Phase 2: Pre-Release Contact

In the months leading up to their release from prison (typically within three months of their expected release date), MIO-CTP clients met with Terry Reilly staff to begin case management services. During

[12] Full data tables for client characteristics are available in Appendix C.

[13] Females comprised 28% of MIO-CTP clients. According to IDOC's FY 2021 Incarcerated Population Report, females accounted for 13% of their incarcerated population as of June 30, 2020, when the program was nearing its end.

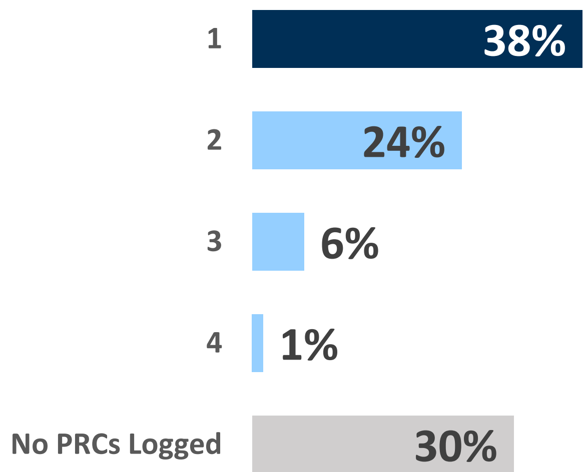
[14] As determined by IDOC based on the results of an LSI-R risk assessment.

[15] IDOC has five classifications for Correctional Mental Health Services (CMHS) clients. CMHS-2 indicates that a client has a documented mental health need that is being treated with medication but is able to function in a general population setting in prison. 68% of MIO-CTP clients were classified as CMHS-2 upon intake (see Appendix B).

these meetings, clients met with a case manager who informed them about the details of the program[16], and a plan was set for beginning post-release behavioral health services.

Of the 466 clients accepted to the MIO-CTP, 325 (70%) had a record of at least one pre-release contact with Terry Reilly staff.[17] For many clients, their time in this phase of the program consisted of one 60-minute meeting. Figure 6 shows that while 38% of clients had one such meeting, 31% had multiple, often shorter meetings that covered the same topics as the one-hour meetings.

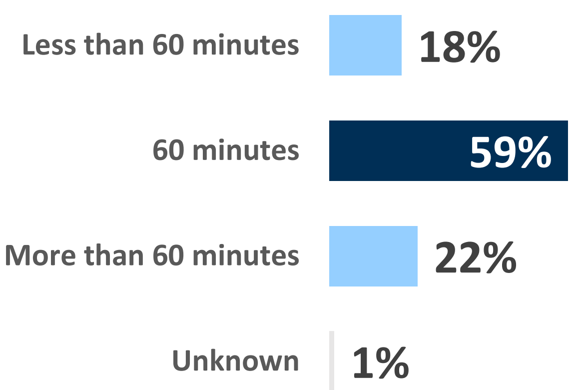
Figure 6.
*Most clients had **one pre-release contact**.*



The average time each client spent in these pre-release meetings was 62 minutes. Of those with a record of at least one pre-release contact, more than half (59%) spent 60 minutes in these meetings. Fewer than one-quarter each had less than one hour of pre-release contact (18%) or more than one hour (22%; see Figure 7 on page 20).

[16] Starting in late 2019, Terry Reilly began conducting some pre-release contacts via phone call. This adjustment continued throughout 2020 as systems adapted to the beginning of the COVID-19 pandemic. Soon after the start of the pandemic in March 2020, Terry Reilly added video conferencing as a third option for contacting clients.
[17] This phase represents the first major point of program attrition due to data quality issues identified in the "Data Collections and Analysis Methods" section. Of the 141 who did not have at least one record of a pre-release contact, 67 (48%) did have at least one record of receiving a post-release service. These individuals are included in the "Phase 3: Post-Release Services" section of this report. For data on only those individuals with complete program data (or "complete cases"), see Appendix B.

Figure 7.
The majority of clients who had pre-release contacts logged had ***one total hour of pre-release contact*** *with Terry Reilly staff.*



Phase 3: Post-Release Services

In total, 274 clients (59%) received at least one post-release service through the MIO-CTP.[18] The average number of sessions per client was five, although of those who did receive services, 57% only attended three or fewer sessions (see Figure 8 on page 21). The average total duration of services provided to clients was just under 3.5 hours.

On average, clients tended to miss about one of every five scheduled service sessions with Terry Reilly staff. Overall, Terry Reilly indicated that out of 1,661 scheduled sessions, 264 (16%) were missed and not rescheduled by clients.[19] However, the average percentage of sessions missed per client was slightly higher (19%), with the average number of sessions missed per client being just under one.

Phase 3 Overview

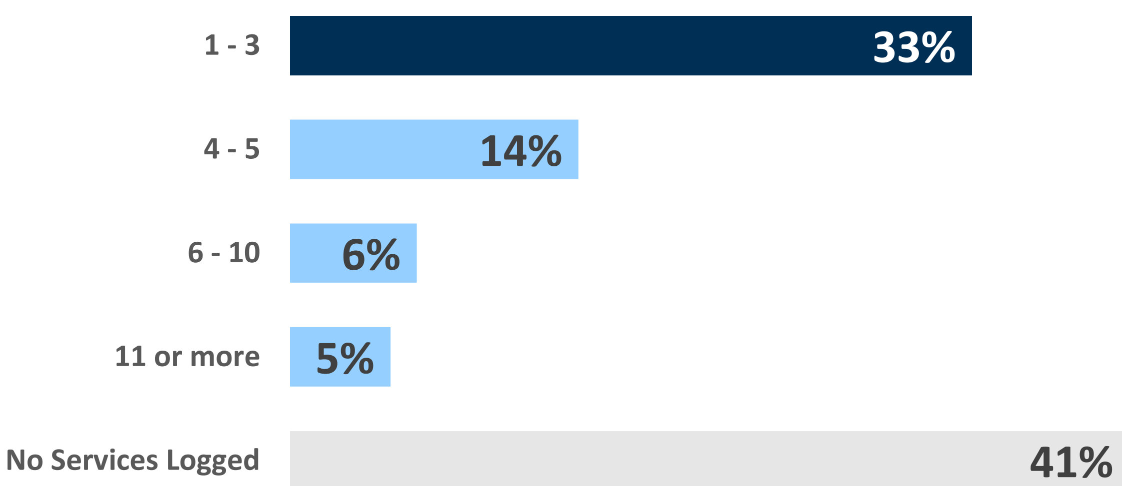
Average post-release service time per client

6

Average referrals to other services per client

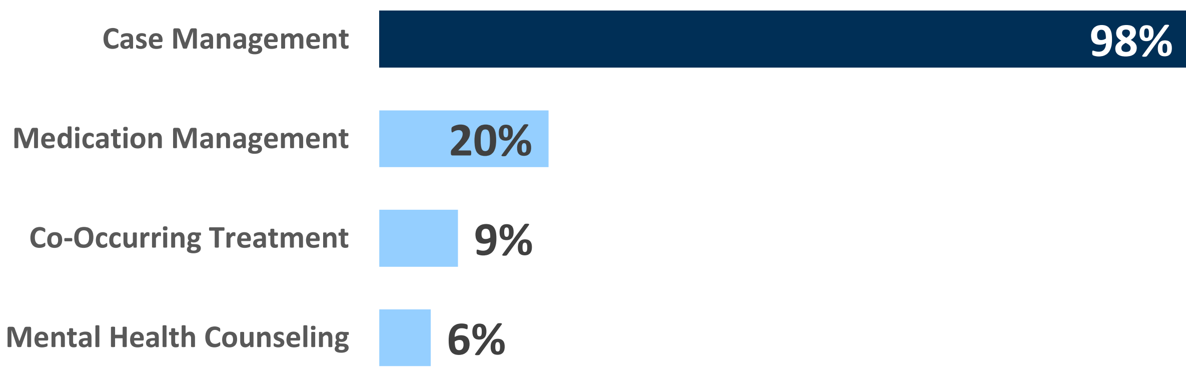
[18] Phase 3 was the second major point of client attrition identified by ISAC. However, some clients also "reappeared" in this phase, meaning they did not have any records in Phase 2 but did have at least one record in Phase 3 (see Footnote 17 on page 19). This section includes data on all clients who had at least one service record in Phase 3, including those who did not have records in Phase 2. For data on only those individuals with complete program data (or "complete cases"), see Appendix B.
[19] Of the 264 missed sessions, 17 (4%) are attributed to 16 clients who did not have a record of attending *any* scheduled services. Nine of those clients had a record of being discharged unsuccessfully due to not starting the program or not completing their treatment plan; the other seven did not have discharge records.

Figure 8.
*Most active clients **attended three or fewer sessions** provided directly by Terry Reilly.*



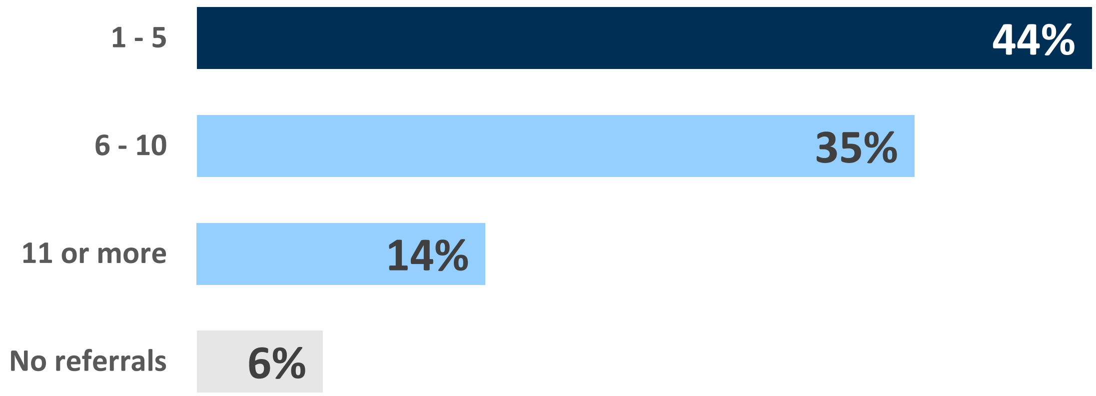
The vast majority of services provided to clients was case management. Nearly all clients (98%) who were provided services by Terry Reilly were provided case management. Although the MIO-CTP is specifically designed for formerly incarcerated people who have mental health needs, only 6% of clients accessed mental health counseling directly from Terry Reilly under this program (see Figure 9).

Figure 9.
*Nearly all active clients **received case management services** provided directly by Terry Reilly.*



One key benefit of the MIO-CTP is the ability to connect formerly incarcerated people with other community-based resources that are not directly part of the program. Such referrals were provided to 94% of clients during Phase 3 (see Figure 10 on page 22). These referrals included some other behavioral health services, but also connected clients with resources to address a diverse set of needs including transportation, housing, food security, medical/dental services, and applying for assistance programs. Referrals to at least 11 outside services were given to 14% of MIO-CTP clients.

Figure 10.
Most active clients ***received between one and five referrals*** *to other services not provided directly by the MIO-CTP.*

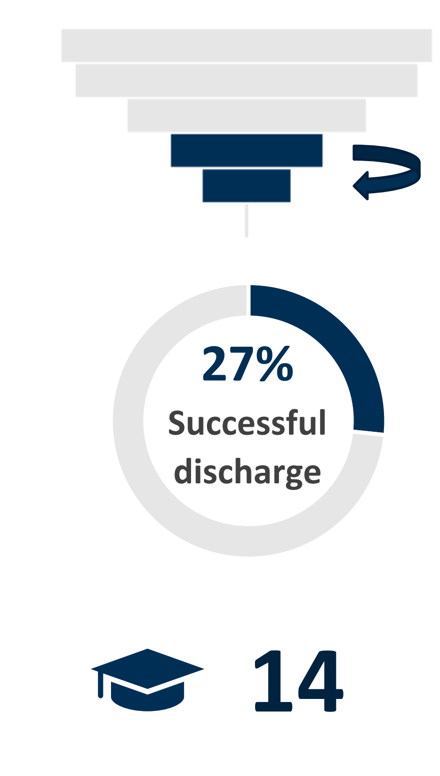


Discharge from Program

Terry Reilly provided discharge records for 244 MIO-CTP clients (52%). The most common discharge type was "transitioned to other services or moved away from service area" (24%), followed by "refused services or absconded after beginning program" (21%; see Figure 11 on page 23). Terry Reilly indicated that 14 clients (3%) successfully completed their full course of treatment.

Among those who had discharge records and attended at least one post-release session (153 clients, or 33% of all clients), the average time spent in the MIO-CTP was 174 days (or 5.7 months). About two-thirds of these clients spent six months or less in the program (see Figure 12 on page 23). Those who were discharged successfully spent less time in the program (160 days, or 5.3 months, on average) compared to those who were discharged unsuccessfully (211 days, or 6.9 months).

Discharge Overview



Clients completed their full course of treatment

Figure 11.
*The most common type of successful program discharge was **"transitioned to other services or moved away from service area".** The most common unsuccessful discharge type was **"refused services or absconded"** after beginning the program.*

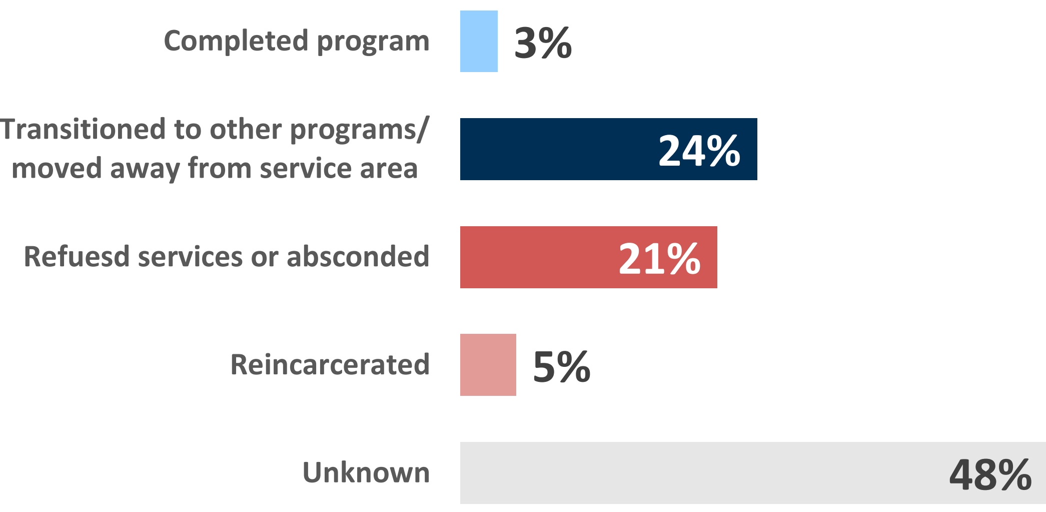
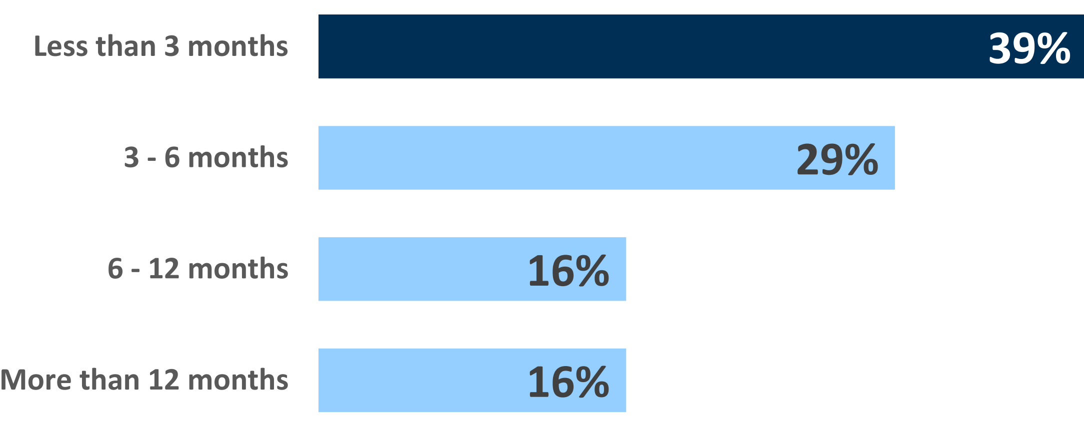


Figure 12.
*Of the 153 clients who attended at least one post-release service and had a discharge record, most clients spent **three months or less** in the MIO-CTP.*



CONCLUSIONS AND POLICY RECOMMENDATIONS

This evaluation project was intended to determine how successful Terry Reilly's MIO-CTP was at improving outcomes for formerly incarcerated people with mental health conditions in the Boise/Garden City area. Ultimately, high rates of client attrition and data quality issues made that task impossible. As such, this report presents a different view of the program by instead focusing on program activities directly carried out by Terry Reilly staff between 2017 and 2020. While this approach cannot give any insight into client outcomes, it does highlight other accomplishments of the program and draw attention to the extent of the problems posed by client attrition and data quality in the evaluation context.

The MIO-CTP's goals included two key metrics of success: (1) reduce recidivism of program participants by 10% compared to non-participants; and (2) provide services to 170 clients per year. Evaluating Terry Reilly's success on both of these metrics was problematic. First, the data collected for this evaluation did not include a thorough follow-up on all clients within a specific time frame, especially after exiting the program, nor include a control group against which to compare those clients. Terry Reilly depended on IDOC to notify them when a MIO-CTP client was reincarcerated or committed a probation/parole violation, but this approach introduces an additional layer of data quality concerns by having one program stakeholder report data to another program stakeholder rather than directly to the evaluator. The data indicates that 5% of clients were reincarcerated while they were still participating in the program. However, 21% of clients either refused services or were unable to be contacted by Terry Reilly after their release from prison, resulting in an unsuccessful discharge from the program and the functional end of data collection on that person. An additional 48% of clients did not have any record of being discharged from the program at all; it is impossible to know what outcomes were experienced by those clients.

Evaluation of the second goal, serving 170 clients per year, was also fraught with data quality issues. The example of some clients having records of post-release services but not having records of pre-release contacts highlights the biggest issue in this area. It is unknown whether the data collected is an accurate representation of program activities, or if some services were simply not included in the data submitted to ISAC. Since the program ended more than a year before ISAC began data analysis, it was determined that attempting to dig into this issue and find any potential missing service records would be impractical and could impose a significant burden on Terry Reilly staff who have moved on to working on other projects. Given that this problem coincided with both the problem of client attrition and the fact that most clients spent less than six months in the program, ISAC decided to view this goal through the lens of the number of clients *accepted* to the program each year, rather than the number *served*. It should be noted, however, that this change in metrics is a significant one that substantively changes the meaning of what is being measured. It is possible that Terry Reilly never intended to accept 170 new clients each year because they did not have the capacity to serve that many new clients in addition to any retained clients from the previous year.

Given the results of the MIO-CTP evaluation, ISAC makes the following recommendations for future program evaluations:

1. ***Evaluators should work closely with program staff to ensure all relevant and necessary data is collected and is accurate.***
   Many programs that provide direct services, especially those receiving grant funding, are not experts in program evaluation and/or data collection. It is incumbent on the evaluator to partner

with program staff to assess their capacity for data collection, come to an agreement on what data should and will be collected, and provide any technical assistance necessary to ensure data quality remains as high as possible. In the context of a complicated program with many stakeholders such as the MIO-CTP, the evaluator should take the lead on coordinating data collection efforts with all partners from whom data is needed. The MIO-CTP specifically was designed to include prison behavioral health staff, community corrections officers, and many community-based service providers. Evaluating a program in that context requires data to be collected from all of those partners to get the full picture of how the program functions and what outcomes clients are experiencing. The burden for coordinating that effort should lie with the evaluator, who can work with each stakeholder individually as well as the whole group to determine what data will be collected and how collection will occur. This will help mitigate data quality issues such as those encountered in this evaluation.

2. *Evaluators and service providers should work together to develop a client retention plan.*
   Even though full data was available for 120 MIO-CTP clients, this only represents about a quarter of clients initially accepted to the program. An evaluation project needs at least an 80% retention rate to generate reliable conclusions about client outcomes and, by extension, program effectiveness. Program evaluators should be aware that client attrition is a major, and common, threat to evaluation design and should work with program stakeholders to develop and implement incentives for clients to remain in the program. Higher client retention rates will lead to better evaluations with more sound conclusions, provide programs with solid evidence of their successes, and allow for any potential program improvements to be identified and implemented more effectively.

APPENDIX A: REFERENCES

Arnold-Williams, R., Vail, E., & MacLean, J. (2008). *Mentally ill community transition program: Annual report to the legislature.* Retrieved from http://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=MentallyIllOffender1208_b4475ac3-bad5-4241-a8d3-d9c0271d99a5.pdf

Baillargeon, J., Binswanger, I.A., Penn, J.V., Williams, B.A., & Murray, O.J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *The American Journal of Psychiatry, 166*(1), 103-109.

Baillargeon, J., Hoge, S.K., & Penn, J.V. (2010). Addressing the challenge of community reentry among released inmates with serious mental illness. *American Journal of Community Psychology, 46*, 361-375.

Bankhead, C., Aronson, J.K., & Nunan, D. (2017). Attrition bias. *Catalogue of Bias.* Retrieved from https://catalogofbias.org/biases/attrition-bias/

Brandt, A.L.S. (2012). Treatment of persons with mental illness in the criminal justice system. *Journal of Offender Rehabilitation, 51,* 541-558.

Carson, E.A. & Anderson, E. (2016). Prisoners in 2015. *Bureau of Justice Statistics.* Retrieved from https://www.bjs.gov/content/pub/pdf/p15.pdf

Castillo, E.D. & Alarid, L.F. (2011). Factors associated with recidivism among offenders with mental illness. *International Journal of Offender Therapy and Comparative Criminology. 55*(1), 98-117.

Cloyes, K.G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to prison return for offenders with serious mental illness released from prison: A survival analysis. *Criminal Justice and Behavior, 37*(2). 175-187.

Draine, J., Wolff, N., Jacoby, J.E., Hartwell, S., & Duclos, C. (2005). Understanding community re-entry of former prisoners with mental illness: A conceptual model to guide new research. *Behavioral Sciences and the Law, 23*, 689-707.

Durose, M.R., Cooper, A.D., & Snyder, H.N. (2014). Recidivism of prisoners released in 30 states in 2005: Patterns from 2005 to 2010. *Bureau of Justice Statistics.* Retrieved from https://www.bjs.gov/content/pub/pdf/rprts05p0510.pdf

Farabee, D., Bennett, D., Garcia, D., Warda, U., & Yang, J. (2006). *Final report on the mental health services continuum program of the California Department of Corrections and Rehabilitation – Parole division.* Retrieved from http://www.cdcr.ca.gov/Adult_Research_Branch/Research_Documents/MHSCP%20Final%20Report%20(3).pdf

Hartwell, S. (2003). Short-term outcomes for offenders with mental illness released from incarceration. *International Journal of Offender Therapy and Comparative Criminology, 47*(2), 145-158.

Hatcher, S.S. (2007). Transitional care for offenders with mental illness in jail: Mapping indicators of successful community reentry. *Best Practices in Mental Health, 3*(2), 38-51.

Hatcher, R.M., McGuire, J., Bilby, C.A.L., Palmer, E.J., & Hollin, C.R. (2012). Methodological considerations in the evaluation of offender interventions: The problem of attrition. *International Journal of Offender Therapy and Comparative Criminology, 56*(3), 447-464.

Hoge, S.K. (2007). *Providing transition and outpatient services to the mentally ill released from correctional institutions.* In Greifinger, R., Bick, J., & Goldenson, J. (Eds.). *Public health behind bars: From prisons to communities* (pp. 461-477)*.* New York, NY: Springer.

Idaho Department of Correction and Idaho Department of Health and Welfare. (2017, January 15). Annual Community Gap Analysis. Retrieved from https://www.idoc.idaho.gov/content/document/annual_community_gap_analysis_2017

Jacoby, J.E. & Kozie-Peak, B. (1997). The benefits of social support for mentally ill offenders: Prison-to-community transitions. *Behavioral Sciences and the Law, 15,* 483-501.

James, D.J. & Glaze, L.E. (2006). Mental health problems of prison and jail inmates. *Bureau of Justice Statistics.* Retrieved from https://www.bjs.gov/content/pub/pdf/mhppji.pdf

Kaeble, D. & Glaze, L. (2015). Correctional populations in the United States, 2015. *Bureau of Justice Statistics.* Retrieved from https://www.bjs.gov/content/pub/pdf/cpus15.pdf

Lovell, D., Gagliardi, G.J., & Peterson, P.D. (2002). Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services, 53*(10), 1290-1296.

Lurigio, A.J., Fallon, J.R., & Dincin, J. (2000). Helping the mentally ill in jails adjust to community life: A description of a postrelease ACT program and its clients. *International Journal of Offender Therapy and Comparative Criminology, 44*(5), 532-548.

Mason, M.J. (1999). A review of procedural and statistical methods for handling attrition and missing data in clinical research. *Measurement and Evaluation in Counseling and Development, 32*(2), 111-118.

Mallik-Kane, K. & Visher, C.A. (2008). Health and prisoner reentry: How physical, mental, and substance abuse conditions shape the process of reintegration. *Urban Institute Justice Police Center.* Retrieved from http://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF

Maruschak, L.M., Bronson, J. & Alper, M. (2021, June). Indicators of mental health problems reported by prisoners. *Bureau of Justice Statistics.* Retrieved from https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf

Miller, H.V. & Miller, M. (2010). Community in-reach through jail reentry: Findings from a quasi-experimental design. *Justice Quarterly, 27*(6), 893-910.

Osher, F., Steadman, H.J., & Barr, H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The APIC model. *Crime & Delinquency, 49*(1), 7996.

Pope, L.G., Smith, T.E., Wisdom, J.P., Easter, A., & Pollock, M. (2013). Transitioning between systems of care: Missed opportunities for engaging adults with serious mental illness and criminal justice involvement. *Behavioral Sciences and the Law, 31,* 444-456.

Seiter, R.P. & Kadela, K.R. (2003). Prisoner reentry: What works, what does not, and what is promising. *Crime & Delinquency, 49*(3), 360-388.

Taxman, F.A., Young, D., Byrne, J.M., Holsinger, A., & Anspach, D. (2002). From prison safety to public safety: Innovations in offender reentry. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/196464.pdf

Travis, J. (2000). But they all come back: Rethinking prisoner reentry. *National Institute of Justice.* Retrieved from https://www.ncjrs.gov/pdffiles1/nij/181413.pdf

Travis, J., Solomon, A.L., & Waul, M. (2001). From prison to home: The dimensions and consequences of prisoner reentry. *Urban Institute Justice Policy Center.* Retrieved from http://research.urban.org/UploadedPDF/from_prison_to_home.pdf

Ventura, L.A., Cassel, C.A., Jacoby, J.E., & Huang, B. (1998). Case management and recidivism of mentally ill persons released from jail. *Psychiatric Services, 49*(10), 1330-1337.

Washington State Institute for Public Policy. (2009). *The dangerous mentally ill offender program: Four-year felony recidivism and cost effectiveness.* Retrieved from http://www.wsipp.wa.gov/ReportFile/1036/Wsipp_The-Dangerous-Mentally-Ill-Offender-Program-Four-Year-Felony-Recidivism-and-Cost-Effectiveness_Full-Report.pdf

Wilson, A.B., Draine, J., Barrenger, S., Hadley, T., & Evans Jr, A. (2013). Examining the impact of mental illness and substance use on time till re-incarceration in a county jail. *Administration & Policy in Mental Health & Mental Health Services Research, 41*(3), 293-301.

APPENDIX B: DATA TABLES – COMPLETE CASES

This section presents data specifically for clients of Terry Reilly's MIO-CTP program data with complete program data (i.e., complete cases), by program phase.[20] Since all clients included here were screened into the program, these tables begin with Phase 2 (pre-release contact) and end with program discharge. Due to issues with data quality and a high level of client attrition[21], 120 clients (24% of all clients screened by Terry Reilly) qualified for inclusion in this section, and ISAC made no attempts to draw any conclusions about program effectiveness based on this subset of MIO-CTP clients, or by comparing them with the full client group. However, this data does give a supplemental view of program activities when compared to the full group (which provides a more complete view of program activities but may not accurately describe the experience of the average client).

Client Demographics

Gender	#	%
Female	27	22.5%
Male	90	75.0%
Transgender	1	0.8%
Other	1	0.8%
Unknown/Did not disclose	1	0.8%

Race	#	%
American Indian/Alaska Native	3	2.5%
Asian	0	0.0%
Black/African American	8	6.7%
White	103	85.8%
Other	5	4.2%
Unknown	1	0.8%

Ethnicity	#	%
Hispanic/Latino	9	7.5%
Non-Hispanic/Latino	107	89.2%
Unknown	4	3.3%

Age at MIO-CTP Intake	#	%
18 - 24 Years Old	4	3.3%
25 - 34 Years Old	32	26.7%
35 - 44 Years Old	40	33.3%
45 - 54 Years Old	29	24.2%
55 Years and Older	11	9.2%
Unknown	4	3.3%

[20] Phases are defined as client screening (Phase 1), pre-release contact (Phase 2), and post-release services (Phase 3).

[21] See the "Data Collection and Analysis Methods" section for more information.

Marital Status	#	%
Single	63	52.5%
Married	15	12.5%
Divorced	28	23.3%
Separated	7	5.8%
Widow	2	1.7%
Unknown	5	4.2%

LSI-R Risk Level	#	%
Low	2	1.7%
Low/Moderate	15	12.5%
Moderate/High	29	24.2%
High	73	60.8%
Unknown	1	0.8%

Most Serious Charge Incarcerated For	#	%
Drug/Alcohol	36	30.0%
Property	20	16.7%
Sexual	16	13.3%
Violent	45	37.5%
Weapon	1	0.8%
Unknown	2	1.7%

Previous Behavioral Health Diagnoses	#	%
Previous Mental Health Diagnosis	42	35.0%
Previous Substance Use Disorder Diagnosis	33	27.5%

IDOC CMHS Level of Care	#	%
CMHS-1	28	23.3%
CMHS-2	90	75.0%
ACHMS	0	0.0%
ICHMS	2	1.7%

Prison Release Type (Released to…)	#	%
Full-term	12	10.0%
Parole	87	72.5%
Probation	19	15.8%
Unknown	2	1.7%

Expected Employment Upon Release from Prison	#	%
Full Time	4	3.3%
Part Time	1	0.8%
Self-Employed	0	0.0%
Retired	0	0.0%
Disabled	3	2.5%
Unemployed	112	93.3%
Unknown	0	0.0%

Expected Housing Upon Release from Prison	#	%
Rent/own	0	0.0%
Friends/Relative	19	15.8%
Transitional housing	82	68.3%
Assisted living/nursing home	2	1.7%
Shelter	12	10.0%
Street/car/camping	1	0.8%
Other	2	1.7%
Unknown	2	1.7%

Phase 2: Pre-Release Contacts

Number of Pre-Release Contacts	#	%
1	69	57.5%
2	38	31.7%
3	13	10.8%
4	0	0.0%
None	0	0.0%

Total Pre-Release Contact Time	#	%
Less than 60 minutes	25	20.8%
60 minutes	62	51.7%
More than 60 minutes	31	25.8%
Unknown	2	1.7%

Phase 3: Post-Release Services

Number of Post-Release Services	#	%
1 - 3	62	51.7%
4 - 5	28	23.3%
6 - 10	15	12.5%
11 or more	15	12.5%
None	3	2.5%

Post-Release Service Type	#	%
Case Management	116	96.7%
Co-Occurring Treatment	14	11.7%
Medication Management	37	30.8%
Mental Health Counseling	14	11.7%

Number of Referrals to Other Services	#	%
1 - 5	48	40.0%
6 - 10	36	30.0%
11 or more	27	22.5%
None	9	7.5%

Discharge from Program

Client Discharge Type	#	%
Completed program	5	4.2%
Transitioned to other program/moved away from service area	81	67.5%
Refused services/absconded	19	15.8%
Reincarcerated	14	11.7%
Deceased	1	0.8%

Months in MIO-CTP	#	%
Less than 3 months	36	30.0%
3 - 6 months	38	31.7%
6 - 12 months	23	19.2%
More than 12 months	23	19.2%

APPENDIX C: DATA TABLES – CLIENT DEMOGRAPHICS

Gender	#	%
Female	129	27.7%
Male	322	69.1%
Transgender	2	0.4%
Other	1	0.2%
Unknown/Did not disclose	12	2.6%

Race	#	%
American Indian/Alaska Native	9	1.9%
Asian	2	0.4%
Black/African American	27	5.8%
White	399	85.6%
Other	22	4.7%
Unknown	7	1.5%

Ethnicity	#	%
Hispanic/Latino	42	9.0%
Non-Hispanic/Latino	409	87.8%
Unknown	15	3.2%

Age at MIO-CTP Intake	#	%
18 - 24 Years Old	31	6.7%
25 - 34 Years Old	145	31.1%
35 - 44 Years Old	142	30.5%
45 - 54 Years Old	82	17.6%
55 Years and Older	38	8.2%
Unknown	28	6.0%

Marital Status	#	%
Single	305	65.5%
Married	32	6.9%
Divorced	85	18.2%
Separated	19	4.1%
Widow	6	1.3%
Unknown	19	4.1%

LSI-R Risk Level	#	%
Low	8	1.7%
Low/Moderate	43	9.2%
Moderate/High	124	26.6%
High	265	56.9%
Unknown	26	5.6%

Most Serious Charge Incarcerated For	#	%
Drug/Alcohol	181	38.8%
Property	76	16.3%
Sexual	50	10.7%
Violent	127	27.3%
Weapon	1	0.2%
Unknown	31	6.7%

Previous Behavioral Health Diagnoses	#	%
Previous Mental Health Diagnosis	108	23.2%
Previous Substance Use Disorder Diagnosis	77	16.5%

IDOC CMHS Level of Care	#	%
CMHS-1	133	28.5%
CMHS-2	319	68.5%
ACHMS	4	0.9%
ICHMS	10	2.1%

Prison Release Type (Released to…)	#	%
Full-term	48	10.3%
Parole	298	63.9%
Probation	100	21.5%
Unknown	20	4.3%

Expected Employment Upon Release from Prison	#	%
Full Time	17	3.6%
Part Time	2	0.4%
Self-Employed	1	0.2%
Retired	1	0.2%
Disabled	8	1.7%
Unemployed	431	92.5%
Unknown	6	1.3%

Expected Housing Upon Release from Prison	#	%
Rent/own	9	1.9%
Friends/Relative	80	17.2%
Transitional housing	302	64.8%
Assisted living/nursing home	6	1.3%
Shelter	24	5.2%
Street/car/camping	3	0.6%
Other	19	4.1%
Unknown	23	4.9%

Conducting quality justice system research for Idaho since 1976.

Idaho Statistical Analysis Center
Planning, Grants & Research
Idaho State Police

Thomas Strauss, MPA
ISAC Director & Principal Research Analyst

isp.idaho.gov/pgr/sac

pgr@isp.idaho.gov

(208) 884 - 7040