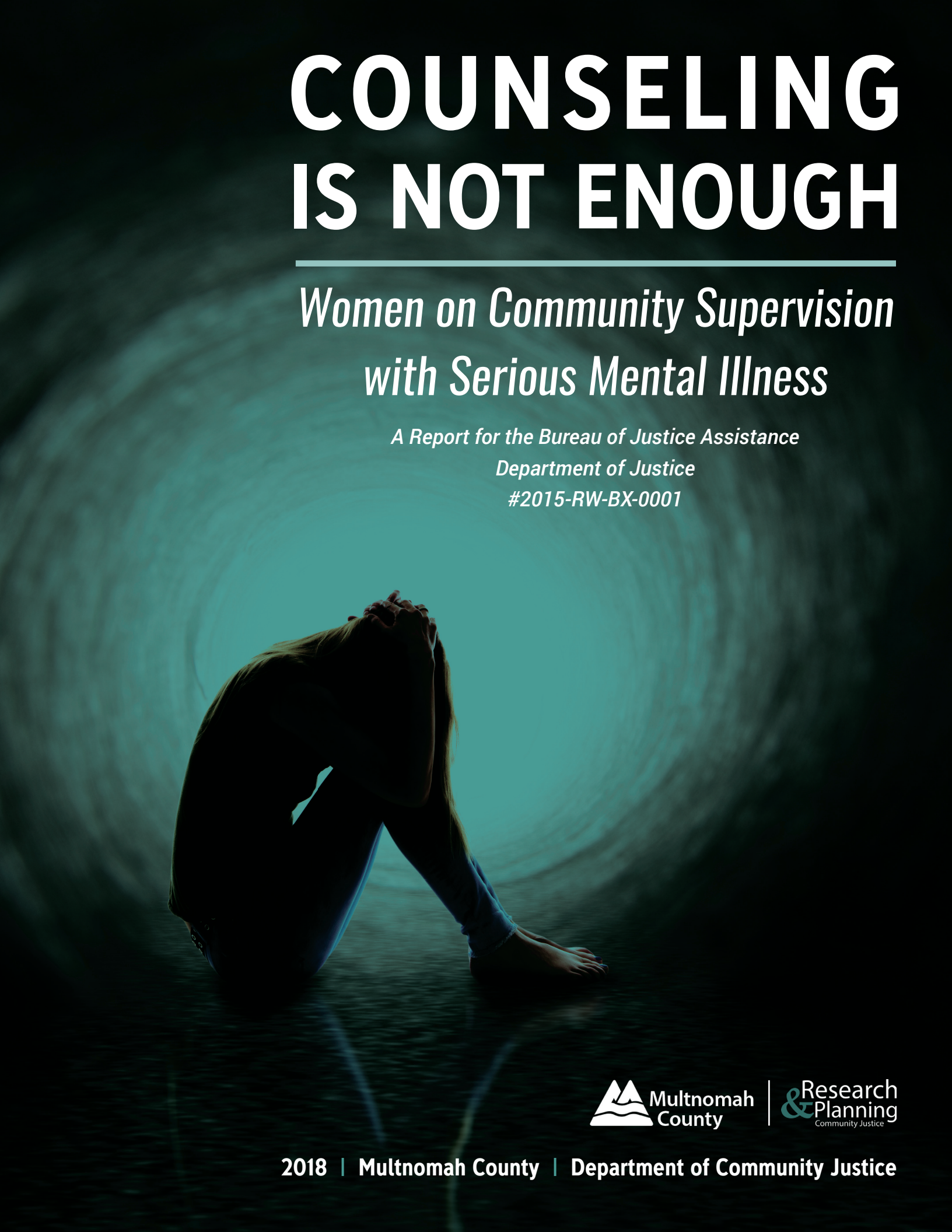
COUNSELING IS NOT ENOUGH

Women on Community Supervision with Serious Mental Illness

A Report for the Bureau of Justice Assistance
Department of Justice
#2015-RW-BX-0001



Multnomah County | Research & Planning Community Justice

2018 | Multnomah County | Department of Community Justice

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Women on Community Supervision with Serious Mental Illness

A Report for the Bureau of Justice Assistance, Department of Justice

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Second Chance Act Targeting Offenders with Co-Occurring Substance Abuse and Mental Health Program
Second Chance for Women

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EXECUTIVE SUMMARY

Set in Multnomah County, Oregon, this project integrated existing and grant funded resources to ensure justice-involved women with co-occurring mental health and substance abuse (MH-SA) disorders had access to quality assessment, treatment, case management, and counseling support at a level that met the clinical needs of all who were referred.

Thirty-eight women were served by the grant. Common primary mental health diagnoses of the group included post-traumatic stress disorder (PTSD), depression, and schizophrenia. Common drugs of choice were heroin, methamphetamine, and marijuana. All women were justice-involved with 53% on probation and 47% on post-prison supervision. All women were assessed with an actuarial risk tool and 92% were assessed as high risk for recidivating.

A multi-phase program evaluation was conducted that included: 1) an analysis of recidivism and other public safety outcomes of the participants, using a randomized control trial to help measure success, 2) a case file review of the experiences of ten women who participated in the program, and 3) qualitative observations gathered from members of the project team.

Quantitative results suggest counseling alone is not enough to create long-lasting stability for women with co-occurring disorders and complex care needs. This resource needs to be part of a larger intervention and stabilization plan.

Qualitative results identified challenges, such as the clients' lack of acknowledgement of their own mental health issues, lack of medication compliance, challenges of service coordination, housing barriers, and difficulties identifying and separating mental health versus substance abuse needs.

Recommendations from this study include the creation of a community-based setting that offers the observed benefits of some of the County jail sentences experienced by these women, improvements to medication access and medication monitoring, co-location of mental health and probation/parole services, and investments in more low barrier, community-based housing.

Further study is recommended to expand on the short and long-term outcomes of intervening with this complex and challenging population.

TABLE OF CONTENTS

INTRODUCTION

Who We Are

The Second Chance for Women (SCW) Grant Program created a new collaboration for the Multnomah County's Department of Community Justice (DCJ), Sheriff's Office (MCSO), and Cascadia Behavioral Health. The project integrated existing and grant funded resources to ensure justice-involved women with co-occurring mental health and substance abuse (MH-SA) disorders had access to quality assessment, treatment, case management, and counseling support at a level that met the clinical needs of all who were referred. A quantitative and qualitative evaluation was also funded to document our efforts.

Our goals were to enhance services so that we could help provide stabilization in these women's lives, reduce arrests in the community, prevent re-entry into the jail system, and encourage successful transition off of community supervision.

Who We Served

Thirty-eight women were served by the grant during this period. All women were justice-involved with 53% on probation and 47% on post-prison supervision. To be eligible, the participating women had to meet clinical criteria demonstrating a co-occurring mental health and substance abuse problem. Common primary mental health diagnoses of the group included post-traumatic stress disorder (PTSD), depression, and schizophrenia. Common drugs of choice were heroin, methamphetamine, and marijuana. All women were assessed with an actuarial risk tool and 92% were assessed as high risk for recidivating. Together, these women had been booked into the Multnomah County jail 706 times prior to joining the program. Their average age was 38 years.

> ***All of these women have a lot of things like kids and substance use and transportation issues and homelessness that prevents… them from operating in that traditional outpatient model. (project team member)***

Services Provided

Funding ensured that a dedicated probation/parole officer (PPO) with specialized training in gender responsivity and mental health disorders supervised all of the women under this grant. Additionally, all women had access to mental health counseling and case management services with a dedicated counselor and prescriber who focused solely on these participants. This reduced the amount of time needed to quickly screen and engage these women. This also allowed counseling sessions to be offered proportionate to any client's symptom acuity and wraparound needs. For example, several women had as many as 300 contact sessions throughout the duration of their treatment. A unique aspect of these services is that many were offered at the probation/parole office. This was not only convenient for the clients but also allowed enhanced communication and coordination across community supervision and mental health activities. Both sides met regularly and mirrored their shared goals in their case plan and client contacts.

> ***Having mental health services on-site is important, because they understand what our County's values… and they understand what we're trying to do as POs.***

What is Different About This Program?

The program sought improvements over the business-as-usual approach to serving women with co-occurring disorders in several ways. First, services continued while clients were incarcerated. Cooperating with the Sheriff's Office, the grant-funded counselor continued to meet regularly with the women in jail. Usually, mental health services are suspended in jail and clients with Medicaid often have to reactivate benefits upon release. Second, the services offered were much more intensive and provided by a clinical counselor. Without the grant, these clients would have only been provided with case coordination services. Lastly, the supervising PPO had an established and coordinated relationship with the behavioral health provider. Women with mental health issues who are supervised on generic caseloads often have PPOs who have no relationship with mental health providers and experience more barriers engaging the client into appropriate services.

> ***[Clinician name] was able to get them into things that I didn't have access to, even know what it was about. Even if I did have access. I don't know if I'd have the time to do it. (project team member)***

About Multnomah County

Multnomah County is one of 36 Counties in the State of Oregon and encompasses the City of Portland. As the most populous county, Multnomah has over 807,000 residents. Community Corrections is county-operated in Oregon and is run by the Department of Community Justice in Multnomah County. The Department operates with approximately 125 officers who jointly manage both probation and post-prison clients on their caseloads. On any given day, the department manages about 7,860 adults with a typical caseload size of 35 - 50 per officer.

OUTCOME EVALUATION

Evaluation Plan

Research and Planning (RAP) had the responsibility for evaluating this program. This report reflects three sets of activities[1] :

- The first part was an evaluation of the public safety outcomes of the participants, using a randomized control trial to help measure success. This relied heavily on administrative data tracked by the clinicians and probation/parole officers. We also used a local public safety data warehouse to examine factors such as jail bed usage and conviction rates. Lastly, we used data provided from the Oregon State Police to report on arrest incidents and charge types.

- The second part was a case file review of the experiences of ten women who participated in the program. This relied on the case files and case notes tracked by the clinicians and probation/parole officers.

- The third part involved a workshop with members of the project team to help describe the context for the quantitative findings and the case file reviews. Participants were asked to provide additional context and identify what factors might be missing from the analyses.The group reflected on the meaning of the findings and helped offer recommendations.These conversations were audio-recorded and then transcribed. Quotes from the clinicians, managers and officers who participated in this workshop appear throughout this report.

Study Eligibility

To be eligible for the program, participants were required to: 1) Have a diagnosis of a major mental illness and co-occurring substance abuse disorder, 2) Have a significant impairment in one or more life domains that seriously impair functioning in the community, 3) Be under the jurisdiction of the Department of Community Justice on probation or parole, and 4) Have a recidivism risk of medium or higher. In addition to data on diagnoses and risk, the evaluation also investigated indications of mental health medication prescriptions and location of each participant at the time of the referral.

[1] Access all of the evaluation products at: https://multco.us/dcj/research-and-planning-rap

Random Assignment Process

Random assignment was used to assign eligible women into a treatment or control group. An experimental design was chosen because there were more eligible women for this program than capacity could serve. This also allowed RAP to use research methods that created two similar groups that could be followed over time to identify the program's impact.

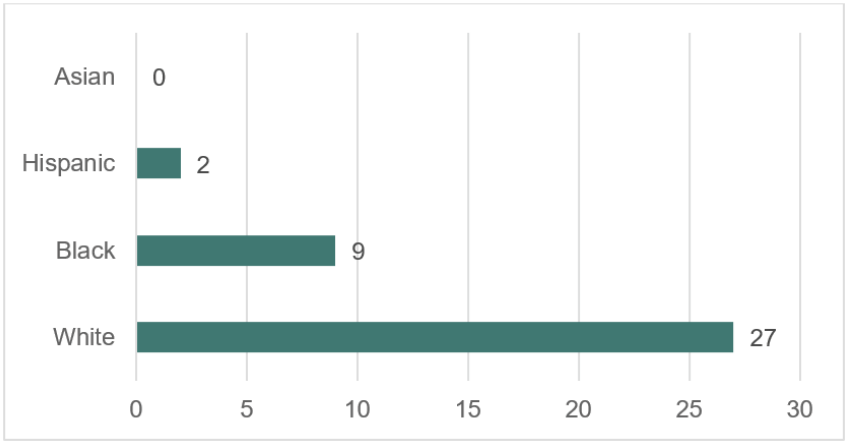
The assignment process flowed in the following manner. A PPO would identify women who appeared to have a co-occurring mental health and substance abuse issue to Cascadia Behavioral Healthcare for an evaluation. Cascadia would then conduct additional screening and make the final determination of eligibility. Once established, Cascadia staff logged eligible women into a web-based tool created by RAP to randomize offender assignments. Only members of the evaluation team determined assignments according to a random numbers list maintained in RAP. Once logged, women were assigned to either a treatment or control condition. During the grant period, 38 women were assigned to the treatment group and 42 to the control group (business-as-usual).

Once assigned, all clients remained in their designated group throughout the study period. Engagement in the specialized services was voluntary and consent forms were collected on each participant. Data was collected on these women from referral through the completion of their supervision. Many women were still on active supervision when the grant period ended. In total 19 of the 38 women in the treatment group were still on supervision when the grant period ended. As a result, this report uses defined follow-up windows that begin upon the client's referral date. Outcome windows of 3 months, 6 months and 1 year were all used to compare progress of the treatment and control groups.

> ***We often talk a lot about the idea that some of our folks are too mentally ill for this lower end of care and not mentally ill enough for the highest end of care. And that these people in the middle kind of get lost. (project team member)***

Evaluation Findings: Description of Treatment Group Participants

FIGURE 1: Demographic Characteristics of Women Served by the Grant (n = 38)



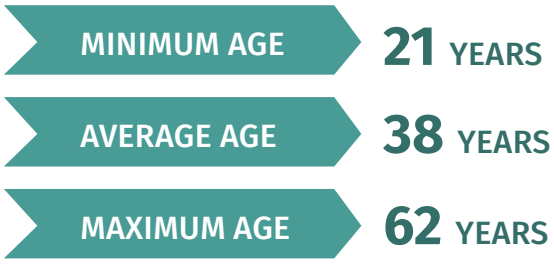


FIGURE 2: Risk Comparison of Program Participants[2]

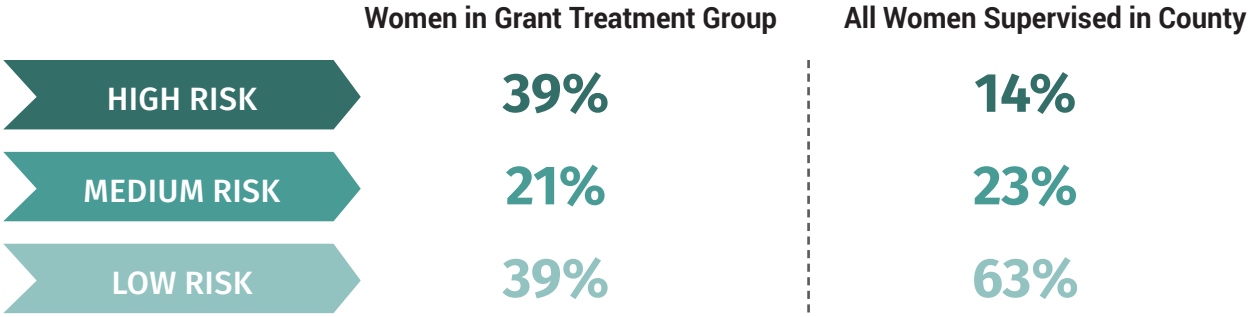
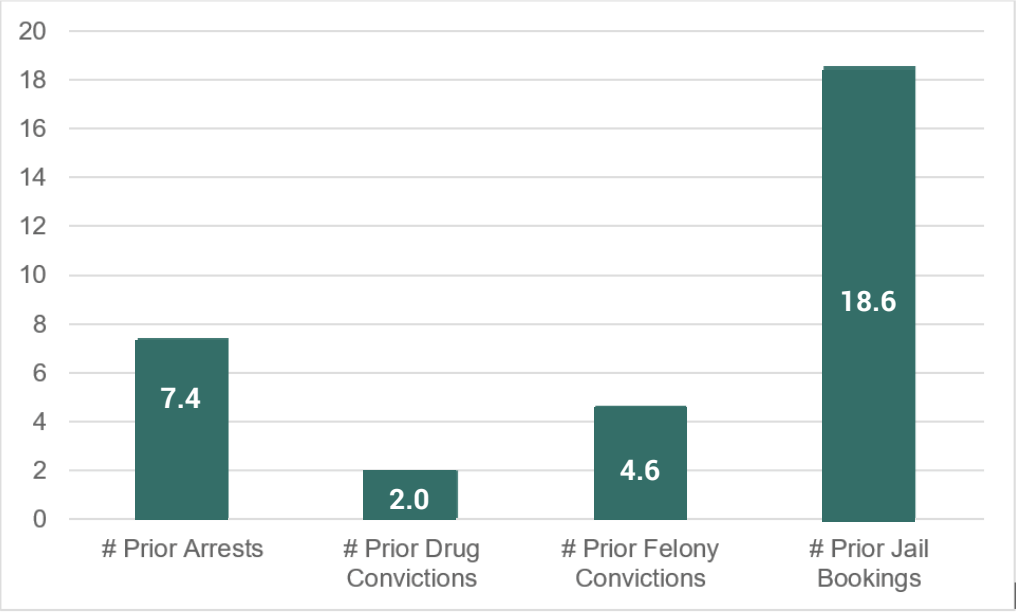


FIGURE 3: Level of Service/Case Management Inventory Domains of Program Participants[3] - % High or Very High Risk/Need

Overall	92%
Criminal History	46%
Education & Employment	57%
Family & Marital	65%
Recreation	89%
Companions	89%
Drug & Alcohol	78%
Procriminal Attitude	49%
Antisocial Pattern	43%

[2] As assessed by the Public Safety Checklist: https://risktool.ocjc.state.or.us/psc/cc/
[3] As assessed by the LS/CMI: https://www.mhs.com/

FIGURE 4: Criminal History[4] of Program Participants (n=38)



Evaluation Findings: Comparison of Groups

Figure 5 displays the similarities of the two groups on their initial referral date.

Figure 6 illustrates that nearly half of the treatment group were prescribed some form of medication to manage mental health symptoms compared to 36% of the control group. Additionally, a relatively large percentage of women in both groups were listed as having no known medications.

As for location, over half of the treatment group were incarcerated at the time of referral whereas a large portion of the women in the control group were either homeless or in jail. Less than a quarter of both groups had an identifiable residence (either permanent or temporary).

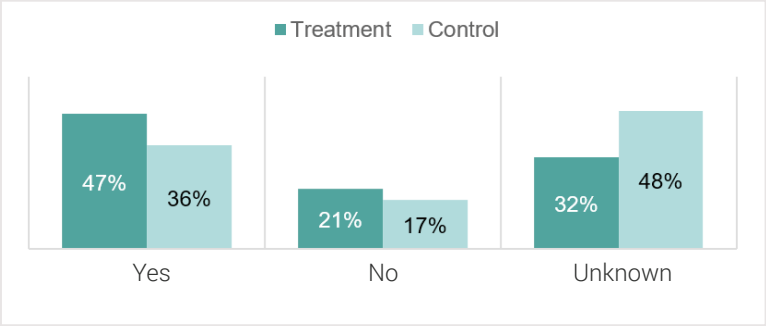
FIGURE 5: Comparison of Client Characteristics Between the Treatment & Control Group

	Treatment Group (n=38)	Control Group (n=42)
% Person of Color	**29%**	**17%**
Average Age	**37.8**	**37.2**
Avg. Criminal Risk Score at Referral	**28 (high)**	**29 (high)**
# Prior Arrests	**7.4**	**8.7**
# Prior Drug Arrests	**2.8**	**2.8**
# Prior Felony Convictions	**4.6**	**4.2**
# Prior Jail Bookings	**18.6**	**15.8**

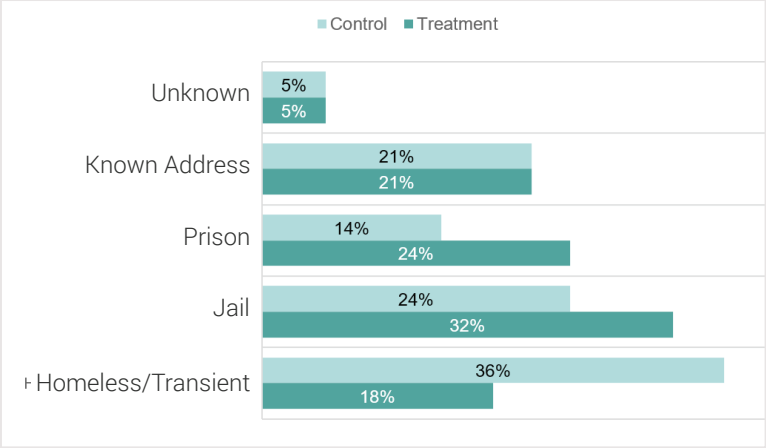
[4] Criminal history includes all known criminal history recorded in the statewide database DOC400/CIS up to the referral to the grant program. Therefore, the length of this period of time varies by participant.

FIGURE 6: Comparisons of Treatment & Control Group at Time of Referral

Mental Health Medication Prescription at Time of Referral		
	Treatment (n=38)	Control (n=42)
Yes	**47%**	**36%**
No	**21%**	**17%**
Unknown	**32%**	**48%**



Location at Time of Referral		
	Treatment (n=38)	Control (n=42)
Homeless	**18%**	**36%**
Jail	**32%**	**24%**
Prison	**24%**	**14%**
Known Address	**21%**	**21%**
Unknown	**5%**	**5%**



Supervision Outcomes

We examined several variables related to participation and compliance on community supervision. Overall, there were no significant differences found between the treatment and control group. Within the treatment group, 8% received a urinalysis (UA) test at least once in the first three months following referral compared to 5% of the control group (Figure 7). The treatment group did not receive significantly more urinalysis tests nor did they experience more positive or negative tests within the first 3 months, 6 months or 12 months following referral.

FIGURE 7: Comparison of Supervision Outcomes Between Treatment & Control Group

There were competing theories on whether the treatment group would receive more or less PPO initiated administrative sanctions. Some expected more sanctions since the PPO had more focused time with the treatment group clients and could better react to problematic behaviors. Others expected the treatment group to experience fewer sanctions due to expectations of improved behavior. In our final analysis, we saw no statistically significant difference in sanctions overall or in the use of jail sanctions specifically (Figure 7).

Lastly, we saw no differences in the frequency of abscond incidents (Figure 7) or the length of time a client was on abscond status. Within the treatment group, 26% had an abscond event reported over the first year following referral compared to 24% of the control group. In order for the difference to be statistically significant, 48% of the control group would have needed to abscond.

> ***It's a lot easier to get someone to stay and sit and talk with you if they're not already mentally going into 'okay, where am I going to find food tonight? Is it going to rain? Do I have a tarp?' (project team member)***

Service Referral Outcomes

One objective of the program was to provide quick and accessible referrals and services to participants. As such, we analyzed whether or not there were significant differences in referrals to housing, mental health treatment, and substance abuse treatment. The grant-funded program encompasses services that target both mental health and substance abuse, and, as such, additional referrals for these two areas would not have been made for those accepted into the treatment group. For those in the control group, the PPO would have had to make outside referrals for mental health and substance abuse services. Since the grant-funded program did not directly provide housing, outside referrals for housing were made for both the treatment group and control group.

Figure 8 shows that there were significant differences between groups for both mental health and substance abuse referrals. The treatment group was significantly more likely to have a referral for these two services relative to the control group (p<0.001). Additionally, we were interested in the estimated timeframe for such referrals. As shown in the table, the treatment group immediately began receiving services for mental health and substance abuse treatment whereas the control group waited, on average, 135 days and 126 days, respectively. Lastly, we found that although the treatment group was more likely to have a housing referral, the difference was not significant.

> ***It wasn't really the right time to be referring a lot of folks to employment because all the other things needed to be addressed like mental health stability, chronic substance abuse, etc. (project team member)***

FIGURE 8: Comparison of Service Referral Rates of Treatment & Control Group

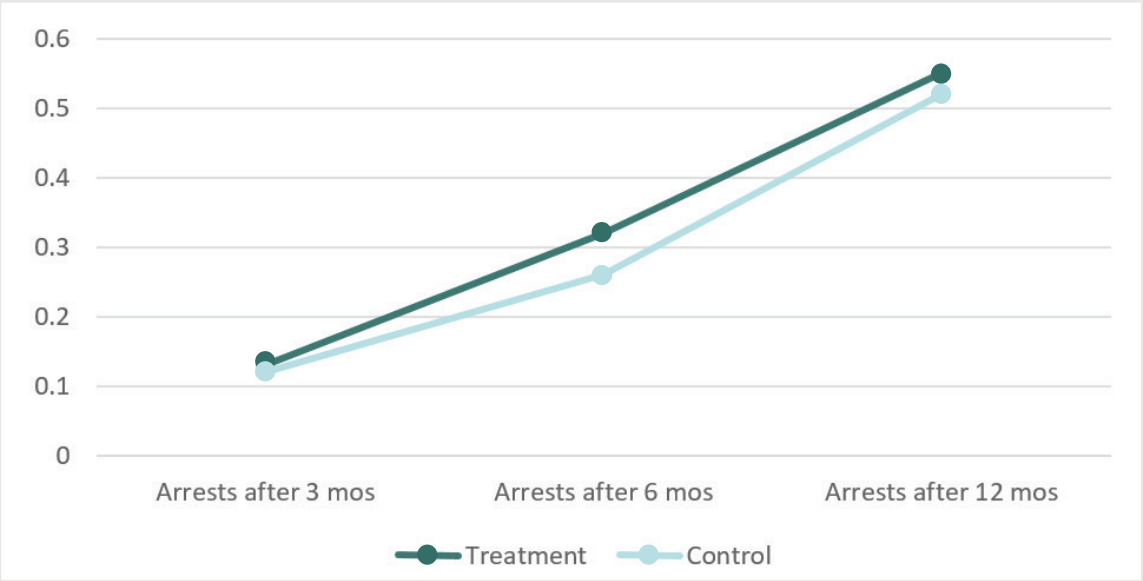
	Treatment Group (n=38)	Control Group (n=42)
Proportion of Clients Receiving Housing Referral **Average # Days from Referral**	65.8% **135**	54.8% **119**
Proportion of Clients Receiving Mental Health Referral *** **Average # Days from Referral** ***	100% **0**	47.6% **135**
Proportion of Clients Receiving Substance Abuse Referral *** **Average # Days from Referral** ***	100% **0**	42.9% **126**

Probability of difference due to chance: * p < .05, ** p < .01 *** p < .001

Public Safety Outcomes

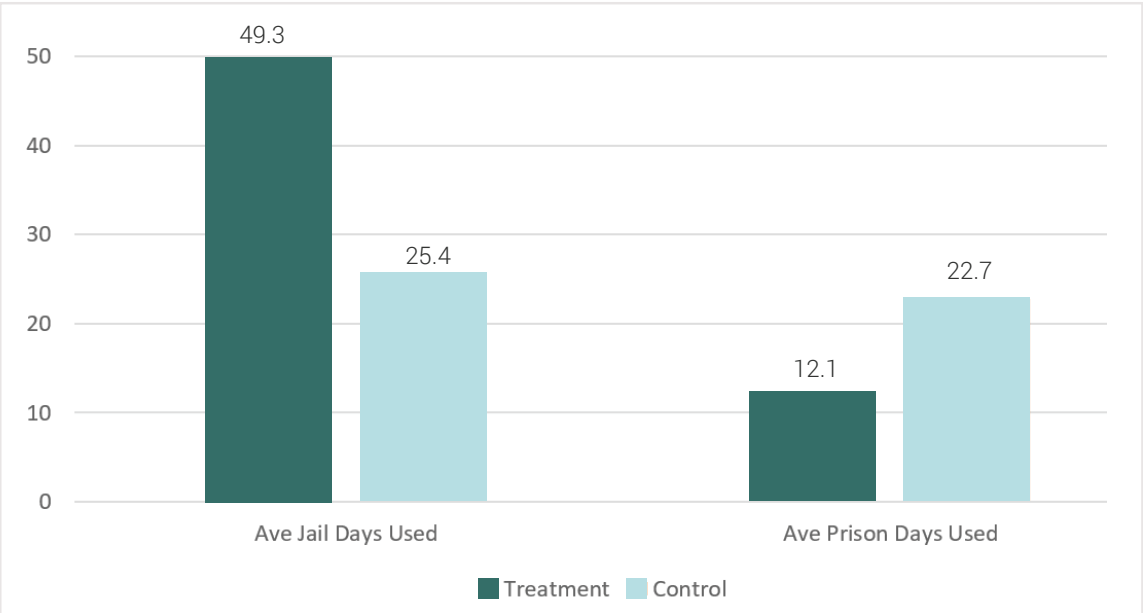
Despite that fact that program participants experienced early engagement and more access to counseling services, this was not enough to change their trajectory of arrests for new charges. Following both the treatment and control groups at 3 months, 6 months and 12 months post-referral, we saw no statistically significant difference between the groups with regards to recidivism (Figure 9).

FIGURE 9: Re-arrest Rates of Treatment & Control Group



Similarly, the two groups remained similar in their subsequent use of local jail and state prison beds. Although on average the treatment group used more jail bed days but fewer prison bed days than the control group, this result was not determined to be statistically significant (Figure 10).

FIGURE 10: Use of Jail and Prison Beds of Treatment & Control Group - Within 1 Year of Referral



We also further explored whether the types of crimes for the clients who recidivated were different across the control group and treatment group. The hypothesis was that the treatment group would show more property and statutory crimes while the control group would show more person-related crimes. Once again, these differences were not statistically significant and did not trend in this direction (Figure 11).

FIGURE 11: Comparison of Recidivism Charge Types of Treatment & Control Group[5]

> ***So I think a lot of times when we think we put resources with clients, that [the client] will change quickly, and it can take time… (project team member)***

Strengths & Limitations

We examined many of the variables commonly used to assess "success" on community supervision, that is, recidivism by number and type of future arrests. We were also able to examine incarceration episode impacts on our local jail and state prison institutions. However, these analyses are limited in several important ways. First, the sample sizes of these two groups are small. This means that any difference would need to be extremely large to be found statistically significant. For binary measures like recidivism rate, the necessary difference would be about 20 percentage points (e.g. the difference between 10% and 30%). For continuous measures like the average number of days in jail or prison, the difference needs to be of far greater magnitude due to skewed distributions and outliers. Second, the traditional measures of success may not be appropriate for women with severe and concurrent needs. Program staff frequently mentioned in the project workshop that their main goals were to increase periods of stability for each client. A more detailed description of the client needs and periods of stability can be found in the case review findings section of this report. Finally, the women in the treatment group were on smaller caseloads with more frequent contacts and a higher level of monitoring by both the PPOs and clinicians. It is possible that the reported rates of activity of the control group would have been higher had the level of surveillance been equal across the groups.

> ***Success looks a little bit different on these caseloads than maybe the generic caseload. …Someone who's having frequent hospitalizations, frequent police contact, frequent going in and out of jail…We're trying to really spread [those incidents] out, and that can look like a win for us…We may look at recidivism, but I don't really think that really captures exactly how successful the probation was or not because they're pretty complex, these clients. (project team member)***

[5] Charges do not total 100% because each person can be arrested for more than one type of charge.

Discussion of Outcomes

The services experienced by the women in this program, mainly early engagement and increased access to on-site counseling services, did not create long-term impacts on this population to the extent that they could be seen as statistically different from a matched control group. Long-term, sustainable change is a known challenge for those struggling with addiction and mental health disorders. Frequent relapse is a reality for those being treated under the best of circumstances. Many of the women served by this grant also experienced multiple and overlapping barriers to recovery. Some barriers suggested by the project team in our workshop include:

Lack of client acknowledgement of mental health issues

> *Part of the actual mental health illness itself is basically not thinking you have a mental illness. And so expecting folks who may be schizophrenic, to say, like "I want to go to treatment," is not really realistic…The way that the system works doesn't actually work well with the mental illness itself.*

> *If they don't have the insight, then well, what's their buy-in?*

Challenge of coordinating government funded services

> *A lot of folks that we work with are not really good at navigating the system, or don't have the patience to do it, or the knowledge of how to do it.*

> *Navigating these systems is really difficult. I've been in an insurance battle and I'm not smart by any means, I'm fairly average but I could barely deal with them, right. And it's phone call after phone call. And to have someone who's homeless with mental illness who has some addiction issues, I don't get how they navigate these systems.*

Housing barriers

> *It's very hard to place mentally ill females in treatment because nobody wants them.*

> *[Client name], yeah, continually got banned from places, and so your options get smaller and smaller as you go along.*

Lack of medication compliance/medication efficacy

> *I think she engaged more in the beginning, and then she stopped taking the meds. She got pretty paranoid around several things, and she kind of disengaged.*

> *There's not a step-down medication treatment for meth.*

> *She never really agreed to take the therapeutic level of medications.*

Difficulty separating mental health issues from substance abuse

> *When you get those moments along a long enough period of sobriety, really, you're like, 'No, this is just drugs. This is not a true mental illness.'*

> *She's another example of the ones whenever she was not using these [drugs], psychotic symptoms went away.*

CASE REVIEW INVESTIGATION

Case Review Process

In order to enhance our understanding of the impact that the program had on our participants, we decided to incorporate qualitative case reviews. In doing so, we only selected from those participants who had already completed their treatment (either successfully or unsuccessfully). In total, 10 cases were selected with the majority assessed as high criminal risk based on the LS/CMI. From there, we analyzed the variation in levels of program engagement based on the Level of Care scores provided by the mental health clinician. We found that half of the women scored low on program engagement and the other half scored high on program engagement. When breaking this engagement measure down by successful and unsuccessful completions, some patterns emerged (e.g., lower engagement led to unsuccessful completion). However, this pattern was not true for every case. This led us to believe that something else may be influencing program success and provided us with sufficient justification to include all 10 women in our case review process to determine what patterns would emerge.

The 10 cases were analyzed using two sources of qualitative data. The first was the Department of Corrections Case Management system that is used by supervision officers to record contact with clients as well as progress on supervision. The second source of data came from case files provided by the program clinicians that describe every contact with the client, treatment notes, treatment goals, and clinician's contact with supervision staff. Both sources were date and time stamped and provided text that could be read and translated into key events. Using these two sources, we are able to access accurate and detailed descriptions of each participant's progress through treatment and highlight both innovations and barriers to success.

Case Findings

On the following pages, each of the 10 cases are described, including a timeline of key events.

A.K. | *Successful*

AK was an early participant in the Second Chance for Women (SCW) program. She came into the program with diagnoses for bipolar II disorder and amphetamine use disorder. Almost immediately upon being released from jail, her PO and SCW clinician referred and successfully placed her in a stable residential program. However, AK was not only struggling with stabilizing her mental health, but was also facing significant medical issues. She had been diagnosed with cancer and was receiving ongoing chemotherapy and radiation treatment throughout her involvement in SCW.

AK's cancer diagnosis presented unique barriers to her substance abuse and mental health treatment, particularly while in her residential program. AK suffered from several side effects of her cancer treatment that were believed to be impairing her memory and engagement. The rigidity of residential treatment proved to be a challenge for her as she faced disciplinary action for her behavior on several occasions and eventually was removed from residential treatment.

In the midst of these challenges, her SCW clinician provided continuous emotional support not only during their office visits, but also by attending her medical appointments and encouraged her to communicate openly with her doctor.

As the client approached the end of her involvement in the SCW program, she began to disengage more and more. However, the SCW team continued to ensure that her medication and housing needs were being met while also coordinating with medical staff to address their concerns about her cognitive state. The SCW team also observed that she was reacting well to her cancer treatment and had successfully abstained from using methamphetamines as she exited the SCW program.

MONTH 1

- SCW clinician assists client with referral for residential treatment

MONTH 2

- Residential treatment staff report disruptive behavior by client
- Client refuses to engage in services
- Client tests positive for methamphetamine
- SCW clinician notes concerns with client's cognitive state

MONTH 3

- Client continues to struggle with rules at residential treatment facility and is placed on final behavior contract by staff
- SCW clinician continues to request that residential treatment arrange cognitive testing for client

MONTH 4

- SCW staff learn that client had been diagnosed with cancer
- Residential staff note that they are concerned about client's boyfriend's influence on her substance use when he visits

MONTH 5

- Client elopes from residential treatment
- SCW staff attempt to locate medical housing for client and ensure she has enough medications
- Client suffering from severe medical issues due to cancer diagnosis

MONTH 7

- Client reports ongoing sobriety
- Client living with her sister
- Client demonstrates resistance when discussing mental health medication
- SCW clinician continues to recognize cognitive deficits in client

MONTH 8

- Client met frequently with SCW clinician and clinician attended medical appointment with her
- Client responding well to chemotherapy
- Client continues to abstain from methamphetamine

MONTH 9

- Client cancelled a series of SCW appointments and shows signs of disengaging
- Client is evicted from hotel where she is staying and declines shelter bed referral from SCW clinician

MONTH 10

- Client continues to disengage from treatment and cancel appointments
- SCW clinician coordinates with client's primary care physician regarding client's cognitive state and ongoing prescription needs

MONTH 11

- Client placed on abscond status and file prepared for closure

L.T. | *Successful*

LT had been diagnosed with chronic PTSD before joining the SCW program. From the very start of her engagement in the program, the SCW team found very few opportunities to work closely with this client. LT did not have an address or phone, which limited staff's ability to contact her and check-in. Although her SCW clinician attempted to provide her with shelter and housing options, LT often refused them, insisting that she needed options that would accommodate both herself and her adult son. This severely restricted the clinician's options as such resources were not available and often led to the client choosing to be homeless rather than being separated from family.

Despite these barriers, both the client's PO and SCW clinician made attempts to meet with LT in the community. Her PO would search for her near locations where she claimed she was staying, and her clinician would attempt to set up opportunities to meet at more convenient locations for the client. However, the limited contact with LT made it difficult for the SCW team to make significant progress regarding her mental health needs.

Their inability to provide her with consistent medication prevented LT from escaping severe delusional thinking which further exacerbated her lack of contact with the team. Although she increasingly disengaged towards the end of the program, she completed SCW without any new charges.

MONTH 1

- Client is arrested and placed in custody
- Client reports being homeless and sleeping on the streets
- Client is not able to meet with SCW clinician and has no contact info

MONTH 2

- Client only meets with SCW once
- Clinician helps her with housing application
- Clinician continues to struggle contacting her

MONTH 3

- SCW staff are unable to locate client
- Warrant is filed

MONTH 5

- Client arrested for warrant and placed in custody
- SCW clinician completes enrollment paperwork with client in custody

MONTH 6

- Client refuses shelter referrals because they will not accommodate her adult son
- Client misses office visit with PO and cannot be located in community

MONTH 7

- SCW clinician and PO continue to struggle with contacting and locating client

MONTH 8

- Warrant filed
- Client arrested and placed in custody
- Client reports being homeless and presents delusional thinking

MONTH 9

- Client continues to refuse staying at shelters without her son

MONTH 10

- Client arrested
- SCW staff meet with client several times
- Client demonstrates delusional thinking

MONTH 11

- Client fails to report and is arrested on new warrant
- SCW clinician meets with client repeatedly while in custody
- Client begins to disengage from treatment

MONTH 12

- Client continues to not make contact
- Warrant filed

MONTH 13

- Client's file prepared for closure

J.W. | *Unsuccessful*

JW entered the SCW program with schizoaffective disorder, opioid use disorder, and sedative, hypnotic, or anxiolytic use disorder. Upon release from jail, JW continued to struggle with substance use. Additionally, JW suffered from a traumatic assault and was severely beaten shortly after her release. She began coping with the pain by using marijuana and taking extra pain medication beyond the recommended dose.

Within the first few months, JW reported multiple relapses involving the use of heroin. As a result, she was discharged and/or absconded from multiple housing and residential programs over a short span of time. When JW was not in stable housing, the client repeatedly disengaged from the SCW program and both her PO and SCW clinician had difficulty contacting her. Although staff made many attempts to reach out to her, this did not result in many successful check-ins.

Throughout the course of her SCW involvement, the client had multiple occasions of high engagement in treatment that were quickly followed by relapses and/or new criminal charges. Reflecting on this case, it became more evident to the SCW team that JW's greatest struggle was the severity of her criminality and continuous substance use rather than the severity of her mental health disorder. After nearly 2 months without contact, and despite the efforts of the SCW team, JW was discharged from the program.

MONTH 1

- SCW clinician meets with client while she is still in custody and preparing for release
- Client is placed on waiting list for housing

MONTH 2

- SCW clinician meets with client regularly in person and via phone
- Client leaves transitional housing
- Client severely assaulted and hospitalized
- Client reports being in severe pain and relapsing (heroin)

MONTH 3

- Client reports taking higher dose of pain medication than prescribed to manage pain
- Housing staff report client's behavior is problematic and believe she is using and may be discharged

MONTH 4

- Client reports relapsing (heroin)
- Client referred to residential treatment
- Client elopes from residential treatment
- Client reports using heroin daily
- Warrant issued

MONTHS 5-7

- Client has no contact with PO or SCW staff

MONTH 8

- SCW clinician makes phone contact once with client
- Client reports having used crack cocaine

MONTHS 9-10

- Client has no contact with PO or SCW staff

MONTH 11

- Client arrested on warrant and placed in custody
- Clinician meets with client repeatedly in custody and client begins to attend more appointments
- Client reports staying sober

MONTH 12

- Client reports relapsing again
- Client reports not having her mental health medication and feeling depressed

MONTH 13

- Client reports not taking mental health medications
- Client reports she is dosing at addiction treatment facility
- Client arrested on new drug possession charge and placed in custody

MONTH 14

- Client reports she is still not taking mental health medications
- SCW staff and PO unable to contact client

MONTHS 15-17

- Client has no contact with PO or SCW staff
- Warrant issued
- Client is discharged from SCW

R.R. | *Unsuccessful*

Prior to the SCW program, RR had been diagnosed with PTSD and cyclothymia and had a history of marijuana and methamphetamine use. Additionally, RR had a long history of involvement in the criminal justice system and an elevated level of criminality. Subsequently, RR struggled to stay in residential treatment due to her behavior, despite SCW staff and residential staff acknowledging she had the capacity to complete the program.

She presented to SCW staff as someone who knew how to manipulate others and the system. The SCW team were made aware that RR had a network of substance using peers that were easily accessible to her and noted that RR repeatedly made attempts to minimize her negative actions.

Shortly after eloping from residential treatment, she was found attempting to buy methamphetamine. Following her arrest and brief stay in jail, RR was placed on GPS as a sanction for her behavior. However, even with GPS monitoring, she continued to disregard her conditions of supervision and repeatedly missed curfews, traveled to locations that were prohibited, continued to use methamphetamines, and eventually disengaged entirely from the SCW team. After an extended period of time without contact, the SCW team closed her case with plans to revoke RR if arrested.

MONTH 1

- SCW clinician checks in regularly with client while she is still in custody
- Clinician assists client with completing housing applications

MONTH 2

- Client enters residential treatment
- Residential treatment staff report client is doing well and following rules

MONTH 3

- Client has incident at residential treatment and gets into verbal argument with staff

MONTH 4

- Residential staff report client is behaving well
- Client is staying sober

MONTH 5

- Client elopes from residential treatment while out on a pass
- Client allowed to return but is sanctioned
- Residential treatment staff concerned about client's network of substance using friends

MONTH 6

- Client is struggling with behavior in residential treatment and attacking other residents
- Client elopes from treatment
- Client arrested for attempting to buy methamphetamine
- Client is arrested and placed in custody

MONTH 7

- Client placed on GPS monitoring following recent arrest
- Client violates GPS conditions and leaves state
- Client admits to using methamphetamine

MONTH 8

- Client arrested on probation violations (leaving state, failing to report, using controlled substances) and placed in custody

MONTH 9

- Client fails to report to PO and SCW staff upon release
- Warrant issued

MONTH 10

- File is closed and client to be revoked

S.H. | *Unsuccessful*

SH entered the SCW program with schizophrenia and psychotic disorder diagnoses, as well as a history of methamphetamine use. Very early in her participation in SCW, SH struggled with continued substance use and tested positive for THC, amphetamine, and opiates.

Staff successfully placed her in residential treatment shortly after beginning the program; however, SH demonstrated significant mental health concerns and absconded from the facility within days of entering residential. These increases in symptomatic patterns may have been exacerbated by the 4-week delay between the client's entry into residential and her appointment to meet with a residential prescriber to discuss medication needs.

During this time, the client repeatedly fixated on the delusion that her children were experiencing abuse. SH also reported to her clinician that she had stopped taking her antipsychotic medications and repeatedly engaged in new criminal offenses during her participation in SCW, ultimately leading to her incarceration after only 3 months in the program.

Although SH maintained contact frequently with her PO during her time in the community, there were multiple occasions where the client did not show for her appointments with the SCW clinician. Thus the level of service the clinician could provide was limited prior to the client being placed in jail. While incarcerated, the SCW clinician used this time as an opportunity to meet regularly with SH and establish rapport. However, after nearly 4 months in custody, the client's new charges led to a new prison sentence and the client's case was closed.

MONTH 1

- Client enters residential treatment
- Client not able to see prescriber to get mental health medications and demonstrates significant mental health issues
- Client tests positive for THC, Amphetamine, and Opiates, and later absconds from treatment

MONTH 2

- Client is arrested for criminal trespassing and theft and is placed in custody

MONTH 3

- Client enters another residential treatment facility and leaves days later
- Client enters hospital for stimulant abuse
- PO attempts to assist with housing needs, but client refuses to stay in shelter

MONTH 4

- Client arrested on new charges and placed in custody

MONTH 5

- SCW clinician meets repeatedly with client while she remains in custody
- Clinician refers client to additional residential treatment facilities in preparation for her release

MONTH 6

- Client remains in custody and clinician continues to check-in

MONTH 7

- Client sentenced to 18 months prison for new charges and file is closed

B.V. | *Unsuccessful*

Prior to SCW, BV had been diagnosed with PTSD, bipolar disorder, and depression. Early on in her participation, BV and her boyfriend (also in recovery) requested permission to live together. The SCW team were cautious about this arrangement and took steps to support the client's recovery prior to approving the request (i.e., initially placing her in stable housing after her release).

BV showed strong motivation and determination early on in the program. She was actively seeking employment, engaging in support groups, and following the rules of her housing facility. However, following the client's transition to living with her boyfriend, BV demonstrated disruptive changes in behavior and progress. She maintained contact for some time with the SCW team, but reported ongoing issues between her boyfriend and housing manager.

During this time, BV reported that her boyfriend had been abusive and was using methamphetamines again, admitted to relapsing with her boyfriend, reported that she had stopped taking her antipsychotic medications, and that she was experiencing increased anxiety due to the possibility of losing her housing.

BV would demonstrate periods of stability and sobriety in the absence of her boyfriend; however, contact with him (despite a no contact order) often led to further abuse, periods of relapse, and decreased engagement with the SCW team. Eventually, BV was arrested and placed in custody again, but given another opportunity upon her release. However, BV chose instead to abscond and was eventually discharged from the SCW program.

MONTH 1

- SCW clinician meets with client repeatedly while she is still in custody
- Clinician sets up housing for client upon release

MONTH 2

- Client continues to follow rules and demonstrate good behavior at her housing location
- Client is approved to live with boyfriend
- Client reports stopping her mental health medication

MONTH 3

- Client continues to report not using her medication
- Client misses several SCW appointments
- Client reports frustration with housing manager

MONTH 4

- Client reports ongoing issues with housing manager
- Client finds employment and starts working

MONTH 5

- Client's boyfriend is removed from the house by housing manager
- Client reports she will be losing her housing and job
- Client reports she and her boyfriend relapsed
- Client is victim of domestic violence

MONTH 6

- Client under no contact order with boyfriend
- Client enters new housing program
- Client reports medication compliance and sobriety

MONTH 7

- Client violates no contact order with boyfriend
- Client stops reporting to housing program

MONTH 8

- Client is removed from housing program
- Client admits to using methamphetamine with her boyfriend

MONTH 9

- Client enters residential treatment but elopes days later
- Client is reported to be staying with her boyfriend
- Warrant issued

MONTHS 10-11

- Client has no contact with PO or SCW staff

MONTH 12

- Client arrested and placed in custody
- Client referred to housing program upon release
- Client absconds from treatment
- Warrant submitted

MONTHS 13-14

- Client has no contact with PO or SCW staff
- Client is discharged from SCW

M.P. | *Unsuccessful*

Prior to the SCW program, MP had been diagnosed with PTSD, borderline personality disorder, and opioid abuse. MP came into the program under unique circumstances. From the very start, MP expressed to SCW staff that her only interest in participating in treatment was to increase her chances of regaining custody of her children. She admitted to the SCW team that she did not feel she needed treatment or counseling and often refused to meet with the SCW clinician.

In order to be closer to her children, MP decided to live nearly 30 miles away from the SCW office location. This presented additional barriers to the SCW clinician meeting her in the community and prevented the clinician from providing her with shelter options when she reported being homeless. MP also continued to struggle with substance use while in the SCW program, which placed further limitations on housing options (i.e., several housing referrals required evidence of sobriety). Eventually, MP was arrested and discharged from the program.

MONTH 1

- Client misses several appointments with both her PO and SCW clinician
- Client demonstrates little interest in the program

MONTH 2

- Client misses nearly every appointment with both her PO and clinician
- Client refuses to quit marijuana despite subsequent limitations for housing

MONTH 3

- Client arrested and jailed in neighboring county
- Client continues to be homeless

MONTH 4

- Client arrested on Failure to Appear warrant and placed in custody
- Client continues to struggle attending appointments with clinician

MONTH 5

- Client continues to struggle with reporting to PO and clinician due to location and lack of transportation
- Client revoked her consent to participate in program

MONTH 6

- Client discharged from program

N.T. | *Successful*

NT had been diagnosed with major depressive disorder and had a history of methamphetamine use prior to entering the SCW program. Almost immediately, NT presented the SCW team with challenges regarding housing referrals. She had a history of being discharged from multiple locations which required staff to fight relentlessly to demonstrate NT's stability in order for her to be reinstated. This ongoing barrier made it difficult to find opportunities to help stabilize NT enough to support her other needs (e.g., sobriety).

Additionally, NT was faced with many legal issues while in treatment and was incarcerated repeatedly for new offenses. As a result, her frequent incarcerations became periods of stabilization. SCW staff used these moments as an opportunity to connect and build rapport with her and encourage NT to want to engage more frequently with her clinician. Although the SCW team noted these circumstances and the setting were not ideal, they took full advantage of coordinating with jail staff to ensure she was compliant with her medications. Once NT was actively taking her medications, both the SCW clinician and PO saw remarkable behavioral changes.

NT's mental health symptoms diminished and she was able to recognize how her substance use and past behaviors impacted those closest to her. As she approached the end of her participation in the SCW program, NT began to learn and practice social skills to avoid risky situations related to her substance use and demonstrated increased motivation to stay sober.

MONTH 1

- SCW clinician meets with client regularly to build rapport while client is still in custody

MONTH 2

- Client is positive for methamphetamine use and is removed from housing by staff
- Client violates no contact order with ex-husband

MONTH 3

- Clinician notes increases in MH symptoms
- Client admits to recent methamphetamine use

MONTH 4

- Client arrested on new charges and placed in custody
- Clinician meets regularly with client while in custody

MONTH 5

- Client arrested again on new charges and placed in custody
- Client shows signs of ongoing mental health symptoms
- Clinician sets up referral to residential treatment

MONTH 6

- Client remains in custody and clinician checks in frequently

MONTH 7

- Client remains in custody and clinician checks in frequently
- Clinician establishes communication with corrections staff to closely monitor medication compliance

MONTH 8

- Client is placed in residential treatment but shows immediate signs of problematic behavior
- Client is discharged from residential treatment and arrested
- Client is placed in custody

MONTH 9

- Client confirms she is taking her medication and shows decreases in MH symptoms

MONTH 10

- Client is still in custody and clinician checks in with her frequently
- Clinician fights to get client accepted into another residential treatment facility

MONTH 11

- Client enters residential treatment but absconds shortly after
- Warrant is issued
- Client arrested and placed in custody
- Client admits she stopped taking medication

MONTH 12

- Client released from custody and placed in residential treatment

MONTHS 13-14

- Client continues to stay at residential treatment
- Client is accepted into new housing program

(continues on next page)

N.T. | *Successful* *(cont.)*

MONTH 15

- Client reports she is not taking medications
- Client admits to methamphetamine use
- Client is evicted from housing
- Client is arrested and placed in custody

MONTHS 16-17

- Client still in custody and clinician meets with her regularly
- Clinician struggles to find suitable housing where client will be accepted back

MONTH 18

- Client is released from custody
- Clinician able to maintain frequent contact with client
- Client begins dosing at addiction treatment facility and reports ongoing sobriety

MONTH 19

- Client continues to remain sober
- Clinician is able to teach client skills for avoiding relapse

MONTH 20

- Clinician makes arrangements for client's ongoing medication needs and continues to meet with her regularly
- Client continues to stay sober
- Client completes supervision and file is closed

D.E. | *Successful*

DE came into the SCW program with a schizoaffective disorder diagnosis. Early on in her participation, DE struggled with medication compliance and was considered to be one of the highest acuity cases involved in SCW treatment. As a result, she experienced frequent mental health symptoms during her time in the program (e.g., hallucinations, depression, delusional thinking).

DE also struggled to maintain contact with SCW staff and violated her no contact order with her family in the early stages of treatment. Due to her severe symptomatic patterns, the SCW team determined that the best option for stabilization was temporary hospitalization. SCW staff coordinated with DE's social worker and hospital staff to determine next steps upon her release; however, DE's symptoms escalated despite her medication compliance.

The SCW clinician recognized the severity of DE's circumstances and the limited housing options that would be suitable for the client.The clinician emphasized to others treating DE that she needed supportive housing that could better monitor her medication needs. Eventually, the SCW team determined that transferring her to long-term care within a secure residential treatment facility was the most appropriate level of care given her circumstances and her SCW file was closed.

MONTH 1

- Client is placed in housing program
- Client denies mental health issues and refuses to comply with medications

MONTH 2

- Client continues to not take medications
- Client demonstrates increase in mental health symptoms
- Client placed on mental health hold and hospitalized
- Client violates no contact order with family, is arrested, and placed in custody

MONTH 3

- Client remains in custody and refuses to see SCW clinician
- Client demonstrates ongoing mental health symptoms and instability

MONTH 4

- Client still symptomatic
- SCW staff determine hospitalization was necessary to stabilize client

MONTH 5

- Client remains hospitalized and shows limited progress with mental health symptoms
- Clinician continues to meet with client at hospital

MONTHS 6-7

- Client remains hospitalized
- Client's mental health symptoms continue to escalate

MONTH 8

- Client remains hospitalized
- Client begins to make some improvements with medication changes

MONTH 9

- Client transferred to secure residential treatment facility in another city for ongoing care

V.Y. | *Successful*

Prior to SCW treatment, VY had been diagnosed with chronic psychotic disorder, schizophrenia, and delusional disorder. VY demonstrated at an early stage that she was resourceful and had the ability to independently meet several of her own needs. She was able to navigate housing and shelter options on her own, as well as locate and attend support groups.

However, the SCW team did struggle to establish consistent, in-person meetings with her and often resorted to phone calls, which limited staffs' capacity to obtain a complete overview of her progress. VY also struggled with a lack of insight into her own mental health and developed paranoid delusions regarding her medications and their side effects. Subsequently, much of her criminal behavior appeared to stem from her mental health, and her lack of medication compliance led to aggressive behaviors that often resulted in removal from housing.

Despite some continued symptoms, the SCW clinician noted improvements and increased stability closer to the client's treatment completion. VY was demonstrating progress through her continued attendance in support groups, continuing to stay in a shelter, and avoiding further criminal behavior.

MONTH 1

- Client refuses medication and shows increased signs of mental health symptoms
- Client demonstrates disruptive behavior at shelter
- Client resistant to meeting with clinician in person

MONTH 2

- Client still shows reluctance to take antipsychotic medication
- Client is evicted from shelter for assaulting staff and locates a new shelter on her own

MONTH 3

- Client still resistant to taking her antipsychotic
- Client demonstrates delusional thinking

MONTH 4

- Client meets more frequently with clinician in person
- Client still demonstrating mental health symptoms

MONTH 5

- Clinician continues to check-in regularly with client
- Client continues to find shelter options on her own
- Client continues to have elevated mental health symptoms

MONTH 6-7

- Client demonstrates increased stability
- Client reports receiving additional services in the community and attends groups
- Client's file is closed

Strengths & Limitations

The case review data provided a rich source of information to supplement the outcome explanation. Although several quantitative findings were non-significant, the qualitative analysis was able to fill these gaps by revealing the individual barriers to treatment success. The level of detail comprised within the case management system and clinical case files provided the report with a clear outline of significant events and illustrated themes that would not have been identifiable from quantitative analyses alone.

However, the qualitative review did present some limitations. In particular, we were limited to only information that was documented by treatment and supervision staff. If information was not recorded accurately or not shared with the research team, we were not able to report it. Therefore, there was some risk for missing events if they were not identified in either source. Additionally, our documentation of the participants was limited to their time in treatment. Therefore, we could not account for major events that may have preceded involvement in the program and subsequently impacted success.

Finally, these findings cannot be easily extended to a wider population not only due to sample size, but also due to the very nature of our qualitative approach and the unique attributes of the study participants. Therefore, we cannot say with certainty that our qualitative conclusions will apply to other similarly situated agencies and participants.

Discussion of Case Reviews

Although every story was unique, the case reviews as a whole did present broader themes regarding program success. First, it became clear that the term “success” did not fit the standard definition used with most criminal justice populations. Although future criminal involvement was a factor that was considered when determining successful completion, it was not the only criteria, and we found that multiple participants could have very different success stories. For instance, one person’s success may involve a referral to a state hospital for a higher level of mental health treatment whereas another’s success may be defined by their ability to avoid further relapse and to maintain compliance with medications until the end of their supervision. As such, the notion of redefining success for this unique population of offenders emerged.

Additionally, it became evident that time was a crucial factor for many cases. Although the objectives of the program were to provide referrals to housing, education, and employment, it became clear that mental health stability was a priority for the clinicians. Staff focused their efforts on finding adequate housing to help encourage and support sobriety, as well as maintaining medication compliance to reduce symptoms. Subsequently, clinicians often only had enough time with participants to achieve this level of progress and for some, this was the biggest achievement that could be obtained. Education and employment referrals were seen as future goals that could be met at a later stage if there was sufficient time.

Another unexpected theme that emerged was the apparent benefits of jail during treatment. Although the circumstances were not ideal, periods of incarceration actually acted as a form of stabilization for clients. It provided clinicians with an opportunity to meet more regularly with clients, especially if they were prone to miss or cancel their appointments. This allowed the clinicians to build stronger rapport and make necessary referrals. Additionally, jail provided an opportunity for participants to refrain from substance abuse and establish a period of sobriety. Lastly, it allowed corrections staff to more closely monitor medication compliance and evaluate mental health symptoms. While unexpected, this finding presents a larger question about how this same level of stability can be accomplished in the community and whether there is a need for housing options to provide more flexibility for clients to obtain sobriety while housed within the facility. The following comments made by project team members highlight the benefits of jail during treatment.

> *The only thing I can tell you is four months in jail did wonders.*

> *The first thing that stands out to me when I'm looking at this is most of the good contact is happening when she was actually incarcerated.*

> *While she was in jail, it sort of opened up some more opportunities to either refer her, or to also get her to be more sober. Which, obviously we don't want to see her incarcerated for long periods of time, however there was sort of an assistance there with getting her sober, but also making sure to better track her medication.*

CONCLUSION

In consideration of all of the evaluation activities undertaken in this grant, several recurring themes have emerged from our study. These lessons learned are offered to the community of Second Chance grantees as well as other probation, parole, or pre-trial supervision agencies struggling to effectively serve high-risk women with co-occurring mental health and substance abuse disorders.

Counseling is not enough

Based on the outcomes observed between the treatment and control groups, the provision of clinical counseling is not, by itself, enough to create long-lasting stability for women with co-occurring disorders and complex care needs. This resource needs to be part of a larger intervention and stabilization plan.

Create a community-based setting that offers the observed benefits of jail

Practitioners and participants in this program experienced unintended benefits from jail bookings of a certain length. This was made possible, in part, by the practitioners continuing to engage with the women behind bars. Some jail sentences allowed enough time for participant detox, medication access and stabilization, case planning, safety planning, and other beneficial activities. While all agreed that jail was not the ideal setting for these therapeutic activities, none were aware of an equivalent option in the community.

Promote medication access and medication monitoring

Unaddressed or poorly managed mental health symptoms often derailed participant progress and created barriers to an effective therapeutic alliance. Similarly, more medication assisted options were also needed to address the physical symptoms associated with drug and alcohol addiction.

Encourage the co-location of mental health and probation/parole services

This was another area where both the practitioners and the clients experienced benefits. For the women in the program, on-site mental health services removed transportation and other accessibility barriers to counseling. For the practitioners, co-location of services lent itself to improved communication and coordination between clinicians and the probation/parole officers. Through this coordination, resources that were once only known to clinicians or to probation officers should be shared for the purposes of coordinated case planning and intervention.

Invest in more low barrier, community-based housing

Based on recurring themes arising in the qualitative data, a lack of available, low barrier housing created routine challenges in locating and engaging with these women. Many of the women in the program had been disruptive and subsequently banned from the few housing services in the community. Housing challenges kept preempting the participant from making sustainable forward progress towards a healthy, safe, and stable life.

Re-imagine short-term success and find ways to measure it

An emphasis on the long-term goals of traditional recidivism reductions diverts attention and resources from monitoring the more immediate goals of stability and sobriety. Front-end work to define “stability” and related indicators of success would help create shared expectations across practitioners and promote more monitoring and accountability to those goals.

Future studies with this population could help further refine and develop these conclusions. There are several emerging trends from the qualitative data that would benefit from a more sophisticated quantitative analysis if larger sample sizes were available. The complexity of these cases continues to raise questions about how agencies can be most effective with limited resources before probation/parole sentences end.

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