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SECOND CHANCE *for* WOMEN

A report on the insights of key informant interviews with the staff involved in the Second Chance for Women Intensive Services Study, completed by the Multnomah County Department of Community Justice Research and Planning Unit.

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SUMMARY

This report is a result of the analysis of eleven key informant interviews conducted in July and August of 2016. Participants were offered anonymity and included members of the Multnomah County Department of Community Justice and its partnering mental health institution, Cascadia Behavioral Healthcare. Field practitioners, service providers, administrative, and management staff are all represented in the following report. The interviews were designed to gauge the following issues: gaps and deficits in existing service protocols and processes, solutions and strategies for implementing the proposed solutions, and gauge strategies for sustaining these solutions for the long term. Overall, the interviews were remarkably consistent in what was discussed, and what issues participants felt were important.

In general, those interviewed believed that the program design, as supported by the grant, was addressing a serious gap in the treatment of women who find themselves on parole or probation with a co-occurring mental health disorder and substance abuse. The intensive case management for the client and the close cooperation of staff was seen as both needed and consistent with evidence-based practice.

They also agreed that this case management model had been somewhat hindered by the special process of obtaining consent from clients, as required for research. Consenting clients often delayed the onset of intensive case management, and the quick initiation of this process was considered a key part of this model. In response, the team was already taking steps to streamline the consenting process for clients entering the program. This problem will be limited to the duration of the grant, as any continuing program will not be under research ethics protocols and clients can simply be assigned directly to the unit.

An anticipated problem for all staff was the availability of needed resources in the community. This unit, and the grant, does not directly provide housing, jobs, or education. All of these things are ultimately required for a successful stabilization of women with co-occurring disorders. If these resources do not exist in the community, whether from general accessibility or through non-profit providers, then the positive impact of the intensive case management model will likely be mitigated.

The following is a breakdown of the themes to come out of the interviews, accompanied by representative quotations from the key informants.

EARLY SUCCESS

> ***[We're] building a system where everybody's talking, everybody's communicating, and everybody's working together on a routine and frequent basis. These are not people that you can check in once a month on. The communication, and the networking, and the response time needs to be immediate and quick as we move through this.***

At the point of early implementation, staff across all agencies and job descriptions had fully bought in to the purpose and design of new program being implemented.

Participants were philosophically aligned with the purpose and goals of the Second Chance Women's Co-occurring Disorder Grant. They strongly felt the new model being implemented was theoretically sound and should lead to good outcomes for their clients. In particular, they were excited for:

Intensive care coordination

Dedicated program staff

They believed that this model, done well, could and should **increase treatment compliance, and increase client access to needed services.**

> ***I think engagement over time is going to be higher, so I think we're going to see less drop offs. …people have a tendency to kind of engage for the first 30 days and then they're off and running again. And so I think that we'll have longer engagement periods. I think we're definitely going to see less judicial interventions, so less sanctions, less jail time, less days in jail.***

> ***I think what we have to offer and how we're offering it is brand new and not something that's out there currently. So I think that it's pretty unique, which will be good. It's something that's not out there, it's not available a lot, and it's missing.***

EARLY BARRIERS TO GRANT

Consenting Participants

One process was unexpectedly difficult, and caused significant delays in fully implementing the new care program.

All clients were required by internal review board ethics standards to be fully briefed and provide formal consent as a condition of their participation. This consenting process occurred, wherever possible, at their first meeting with their dedicated PPO. Due to the severity of the illness and substance dependency experienced by these clients, this form of consent was difficult and time consuming.

Fortunately, this problem is limited to the grant, due to the restrictions of a formal research process. If the care model is permanently expanded, clients will be normally assigned directly to the unit and will not have to be maneuvered through a consent process.

> ***Typically, because the client's maybe not showing up for a couple weeks to see their PO, and then maybe it gets looked over so then we're looking at another couple weeks. So really that lag time has been our biggest barrier. And we're kind of working to shorten that but I'm not quite sure that we'll ever have-- my idea would be like, let's get them in, going, go. I don't know that we'll ever quite get there.***

> ***Some POs are choosing not to talk to folks about the program until after we find out if they've been assigned to the treatment or control group. Because they don't feel like sending a client up to me, we get excited or get their hopes up, and then have them not to go into the treatment group would be helpful either. So they've been waiting for assignment before they've been having them sign the consent, which I don't disagree with.***

POTENTIAL BARRIERS TO LONG-TERM PROGRAM SUCCESS

Housing, Education, & Work

All key informants were concerned about the availability of third-party welfare services to their clients.

All staff recognized the importance of overall lifestyle stabilization in maintaining clients' mental health and sobriety. This includes access to stable housing as well as work and education opportunities. However, the scw workgroup was unable to provide these things directly, which left them to rely on resources which occur in the community.

Housing was the most immediate concern for most clients. While portland has some transitional housing for those who are trying to break their dependence on substances, they are limited. Often the populations served by the scw have a difficult time being placed in this type of housing due to their co-occurring mental illness. This often means that these clients lack consistent shelter which hinders their treatment and recovery.

Additionally, the ability to fend for themselves long-term meant that clients require access to paid work and training. Both are difficult to obtain for this population for the same reasons stated above.

The scw grant provides intensive care coordination, but many of their clients' critical needs come from outside of what this unit can provide directly. This may impact the overall success of the program and others like it unless more community resources become available to this population.

> ***I think it's always going to be about community resources. …we can only offer so much. But if a lot of the client's success depends on having social supports in the community, having educational and occupational opportunities, housing of course is always going to be a big factor. So those are just kind of things that regardless of how much we can do as a program, if they don't have these other things in place, we're kind of-- it's almost like it's working against us to some extent.***

> ***The services. The same thing I was talking about. I think in the last - about a year - there was a transition center that opened up for mentally ill clients, and we all went to their open house. And the last time I talked to [a manager] about it, they started saying, "Well--" and it was a dormitory type setting. So for staff in those kinds of situations, if you're bringing somebody in that's delusional, criminal, under the influence, any of those things, they're difficult to manage around other people. And so he was telling me that they're starting to say, "Well, we can't take this person, this person, this person." And those are the people the POs are needing to get some help, and get some additional stabilization. And so I think that's been the biggest problem for a long time and it's an ongoing project that people are working on.***

CONCLUSIONS

When asked about what they anticipated as the major impact of the new program, the informing staff all cited that they hoped to see less recidivism and some progress made in finding stable housing and possibly employment.

> ***Ultimately, our goal is to reduce recidivism and increase stability - mental and emotional stability. So, I think we won't see those areas impacted too greatly for awhile, maybe because that there's the delay…. But my hope is that clients will have fewer arrests, fewer hospitalizations or ER visits, and that they'll have more stability in the community.***

At the end of the study period, a series of case studies will be held with these same staff members to see whether this is the case. These case studies will choose cases from a range of outcomes, and examined qualitatively to find patterns of success and barriers that can in turn be used to improve this program in the future.