

# ***The John Eachon Re-entry Program (JERP)***

## ***Process Evaluation***

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Despite this important assistance, the responsibility for any errors resides with the authors.

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## SECTION ONE: *INTRODUCTION*

### *Background/History*

In Colorado and across the nation, the number of incarcerated offenders who suffer from mental illness is on the rise. In 1998, the Colorado Department of Corrections (DOC) reported that 10 percent of the correctional population had serious mental illness (SMI), five to six times higher than the number documented in 1988.<sup>1</sup> That number grew to 24 percent both in Colorado prisons by 2006<sup>2</sup> and in state-run facilities across the United States, according to the Bureau of Justice Statistics.<sup>3</sup>

Likewise, the number of mentally ill persons in county jails in Colorado has increased dramatically in recent years. One metro area jail reported an increase from 16 percent to 31 percent seriously mentally ill inmates within a three-year period. Correspondingly, a recent report indicates that 40 percent of current jail inmates throughout Colorado have some type of mental disorder.<sup>4</sup> Although there are no standardized measurements of mental illness among jail inmates, every jail in the Front Range corridor has reported significant increases.

This population poses significant challenges not only during incarceration, but also after release, the point commonly known as “re-entry”.

**Re-entry into the Community.** Re-entry is the process of transition that individuals make from prison or jail to the community.<sup>5</sup> Commensurate with the burgeoning prison population on a national level, corrections costs have gone from \$9 billion in 1982 to \$60 billion in 2002.<sup>6</sup> These increased expenditures have not resulted in a reduction in recidivism. Approximately two of every three people released from prison in the U.S. are re-arrested within three years of their release.<sup>7</sup> Fifty-two percent return to prison for a new offense or a violation of their terms of release; 26 percent were returned for a technical violation alone.<sup>8</sup> In fact,

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<sup>1</sup> See *Offenders With Serious Mental Illness: A Multi-Agency Task Group Report to the Colorado Legislative Joint Budget Committee* (CDOC, 1998).

<sup>2</sup> Schnell, M. and O’Keefe Leipold, M. (2006). *Offenders with mental illness in Colorado*. Colorado Department of Corrections, Office of Planning and Analysis.

<sup>3</sup> James, D. J., and Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

<sup>4</sup> Metro Area County Commissioners (Katy Human. Triage centers planned for mental-health care. *Denver Post*, April 20, 2008, 16A.)

<sup>5</sup> Thomas P. Bonczar and Lauren E. Glaze, *Probation and Parole in the United States, 1998*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 1999), NCJ 178234.

<sup>6</sup> Lynn Bauer, *Justice Expenditure and Employment in the United States*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 2002).

<sup>7</sup> Patrick A. Langan and David J. Levin, *Recidivism of Prisoners Released in 1994*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 2002), NCJ 193427.

<sup>8</sup> Petersilia, J., (2007). *Employ behavioral contracting for “earned discharge” parole*. *Criminology & Public Policy* 6 (4), 807–814.

the fastest growing category of admissions is violations of release—in other words, people who were already under supervision of the criminal justice system when returned to prison or jail.<sup>9,10</sup> and Beck estimated that 42 percent of the total growth in state prison admissions from 1980 through 1999 were due to parolees violating their supervision conditions.<sup>11</sup> These figures correspond with the Colorado experience in which 47 percent of released inmates were returned to prison within three years as reported in the Schnell and O’Keefe Liepold (2006) study of DOC offenders.

**Re-entry and Mental Illness.** The Colorado Department of Corrections reports that offenders with mental illness (OMIs) face monumental re-entry challenges such as scarce transitional placements or aftercare plans, lack of employment, homelessness, co-occurring substance abuse problems, and difficulties obtaining psychotropic medication.<sup>12</sup> According to Osher, Steadman and Barr (2003) in their study on best practice approach to community reentry for inmates with co-occurring disorders, while OMIs need more assistance to meet their myriad needs as they attempt to re-enter society, discharge planning is one of the least frequently provided services for this population.<sup>13</sup>

The many issues facing offenders with mental illness are often further confounded by the fact that a majority of them also suffer from substance abuse problems. In 1991, Abram and Teplin studied jail inmates with mental illness and found that 72 percent had a substance abuse disorder as well.<sup>14</sup> In their 2006 paper, James and Glaze reported that 76 percent of jail and 74 percent of state inmates showed substance dependence.<sup>15</sup>

In Colorado, these dually-diagnosed offenders have a further reduced chance of acceptance into parole or community corrections programs due to their perceived risk to society. Schnell and O’Keefe Liepold, researchers at the Colorado DOC, report the following:

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<sup>9</sup> Paige M. Harrison and Allen J. Beck, *Prisoners in 2003*, US Department of Justice, Bureau of Justice Statistics (Washington, DC: 2004), NCJ 205335.

<sup>10</sup> Alfred Blumstein and Allen J. Beck, “Population Growth in US Prisons 1980–1996,” *Crime and Justice* 26 (2000): 17–62, cited in Jeremy Travis, Amy L. Solomon, and Michelle Waul, *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry* (Washington, DC: The Urban Institute, June 2001).

<sup>11</sup> Alfred Blumstein and Allen J. Beck, “Population Growth in US Prisons 1980–1996,” *Crime and Justice* 26 (2000): 17–62, cited in Michael Tonry and Joan Petersilia (eds.), *Prisons: A Review of Research*. Chicago, Ill.: University of Chicago Press.

<sup>12</sup> Schnell, M. and O’Keefe Liepold, M. (2006). *Offenders with mental illness in Colorado*. Colorado Department of Corrections, Office of Planning and Analysis.

<sup>13</sup> Osher, F., Steadman, H. J., and Barr, H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The APIC model. *Crime and Delinquency*, 49, 79-96.

<sup>14</sup> Abram, K. M., and Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees. *American Psychologist*, 46, 1036-1045.

<sup>15</sup> James, D. J., and Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

- Twenty-eight percent of OMI's were placed in community corrections during their incarceration compared to 36 percent of inmates without mental illness.
- Offenders with mental illness were granted discretionary parole 14-16 percent of the time, compared to 21 percent for offenders without mental illness.
- Twenty-four percent of offenders with serious mental illness completed their sentence while in prison as opposed to 18 percent of offenders without mental illness.
- OMIs serve approximately four months longer sentences, on average, than offenders without mental illness.<sup>16</sup>

Additionally, while 25 percent of the population has a mental illness in the Schnell and O'Keefe Liepold study, these offenders committed 34 percent of the total disciplinary violations in prisons. This directly relates to the OMI's inability to navigate the harsh environment of a prison setting. However, decision-makers weigh institutional behavior heavily when contemplating the release of an inmate and acceptance into community corrections.

Because of the limited resources within correctional systems to provide the high-level services to meet the needs of OMIs, these offenders are often ill equipped to successfully transition from prison to the community where they must navigate their lives for the long-term. Without assistance and specialized treatment, the probability is high that many of these offenders will eventually return to the criminal justice system.

**Governmental Response.** The issues surrounding the influx of persons with mental illness into the justice system and have garnered a great deal of attention both locally and nationally over the past several years. This phenomenon can be seen as one of the long-term consequences of the deinstitutionalization of the mentally ill in the late 1970s.<sup>17</sup> At the request of the Joint Budget Committee, the Colorado DOC studied the increase of those with mental illness entering the justice system and concluded in a 1999 report that agency collaboration and treatment for individuals with mental illness prior to incarceration were needed.<sup>18</sup> These findings, along with the trends noted above regarding the increasing rates of the SMI in the justice system, led the Colorado General Assembly in 1999 to pass House Joint Resolution 99-1042 (1999),<sup>19</sup> creating the six-member Colorado Legislative Interim Committee on the Study of the Treatment of Persons with Mental Illness in the Criminal Justice System to examine the issues

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<sup>16</sup> Schnell, M. and O'Keefe Liepold, M. (2006). *Offenders with mental illness in Colorado*. Colorado Department of Corrections, Office of Planning and Analysis.

<sup>17</sup> Bassuk, E. L. & Gerson, S. (1978). Deinstitutionalization and mental health services. *Scientific American*, 238 (2), 46-53.]

<sup>18</sup> Offender Programs Report. *Offenders with serious mental illness: a multi-agency task force report to the Colorado Legislature*. Civic Research Institute, Inc. Kingston, NJ. September/October 1999.

<sup>19</sup> C.R.S. 18-1.9-101-107, Continuing Examination of the Treatment of Persons with Mental Illness Who are Involved in the Justice System (2005).

associated with people with mental illness and dual diagnoses entering the Colorado justice system.

This Legislative Interim Committee designated the 29-member advisory Task Force for the Examination of the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System (MICJS, later renamed the advisory Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness Who are Involved in the Justice System —MIJS), comprised of experts representing the spectrum of state and local mental health and criminal justice agencies. Specifically, the Task Force was charged with examining the management of this group, identifying solutions, and recommending legislation to address the rising problem.<sup>20</sup> The MIJS Task Force began meeting regularly in the summer of 1999, identifying several primary issues facing both the mental health and criminal justice systems. This evaluation report reflects a program designed to address a primary issue identified by the Task Force: the lack of services and programming for offenders with mental illness and dual diagnoses re-entering the community from prison.

### ***The Purpose and Background of JERP***

A subcommittee of MIJS Task Force members, comprised of representatives from the Department of Corrections, Division of Criminal Justice, Colorado Sheriff's Association, and Jefferson Center for Mental Health, was formed to address the issue of offenders with mental illness re-entering the community. This group quickly identified the need for development of a strong collaborative program to address re-entry issues. Based on the research literature and their years of experience, the group concluded that core program elements such as housing, treatment for both mental illness and substance abuse, specialized case management, and intensive parole supervision would be crucial to address the needs of this population.

One of the subcommittee members, the executive director of the mental health center serving Jefferson, Gilpin, and Clear Creek Counties (Jefferson Center for Mental Health-JCMH), also chaired a local group examining similar issues from a county perspective.<sup>21</sup> Consequently, the subcommittee identified and approached key stakeholders to determine the feasibility of implementing the collaborative project in Jefferson County.

Through her dual role with these two entities, the executive director was in an ideal position to elicit the participation of Jefferson County's community corrections program, Intervention Community Corrections Services, and the Division of Justice Services in Jefferson County, to create the Jefferson County Integrated Parole Treatment Demonstration Project, later renamed the John

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<sup>20</sup> Ibid.

<sup>21</sup> The Criminal Justice/Mental Health Subcommittee of the Jefferson County Criminal Justice Strategic Planning Committee.



Eachon Re-Entry Project (JERP). (See appendix A for diagram of participating agencies.) A working group comprised of key agency representatives, entitled the Oversight Committee, began working on program design and implementation.

**Program Goal.** As the Oversight Committee continued to identify necessary program components and practices, the Task Force subcommittee members sought funding. Ultimately, the project obtained funding from the Bureau of Justice Assistance in the U.S. Department of Justice,<sup>22</sup> in addition to in-kind resources from the participating agencies this supported the program for 20 months of operation. According to original BJA grant proposal, the JERP was designed as a collaborative project to increase public safety and reduce recidivism through the implementation of a wrap-around services program that facilitate the successful reintegration of male prison inmates with mental illness or dual diagnoses placed in community corrections or paroled to Jefferson or Gilpin County. The program was intended to illustrate that high-intensity, multi-disciplinary service delivery would save criminal justice costs by reducing incarceration days and recidivism among a particularly high-risk parole population.

At the inception of this program, Colorado populations with a DOC-designated high-risk level<sup>23</sup> typically terminated from criminal justice programming with a 49 percent rate of success, while the DOC general offender population successfully terminates in 56 percent of cases.<sup>24</sup> The JERP program aimed to increase the rate of successful terminations for the high-risk offender population to at least 56 percent by providing specialized service delivery. The program began in November 2005 and, in July 2007-after much persistence on the part of project collaborators and community supporters- the Colorado General Assembly awarded the program General Funds for support. In-kind support on the part of the participating agencies continued.

### ***The Current Study***

The initial program design included an evaluation, but funding was not provided. The Office of Research and Statistics (ORS) in the Colorado Division of Criminal Justice (DCJ) sought and obtained grant funding to conduct a process and outcome evaluation of the John Eachon Re-Entry Program. The ORS, as previously mandated by statute, staffed the Task Force and had a history of evaluating its previous initiatives.<sup>25</sup>

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<sup>22</sup> Bureau of Justice Assistance Grant numbers 2005-RE-CX-0001 and 2006-MO-BX-0029.

<sup>23</sup> Scores exceeding 29 on the Level of Supervision Inventory, described in more detail in Section Three.

<sup>24</sup> Numbers provided are from original grant documentation and were not corroborated by DCJ?

<sup>25</sup> For example, Crisis Intervention Teams in Colorado and Community-Based Management Pilot Programs for persons with Mental Illness who are Involved in the Criminal Justice System (HB 00-1034).

This report presents evaluation findings from the first two and a half years of operation—11/1/05 - 5/31/08 that were guided by goals, objectives, and evidence-based principles outlined in original grant documentation. The research project established baseline data to describe the target population and track offenders in future years. The study examined program fidelity to its original design, and program completion, recidivism, and mental health functioning outcome data on all offenders terminating from JERP in the first two years and two months of operation—11/1/05-12/31/07.

The process and qualitative portions of this study exploring program evolution, implementation, and effectiveness extend through the spring of 2008. Many programmatic changes took place when new information came to light. These changes are documented as part of the process evaluation. Barriers and impediments to implementation are described and will provide important information for those who want to replicate the program. Because the evaluation's grant funding is time-limited, it is hoped that the information contained in this report can serve as a lasting blueprint for this program and others like it.

### ***Organization of this Report***

The remainder of this report is organized into five sections. **Section Two** describes the John Eachon Re-Entry Program design and **Section Three** describes the research methods used in the study. Process and outcome evaluation findings are presented in **Section Four** and are organized by the following research questions: 1) Did the program serve the target population; 2) Was the program being implemented as planned; and 3) What outcomes were achieved by offenders at the time of discharge from the program? Finally, the report concludes in **Section Five** with a summary of the findings.

## SECTION TWO: *PROGRAM DESIGN*<sup>26</sup>

### *Evidence-Based Innovative Approach*

From the beginning, and as the program continued to evolve, the Oversight Committee attempted to incorporate into the design of JERP components from several evidence-based programs. The group researched existing programs and practices with promising outcomes and even today continues to explore cutting-edge practices that may improve client outcomes. The following discussion highlights these programs and the components that were incorporated into JERP.

- **Assertive Community Treatment (ACT).** Assertive Community Treatment is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia.<sup>27</sup> The clinical team is made up of several disciplines including psychiatry, nursing, addiction counseling, and vocational rehabilitation. A key feature of ACT is its street-level outreach to individuals often located in homeless settings. The effectiveness of ACT has been well established with over 55 controlled studies in the US and abroad.<sup>28</sup>

The Colorado Division of Behavioral Health (formerly The Colorado Division of Mental Health) oversees the implementation of several ACT programs around the state, one of which is located at The Mental Health Center of Denver (MHCD). The MHCD operates a specialized ACT program to manage those with mental illness who have a history of jail incarceration. According to the Division of Mental Health, outcome data from local programs indicate that the ACT program is successful, with positive post-enrollment outcomes that included increased functioning, reduced substance abuse, and fewer days of incarceration and hospitalization.<sup>29</sup>

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<sup>26</sup> Portions of the following program description were extracted from BJA grant documentation establishing the program.

<sup>27</sup> Available at <http://www.actassociation.org/actModel>

<sup>28</sup> Morrissey, J., and Meyer, P. (2005). *Extending ACT to Criminal Justice Settings: Applications, Evidence and Options*. Paper presented at Evidence-Based Practice for Justice-Involved Individuals: Assertive Community Treatment Expert Panel Meeting. February 18, 2005, Bethesda, MD. Available at <http://gainscenter.samhsa.gov/text/ebp/Papers/ExtendingACTPaper.asp>.

<sup>29</sup> Lee, J.M. (September 2004). *Colorado Criminal Justice Assertive Community Treatment: For Individuals with Mental Illness and at Risk for Involvement with the Criminal Justice System, 2001-2004*. Division of Mental Health, Colorado Department of Human Services, Denver, CO.

While both JERP and ACT serve individuals with mental illness and substance abuse issues, JERP targets a transitioning prison population. While ACT is primarily community-based, the JERP is located in a community corrections facility. Several ACT programs are evolving to address the criminal justice population as well, referred to as FACT teams—Forensic Assertive Community Treatment teams. FACT program goals include reducing incarceration and hospitalization for those involved in the justice system.

Because of the consistent evidence of successful outcomes experienced by those who participate in ACT programs, the JERP development team strived to include several components of ACT into JERP, even though the structure of the ACT program differs substantially from that of JERP. The JERP incorporated a multi-disciplinary approach, including mental health and substance abuse treatment, psychiatry, and nursing, and these program components emanated from ACT.

- **Partnership for Active Community Engagement (PACE).** PACE is an innovative program begun in 1999 in Boulder, Colorado. The goal of PACE is to increase client functioning and reduce jail use by the target population. PACE is an integrated treatment and diversion program that is based on the ACT model, but does not include an outreach component. All PACE staff are located in a single facility and the team represents a wide range of disciplines dedicated to providing services and structure to adult offenders with mental illness who have a history of incarceration. Collaboration with a variety of agencies ensures that clients receive complementary services that address individual needs.<sup>30</sup>

An evaluation conducted by Silvern et al. (2006) found that PACE had several successful outcomes. For example, PACE clients in Boulder County spent an average of 3.4 days per year in jail after entering the program compared to 56 days per year in jail before PACE entry.<sup>31</sup> Overall, the study found that participation in PACE produced statistically significant reductions in the rates of incarceration and in the rates of new criminal charges.

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<sup>30</sup> Przybylski, R. (2008). *What Works: Effective Recidivism Reduction and Risk-Focused Prevention Programs A Compendium of Evidence-Based Options for Preventing New and Persistent Criminal Behavior*. The Colorado Division of Criminal Justice, Denver, CO.

<sup>31</sup> Silvern, L., Bowels, A., Richards, J., Poncelow, J., and Richardson, G. (July 2006). *PACE evaluation study: Final report and progress report #3*. University of Colorado, Boulder, CO. Also see Epp, G., and D'Alanno, T. (October 8, 2004). *Presentation on Boulder PACE for Increasing Access to Mainstream Services for Individuals and Families Experiencing Homelessness: National Learning Meeting*. Sponsored by the U.S. Departments of Health and Human Services, Housing and Urban Development, Veterans Affairs, and Labor. Arlington, VA.

PACE program components that have been incorporated into JERP include the “one-stop-shop” model, whereby all services (both treatment and criminal justice related) are delivered in one setting (on-site at the community corrections facility); collaboration among key agencies; and individualized, structured treatment and case management.

- **Strategies for Self-Improvement and Change (SSIC).** Founded in 2006 by Dr. Kenneth W. Wanberg and Dr. Harvey B. Milkman, SSIC is a program for self-improvement and change for those whose past includes both criminal conduct and substance abuse problems.<sup>32</sup> This 48 - 50 week program is based on a cognitive behavioral approach and includes an extensive assessment process and Motivational Interviewing. It has a comprehensive participant manual, which outlines the goal, objective and activities for each session. It involves mental health and addiction/substance abuse treatment, using individual counseling and intensive outpatient treatment formats.

While no efficacy studies on SSIC were located in the literature by ORS researchers, the program is founded on cognitive behavioral principles, which are supported in the literature and are evidence-based. The intensive assessment process and the use of Motivational Interviewing techniques are also evidence-based practices.

When the JERP was originally created, SSIC was the treatment program of choice for the Oversight Committee, which the Alcohol and Drug Abuse Division (ADAD) had approved for use with offenders.<sup>33</sup> For the first one and a half years of program implementation, this model was employed with all offenders in the JERP program.

At the request of the Colorado Division of Mental Health (DMH),<sup>34</sup> in the summer of 2007, JCMH embarked on the process of replacing the SSIC with Integrated Dual Diagnosis Treatment (IDDT, described below).

- **Integrated Dual Diagnosis Treatment (IDDT).** IDDT is an evidence-based method of service delivery that combines both mental health and substance abuse treatment modalities delivered by either the same practitioner or the same treatment team. According to IDDT

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<sup>32</sup> <http://www.healthinfosource.com/providers/viewProgram.cgi?programID=2226>

<sup>33</sup> Available at [http://www.comcor.org/treatment/intensive\\_residential\\_treatment.htm](http://www.comcor.org/treatment/intensive_residential_treatment.htm).

<sup>34</sup> The Colorado Division of Mental Health has oversight responsibility for mental health centers operating in Colorado. DMH concluded that mental health centers needed to employ three evidence-based programs in their work with consumers. IDDT fit the JERP population the best of the three choices.

training literature,<sup>35</sup> providing effective integrated dual disorders treatment includes the following key components:

- Knowledge about alcohol and drug use, as well as mental illnesses, and the interplay between them;
- Integrated mental health and substance abuse services;
- Stage-wise, individualized treatment that occurs over a period of time;
- Assessment and individualized treatment development;
- Motivational treatment that includes specific listening and counseling skills to help consumers develop awareness; hopefulness, and motivation for recovery; and
- Substance abuse counseling.

Clinicians are provided a toolkit containing 13 tenets from which to base their work with consumers. The model is flexible in that clinicians don't have to follow a specific script. Instead, they utilize the elements applicable to tailor treatments to the specific needs of individual clients. Although not originally designed to do so, the IDDT model has been increasingly implemented with criminal justice populations around the country.<sup>36</sup>

**Re-Entry Policy Council Tenets.** In its original grant documentation, JERP cites work conducted by the Re-Entry Policy Council,<sup>37</sup> which studies the practice of prisoner re-entry. The Council concluded that people released from prison and jail have complex needs: three of four have a substance abuse problem and one of three have some form of mental or physical disability. The Council summarized its key findings in 2003,<sup>38</sup> the following were included as important components of the JERP design:<sup>39</sup>

- Engage leaders in relevant professional fields to invest time and energy to address re-entry;
- Understand re-entry issues in the targeted release jurisdiction;
- Ensure that high-need individuals exiting from prison are released to intense supervision and support;

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<sup>35</sup> Available at [http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTinfoPMHAAJ1\\_04.pdf](http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTinfoPMHAAJ1_04.pdf).

<sup>36</sup> Verbal communication, JCMH IDDT Consultant.

<sup>37</sup> This is a public/private partnership funded in part by the U.S. Department of Justice, U.S. Department of Labor, and the U.S. Department of Health and Human Services and established by the Council of State Governments in 2001 to assist state officials with prisoner reentry. It has published a valuable comprehensive report: *Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community*. Council of State Governments. Re-Entry Policy Council. New York: Council of State Governments. January 2005.

<sup>38</sup> See [www.reentrypolicy.org](http://www.reentrypolicy.org). [http://www.reentrypolicy.org/reentry/THE\\_REPORT.aspx](http://www.reentrypolicy.org/reentry/THE_REPORT.aspx)

<sup>39</sup> These items were included in the original grant documentation submitted to BJA.

- Maximize the value of existing funding by focusing resources on periods immediately preceding and following a person's release to the community and coordinate resources;
- Integrate systems that share clients and link data to promote continuity of care and effective service delivery;
- Create ongoing forums for project oversight, information-sharing, communication and problem-solving across agencies and organizations; and
- Measure performance.

In sum, JERP designers drew from existing programs and best practices. Many of these program components were integrated into JERP, and are discussed in Section Four.

### ***Program Description***

The objectives of JERP, according to the BJA proposal, were to provide individuals with continuity of treatment and access to medication during the transition out of prison and into the community, integrated with a team case management approach, to ensure appropriate structure and support.

The target population consists of male offenders with a DOC-designated diagnosis of a serious and persistent mental illness who have reached their parole eligibility date and are paroling to Jefferson or Gilpin counties. They are further screened to identify whether they meet the eligibility requirements of a) JCMH, b) Intervention Community Corrections Services (ICCS), and c) the Jefferson County Community Corrections Board. Offenders who meet these criteria have the option of participating or not.

For those accepted into the program and willing to participate, services are provided by a multidisciplinary team consisting of two therapists, a nurse, a psychiatrist, a community corrections case manager, a parole officer, and administrative staff from JCMH, ICCS, and DOC. This team provides integrated dual disorder treatment services, with one therapist specializing in mental health and the other in substance abuse treatment. This team meets weekly to clinically review offenders in the program and make joint decisions about various aspects of offender progress, such as service delivery, sanctions for house violations, and employment.

Like most community corrections programs in Colorado, the JERP contains both a residential and a non-residential program component and is based on a progression-regression model. That is, as an offender advances through the program (progression) and he begins to struggle with daily functioning, the team may consider him to be at-risk for violating parole conditions. At that point the team may place him at a higher level of service intensity (regression). This could

include moving him from the non-residential status to residential status with the intention of re-stabilizing his daily functioning, thereby avoiding a return to DOC. In these cases, offenders meet with the multidisciplinary team to discuss the issues identified as problematic before program regression decisions are made. This offender-participation feature of the original program design fulfills an aspect deemed essential to meet program goals: providing offenders the empowering opportunity to voice their perspective, concerns, and reactions to decisions made about him.

When an offender is first released from prison, he enters the residential portion of the program and undergoes a battery of assessments performed by both JCMH and ICCS staff.<sup>40</sup> During the first month, he remains on site, attending groups and individual sessions up to five days a week while adjusting to life outside of prison. After this month, the offender is assessed by the treatment team to determine his capability to obtain employment. If deficiencies are identified that would impede the acquisition of employment, he is enlisted to volunteer at the Summit Center, Jefferson Center's clubhouse-style center, to improve work and social skills in a supported-employment environment while providing a necessary service to the center<sup>41</sup> (see "Collaboration" section below for further discussion).

The treatment team assesses each offender's readiness to transition to the non-residential portion of the program on a regular basis, evaluating their performance against criteria for successful progress in treatment and in general functioning in the residential program. Many non-residential options are explored by the team to best fit each offender's particular circumstances including living with relatives, living on their own, or transitioning to a JCMH residential facility for those with mental illness.<sup>42</sup> While on non-residential status the offender remains responsible for participating in the designated treatment plan and adhering to the parole requirements as outlined by the team.

## ***Collaboration***

As described previously, the JERP initiative was jointly developed by five organizations whose administrations stated their commitment to improving the transition experience of incarcerated persons with serious and persistent mental illness. The concept was born out the MIJS Task Force and had the support of state legislators and private service providers. These entities form the foundation of the collaborative effort. This portion of the report details the efforts of the collaborative partners.

Implementation of JERP involves both management and line staff at each of the participating agencies. While each of the agencies delivers particular services to

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<sup>40</sup> Instruments used will be described in Section Four of this report.

<sup>41</sup> Described below under Collaboration: Jefferson Center for Mental Health.

<sup>42</sup> Teller House is an adult residential program serving persons with mental illness in Jefferson County.



offenders, staff from these agencies provide individualized, comprehensive interventions with the goal of improving each individual's functioning and stability in the community. Offenders are assessed and evaluated by JCMH and ICCS, and subsequently receive services designed to meet their individual needs.

The collaborating agencies, and the services (in italics) each provides are detailed below.

**Jefferson Center for Mental Health (JCMH).** JCMH provides an array of services designed to target individual needs. These services include *mental health and substance abuse treatment* provided by two on-site therapists, one who specializes in mental health and the other in substance abuse treatment. They each deliver individual and group counseling to program participants. With the exception of their first month in the program, residents are required to attend one individual session and one group session with each of the therapists per week, for a total of four therapist contacts per week.

JCMH also employs one half-time Licensed Practical Nurse (LPN) to assist with *psychiatric and medical stabilization*. The nurse monitors medications and, given that the current nurse has a background in mental health counseling, serves as a counselor at times when needed.<sup>43</sup>

One JCMH psychiatrist provides continuity of psychiatric care while offenders are in both the residential and non-residential portions of the program. Having worked at DOC's San Carlos State Mental Hospital for several years, the psychiatrist is experienced with this special population. If an offender is experiencing acute symptoms, JERP staff expedites scheduling the first psychiatric appointment to occur within approximately a week. If the offender is relatively stable, the wait time may be up to one month.

Once an offender is seen, the psychiatrist completes a *psychological evaluation* to assess problem areas and ascertain a *diagnosis*. He then *prescribes medications and makes adjustments as needed*, leaving the psychotherapy to the JERP therapists.<sup>44</sup> The psychiatrist participates in weekly team meetings that track progress.

A key component to the JERP is the availability of *volunteer opportunities* and supported employment for offenders unable to consistently maintain employment due to their illness. Rather than reporting to a place of employment these individuals spend their days at JCMH's clubhouse-type setting, the Summit Center.

The Center offers job readiness including interviewing, resume writing, career exploration and job coaching, transitional employment, supported

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<sup>43</sup> Personal communication with JERP LPN.

<sup>44</sup> Personal communication with the JERP psychiatrist.

and independent employment programs, and peer mentoring for individuals in the community living with mental illness. At Summit Center a work-oriented and structured day offers a respite from JERPs intensive clinical focus to a cooperative and productive vocational environment. Offenders work collaboratively with Jefferson Center staff to accomplish goals, contributing to the offender's overall sense of confidence and self-worth.<sup>45</sup>

JCMH also offers JERP participants access to client advocacy services, which includes accessing needed public benefits. HAF House Emergency Fund for Consumers, providing emergency housing, dental care, food, and transportation, is also available to JERP participants.

**Colorado Department of Corrections (DOC).** DOC has been involved with the JERP in two specific ways. When the program began, DOC identified individuals in prison meeting basic criteria making them eligible for participation in JERP. Once identified, DOC's Division of Community/Parole staff would approach these offenders, explain the program, solicit desire for participation from the offender, and then notify JCMH staff, the next agency in the screening sequence (described in "Target Population" below), of their eligibility. This DOC function was eliminated in the spring of 2007 (see Section Four for further discussion.)

The second key role DOC plays in the JERP is providing correctional supervision within the JERP setting at ICCS. All JERP participants are assigned the same parole officer for the duration of all phases of the program with the goal of enhanced continuity of supervision. It is important that this officer have a heightened understanding of mental health issues, provided somewhat by their participation in weekly team meetings and regular contact with the population.

The parole officer is a key partner in all team meetings and decision-making, given their responsibility as the legal authority regarding the offender/parolee. Therefore, this officer is ultimately responsible for any decisions to return the offender to DOC, while at the same time balancing the necessity to maintain a commitment to the JERP team decision-making approach.

**Intervention Community Corrections Services (ICCS).** ICCS is Jefferson County's Community Corrections program (half-way house) for offenders transitioning to Jefferson and Gilpin counties. They serve both diversion offenders--those directly sentenced by a judge, and transition offenders--those who have served time in prison and are transitioning back to the community. They provide residential transitional housing using a behavior modification type of environment, employing a point and level system. Services provided include:

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<sup>45</sup> Personal communication with JERP participants.

- Case management, which includes needs assessment and referrals to needed programming
- Budget assistance
- On-site job-seeking assistance, including resume development
- On-site educational services that include GED and high school diploma programming
- Alcoholic Anonymous groups

Because accomplishing the tasks included in the above list present challenges for the typical offender, the JERP Oversight Committee anticipated the elevated degree of difficulty those with mental illness may experience when facing such tasks. Consequently, while the above programming applies to all offenders entering ICCS, those in the JERP receive more supportive and intensive monitoring than the average ICCS Case Manager provides, with these services being key to the JERP offender's success.

Similar to the parole officer model mentioned previously, a sole case manager is assigned to all JERP offenders. Like the parole officer, both the case manager and the offenders benefit from the exclusive focus and attention to the special needs of this population. The case manager can track the needs and progress of offenders with greater attentiveness resulting from the smaller caseload. All JERP staff, including the case manager, are keenly aware that mental health crises do not follow a predictable schedule. Given the exclusive focus of the case manager, offenders have increased immediate access to the Case Manager, relative to the access of general offenders at ICCS, allowing problems to be addressed in a timely fashion.

JERP participants are provided residential, treatment and leisure spaces that are not shared with the general population of offenders. JERP offenders room with other JERP participants and while they are assigned an exclusive dayroom area, they do share outdoor leisure and dining hall spaces with the general offender population.

**Other.** During the BJA grant-funding period, members of the Division of Justice Services in Jefferson County provided a variety of supports to the JERP team by participating on the JERP development team, acting as fiscal agents and serving as local grant managers. They remain active stakeholders and participate on the JERP Oversight Committee that meets on a monthly basis. The Division of Criminal Justice's Office of Research and Statistics agreed to conduct the program evaluation, which includes working with ICCS, DOC and JCMH to develop a client database, conduct interviews, and observe program implementation.

## ***Target Population***

Based on the BJA grant documentation, the target population for the JERP program consists of male inmates who would benefit from mental health services. Without a program like JERP, these inmates would likely remain incarcerated in DOC.

**Selection Criteria.** The specific criteria employed to select inmates into the program include those:

- Who have been diagnosed with a serious and persistent mental illness that presents at least moderate impairment in the individual's life;
- Whose crime of conviction is non-violent;
- Who will likely reside in Jefferson or Gilpin Counties upon release from prison or whose crime was committed in one of these counties;<sup>46</sup> and
- Who are 19 months from their parole eligibility date and at least 8 months from their mandatory release date.

The DOC uses a five-level case management classification system that identifies offenders who need special screening or other interventions in a variety of areas, such as medical, assaultiveness, drug and alcohol, and psychiatric.<sup>47</sup> Inmates who are determined to be at least moderately impaired on the Psychiatric Needs Code (P-3-C or P-4), but do not have a persistent or complex medical condition may be eligible for the program.<sup>48</sup> Offenders with active warrants or detainers or those with an extensive history of institutional assaultiveness are not eligible.

Inmates must volunteer and be motivated to participate in this program. They are asked to sign a program contract and an informed consent form that documents their agreement to participate in the program evaluation.

**Selection Process.** The Oversight Committee created a multi-leveled selection process to identify and review potential participants for the JERP. These steps, extracted from the BJA grant documentation, are presented in chronological order:

- Step 1. DOC case management referral to the Division of Adult Parole and Community Corrections (DAPCC)
- Step 2. DAPCC review
- Step 3. Jefferson Center for Mental Health review
- Step 4. Jefferson County Community Corrections Board review
  
- Step 5. JERP Treatment Team review

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<sup>46</sup> Expansion to include offenders from other regions throughout the state is currently being considered.

<sup>47</sup> Admission Data Summary Codes

## Step 6. Intervention Community Corrections Services (ICCS) review

Throughout this process, an offender's specific circumstances are taken into account; however, an offender can be denied acceptance into the program at any of these review points according to the criteria that each entity has developed. While this process was administered for all who were referred to the program for the first year and a half of program implementation, when a breakdown in the offender referral system occurred in April 2007, the above described system underwent significant changes (see Section Four for further discussion.)

### ***Program Goal and Objectives***

The following goal and objectives were included in the original design of the program and submitted to the BJA grantors of the project:

**Goal.** To increase public safety and reduce recidivism through the continued implementation of a pilot wrap-around services program that facilitates the successful reintegration of prison inmates who suffer from serious and persistent mental illnesses and who have paroled to Jefferson or Gilpin Counties, Colorado.

#### **Objectives:**

- 1.1 Integration of correctional supervision, mental health treatment, medication compliance, and substance abuse treatment to provide wrap-around services to offenders with mental illness.
- 1.2 Increase participants' level of mental health functioning, increase economic independence and decrease substance abuse relapse events by providing services in the areas of employment and housing.
- 1.3 Reduce technical violations.
- 1.4 Reduce new crimes committed by program participants.
- 1.5 Reduce community placement failure for transitional community corrections placements.
- 1.6 Reduce compliance failures for medication use.

Attempting to establish a quantifiable goal to assess program success, the Oversight Committee examined current DOC needs assessment scores from the Levels of Supervision Inventory (LSI).<sup>49</sup> (See Section Four for further detail.) Offenders with LSI scores exceeding 29 are considered high-risk by DOC criteria. This population typically terminates from criminal justice programming with a 49 percent rate of success, while the DOC general offender population successfully terminates in 56 percent of cases. Thus, the program aims to

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<sup>49</sup> The LSI is comprised of 54 static and dynamic items across 10 subscales (criminal history, education and employment, financial, family and marital, accommodations, leisure and recreation, companions, alcohol and drug problems, emotional and personal, and attitude and orientation).

increase the rate of successful terminations for the high-risk offender population to at least 56 percent by providing specialized service delivery.

## **SECTION THREE: RESEARCH QUESTIONS, METHODOLOGY, AND DATA CHALLENGES**

### ***Research Questions***

The following research questions provide the framework for the primary analyses and are addressed in the remainder of this report:

- 1. Did the program serving the target population?** Did the program serve those high-level individuals returning to Jefferson and Gilpin counties according to planning documents? If adjustments were made to the acceptance criteria, were these decisions formalized and clearly communicated to all involved parties?
- 2. Was the program being implemented as planned?** That is, was the program delivered as intended based on grant documentation provided to BJA in which evidence-based practices were incorporated in the program design, established policies and procedures, and interagency agreements?
- 3. What outcomes were achieved by offenders at the time of discharge from the program?** Outcomes include criminal justice involvement, including both new crimes committed, technical violations, and returns to DOC; cost avoidance and/or savings; and mental health functioning, substance use relapses, and increased economic independence.

Individual-level outcome domains were selected and reflect areas that would be expected to change (dynamic indicators) due to interventions provided by the program. The individual level dynamic change measures include the following:

- Mental health symptoms and functioning
- Criminal behavior and revocations
- Alcohol and drug use
- Family involvement
- Educational achievement
- Employment
- Housing

Cost avoidance and savings associated with the JERP is also a critical factor in examining program effectiveness and will be discussed in this report.

## ***Methodology***

Data were obtained from a variety of sources to conduct the analyses for this report, including Jefferson Center for Mental Health, Intervention Community Corrections Services, Division of Criminal Justice, and Department of Corrections. Data selected for inclusion into these analyses were based on stakeholder input, the stated goal and objectives of JERP, the ORS research questions, and the availability of data.

The following list outlines the data collected and analyzed as well as where the data came from.

- Individual case review documentation of all residents admitted to the program between 11-1-05 to 10-31-07, which included:
  - Diagnoses and mental health services documented and submitted by Jefferson Center for Mental Health through the Colorado Client Assessment Record (CCAR)<sup>50</sup> used to measure mental health domains.
  - Monthly ICCS case management review documents, which included items such as employment hours, a compliance measure, LSI score, treatment summary, and randomized substance use testing results.
  - Extractions from the ICCS database<sup>51</sup>.
  - Individual offender substance use treatment level assignments based on the Standardized Offender Assessment Revised (SOA-R), which is a battery of substance use assessment measures, including the Simple Screening Instrument (Revised; SSI-R), the LSI, the Adult Substance Use Survey (Revised; ASUS), and the Treatment Recommendation Worksheet (TxRW).
  - Tests of Adult Basic Education (TABE) scores, which are standardized tests assessing basic reading, mathematics, and language skills usually learned in grades 1-12. Both intake and discharge scores were collected and compared.
  - ICCS termination paperwork and DCJ termination forms, which included termination dates and reasons, where they were released to, employment status at entry and termination, educational grade level at entry and termination, and criminal history.
- Document presented to the JBC, dated 12-19-07, as prepared by Dr. Harriet Hall.
- Observations and notes from staff meetings and oversight committee meetings.

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<sup>50</sup> See [http://dcj.state.co.us/ors/pdf/docs/Anita\\_Appendix\\_F.pdf](http://dcj.state.co.us/ors/pdf/docs/Anita_Appendix_F.pdf) to view full CCAR.

<sup>51</sup> The system is called E\*Trac and was developed M+Partners.



- Presentations by JERP staff to Mentally Ill in the Justice System Task Force, the National Criminal Justice Association Annual Conference, and mental health supervisors at the Department of Corrections.
- Observations of Department of Corrections Code of Penal Discipline hearings.
- Observation of a Jefferson County Community Corrections Board meeting.
- Department of Corrections document itemizing referrals, case review dates for each stage of the selection process, and acceptance or denial decisions.
- Grant and program development documentation.

Additionally, researchers conducted the following individual interviews with current and former line staff, supervisors, and administrative personnel connected with the JERP, including:

- Seven from Jefferson Center for Mental Health
- Eight from Intervention Community Corrections Services
- Seven from the Department of Corrections
- Four Community stakeholders from the Division of Justice Services in Jefferson County, the Jefferson County Community Corrections Board, Division of Criminal Justice
- Three Independence House staff members

Four focus groups were conducted with 49 DOC Case Managers and mental health workers.

Focus groups and individual interviews were conducted with the majority of program participants, both current and past, regardless of whether they completed the program successfully or not. The total number of offenders who participated in this phase of the study was 19.

### ***Data Challenges***

Data retrieval challenges existed with this project throughout much of the evaluation period. While JCMH and ICCS both have relatively new electronic data management systems with many capabilities, tapping these sources for the purposes of conducting on-going evaluation activities proved to be quite challenging. Program staff were familiar with uses that directly affected their daily operations, but were relatively unfamiliar with the electronic programs' capacities and to whom appropriate questions regarding these functions should be directed.

ICCS used an outside contractor who had developed several other similar systems for community corrections programs. While he was key in accessing needed data from their system, he was located in another state and direct access to him was limited to working through the ICCS Program Director. Consequently, researchers and program staff had to spend a great deal of time hand-entering

data for nearly the entire data collection period, making the collection and tracking of data on offenders quite cumbersome.

The primary JCMH staff contact provided most of the hand-entered data for nearly the entirety of the collection period. At the end of year one, she tried to access the data electronically, but was unsuccessful. She then continued to enter data onto a separate form for researchers, who then hand-entered this data.

Given these barriers, a primary evaluation goal was set for year two to rectify the accessibility of extractable electronic data from these systems. With the goals of responding to information requests and on-going program improvement, researchers realized that the development of one centralized electronic system combining data from both sources would vastly improve the ability of both program staff and researchers to respond to such requests quickly and efficiently.

In September of 2007, the ICCS Clinical Director convened a meeting with ICCS, JCMH and DCJ staff to try to arrive at better solutions to the data retrieval issues. At that time, Information Technology staff from JCMH were notified of the issues and included in subsequent meetings. Shortly thereafter, data retrieval issues with JCMH were resolved and a system for electronic data submission to DCJ was established. Additionally, ICCS staff was able to devote time to understanding the needs of the researchers and convey those needs to their contractor in a way that eventually led to their ability to retrieve data in an analyzable format. The data were then forwarded to DCJ researchers and the overall goal of having one electronic system with data from both ICCS and JCMH was accomplished at the end of year two. Throughout the process, program staff was responsive to researchers' requests for assistance in correcting and verifying data inconsistencies, leading to a data set that researchers held a high degree of confidence in.

A second barrier to the process portion of this evaluation was researchers' inability to observe two key components of the program. Specifically, the researchers were not given the access to observe group therapy sessions nor the clinical IDDT trainings. The stated reason was for protection of the clinicians' privacy.

## SECTION FOUR: *RESEARCH FINDINGS*

This section is organized around the following research questions:

- 1) Did the program serve the target population?
- 2) Was the program implemented as planned?
- 3) What outcomes were achieved by offenders at the time of discharge from the program?

In each part of this section, the research question is followed by a summary of findings, presented in italics. The summary is followed by the detailed findings. When quotes from interviews and focus groups are used below, the source of the quote is not provided in an attempt to protect the confidentiality of study participants.

### ***Question 1: Did the program serve the target population?***

***Yes and no.*** *The evidence suggests that the men who participated in the JERP met the established criteria identified by program developers. The group had serious mental health or substance abuse problems, or both. However, an inadequate number of men participated in the program because the beds were not filled to capacity. Therefore the process of referring and accepting individuals into the JERP became an important part of answering this research question, along with determining if the characteristics of the men were consistent with the target population identified in the program design.*

*Like all Colorado halfway house referrals, movement from prison into Colorado's Community Corrections system requires the participation of and approval from multiple entities. JERP clients were transitioning from prison, requiring the Department of Corrections to initiate all referrals. In addition, JERP stakeholders identified a specific population for treatment participation who would meet the following basic criteria:*

- *16 months from parole eligibility*
- *Convicted of a nonviolent crime*
- *No medical problems*
- *Acceptable behavior while in prison (in terms of disciplinary violations)*
- *Original crime occurred in Jefferson or Gilpin Counties*
- *Moderate psychiatric problems and co-occurring substance abuse problem*

*The information presented below shows that all program participants were diagnosed with a serious mental illness and nearly all had serious problems with drug and alcohol abuse or dependence. Further, the clients were paroling to*

*Jefferson or Gilpin Counties, and were convicted of non-violent crimes. Information on prison disciplinary infractions and medical problems were not available for analysis.*

*Both the referral rates and the acceptance rates influenced the lower than expected JERP population. The DOC struggled to identify and refer the number of clients necessary to fill the JERP beds at ICCS, particularly in the second year of operation. Of those referred, many were screened out by the program partners. In part, especially in the first year, this can be attributed to common program development and start-up processes. Nevertheless, many of the beds remained unfilled for the duration of the study.*

*Nearly half (43 of 99) of the inmates referred to JERP by DOC case managers were denied by decision makers at the various screening points. DOC's community corrections division rejected 13 of the 42. Another eight inmates were rejected by the community corrections screening board, and three were rejected by the Jefferson Center for Mental Health who reviewed the DOC medical/mental health files to ensure that each individual's clinical needs could be met through JERP services. Finally, ICCS denied 14 inmates, presumably for disciplinary problems while in prison (again, the reasons for rejection were not available for analysis), the full Jefferson County Community Corrections Board screened out three, and another two inmates refused to participate in the program. Data on specific reasons for rejection by any of the entities were not available. This study identified the need to clarify and perhaps expand the criteria for acceptance into the program.*

*Ironically, although hundreds of DOC inmates with mental health and substance abuse problems were presumably in need of community treatment, the beds in the JERP program were only filled to capacity briefly at one point in time in these first two years of operation. Multiple problems seemed to contribute to the lack of clients:*

- The acceptance criteria for program participation was extremely narrow, making many DOC inmates in need of community services ineligible for the program. In fact, only half of those referred by DOC and meeting the most basic program criteria were accepted into the program.*
- The referral process seemed extremely cumbersome and men could be rejected by at least five separate entities for a variety of reasons*
- The in-county participation criterion was consistently mentioned as a barrier to maximizing the use of JERP beds.*
- A significant lack of referrals from DOC prevented the program from operating at capacity, particularly after federal grant funding was replaced with state funding in July 2007. DOC received none of the state funds*

*directed to program operations. While vacant beds were a problem prior to the change in funding from federal to state dollars, it was at this point that referrals to the program significantly plummeted.*

*In sum, then, the group that participated in JERP reflected the target population initially identified by program developers. However, too few men received services at JERP because beds were not filled to capacity.*

## **FINDINGS**

The findings presented here begin with a brief description of the selection process for the JERP. Next, characteristics of the 42 men who participated in the program during the first two years of operation are presented. Finally, barriers to serving the target population were identified by interviewing stakeholders and program staff. This discussion follows the descriptions of the JERP clients.

### **JERP Eligibility Criteria.**

Offenders referred to all community corrections agencies in Colorado must meet certain criteria and be approved by all entities involved. The first criterion is in statute: the offender must be within 16 months of parole eligibility.<sup>52</sup> DOC identified these cases and forwarded the names to DOC's community division. In the first year of program implementation, DOC's community division<sup>53</sup> identified from this pool of inmates JERP-eligible individuals who met the following criteria:

- 16 months from parole eligibility
- Convicted of a nonviolent crime
- No medical problems
- Acceptable behavior while in prison (in terms of disciplinary violations)
- Original crime occurred in Jefferson or Gilpin Counties
- Moderate psychiatric problems and co-occurring substance abuse problem

Once these individuals were identified, the case was referred to Jefferson Center for Mental Health where the person's clinical records from DOC were reviewed to ensure that JERP services were appropriate and adequate. Next, ICCS reviewed the case for institutional behavior and risk indicators, and finally the referral went to the local community corrections screening board.

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<sup>52</sup> Technically, according to *AR 250-03, Section IV, Procedures*, inmates who are eligible at 16 months are referred at 19 months.

<sup>53</sup> This is the Division of Adult Parole, Community and Youthful Offender System.

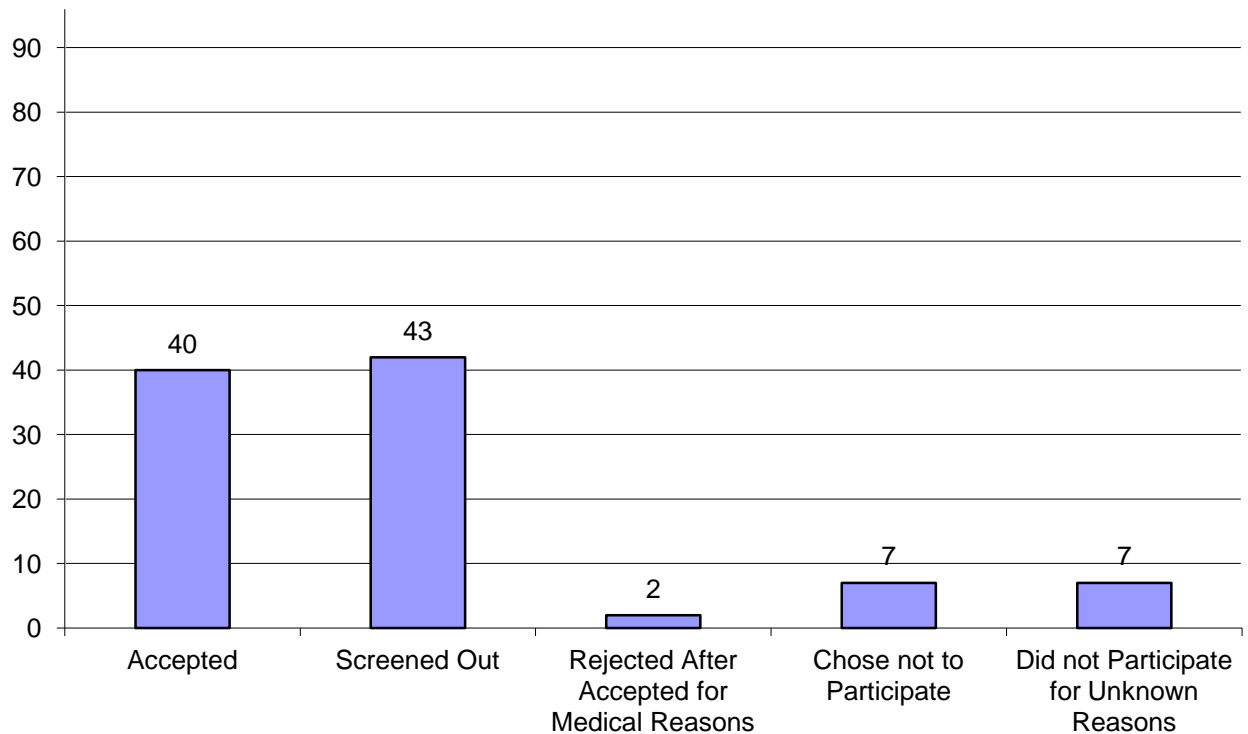
This process resulted in screening out half of those referred from DOC. Data were not available to identify the reasons for denial at any of the decision points.

**Accepted and Screened Out.** Figure 1 reflects the outcome of the 99 offenders referred to the program because they met the basic DOC eligibility criteria for placement in the statewide community corrections system.

Of 99 referrals made by DOC between October 1, 2005<sup>54</sup> and October 31, 2007:

- 42 (42.5%) were accepted
- 43 (43.5%) were screened out
- 7 (7%) refused to participate prior to the full screening process
- 7 (7%) did not participate for unknown reasons

**Figure 1. Number of Referrals Accepted and Screened Out**



Data Source: DOC and JCMH documents.

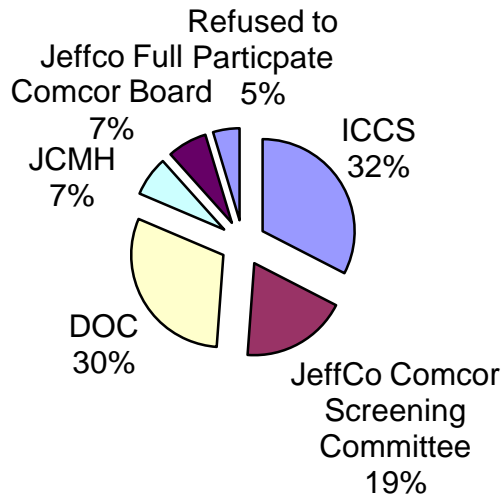
While Figure 1 indicates how many referrals were made to the program, Figure 2 below identifies the point at which denied cases were screened out. The reasons for these denials were unavailable for analysis. Likewise, reasons offenders

<sup>54</sup> While seven referrals were made to the program in October 2005, they were not admitted until November 2005. Thus, the time period selected for this evaluation time period begins in November 2005 when the first participant was admitted.

refused to participate were unavailable. The 43 of 99 referred inmates were screened out by the following entities:

- DOC/Community Division screened out 13 (30%)
- ICCS denied 14 (32%)
- Jefferson County Community Corrections Screening Committee denied 8 (19%)
- JCMH screened out 3 (7%)
- Full Jefferson County Community Corrections Board screened out 3 (7%)
- Two refused to participate for unknown reasons (5%)

**Figure 2. Agency That Screened Out Referrals**



Data Source: DOC and JCMH documents.

### **Program Participants**

The following information provides a summary of the findings based on the analysis of quantitative data provided by JERP affiliated staff as well as Court Link (<https://w3.courtlink.lexisnexis.com/Colorado/SignOn.aspx>). (See page 10-11 under “Criminal History” for further detail.) Information on demographics, education, adult criminal histories (including previous placements and revocations), and problem severity is presented below. Information regarding the overall population included data from all but two program participants from November 1, 2005 through December 31, 2007, who were rejected after being accepted due to medical reasons. Thus, a total of 40 individuals are described in the analyses below.

**Demographic Information**<sup>55</sup>. The age of men in the program ranged from 20 to 50. Three-quarters of the participants were under age 40; the mean age at intake was 33.7 years and the median age was 32. Just over three-quarters (77.5%) were Caucasian; nearly 44% were single. Just over half (20) were known to have children.

**Table 1. Demographic Characteristics of JERP Clients**

		<b>(n = 40)</b>	
		<b>Number</b>	<b>Percent</b>
<b>Age at Intake</b>	<b>18 – 24</b>	4	10.0
	<b>25 – 30</b>	11	27.5
	<b>31 – 39</b>	15	37.5
	<b>40 or older</b>	10	25.0
	<b>Total</b>	<b>40</b>	<b>100.0</b>
<b>Ethnicity</b>	<b>White (non-Hispanic)</b>	31	77.5
	<b>Hispanic</b>	4	10.0
	<b>African American</b>	5	12.5
	<b>Total</b>	<b>40</b>	<b>100.0</b>
<b>Marital Status at Intake</b>	<b>Single</b>	17	43.6
	<b>Divorced</b>	10	25.6
	<b>Married</b>	7	17.9
	<b>Common Law</b>	3	7.7
	<b>Widower</b>	2	5.1
	<b>Total</b>	<b>39</b>	<b>99.9</b>
	<b>Missing</b>	1	N/A

Note: Total percentages may be less than 100% due to rounding.

Data Source: ICCS Database

**DSM Diagnosis.** The American Psychiatric Association (APA) created the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 2000) to assess and diagnose individuals in multiple areas (i.e., axes). There are five axes included in the DSM-IV multi-axial classification: Clinical disorders (Axis I), personality disorders (Axis II), general medical conditions (Axis III), psychosocial/environmental problems (Axis IV), and global assessment of functioning (also known as GAF; Axis V). However, for the purposes of this report only Axis I will be discussed. Axis I disorders are those assumed to be amenable to treatment (whereas personality disorders are not). Examples of such disorders include, but are not limited to, mental disorders due to a general medical condition, substance-related disorders, schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders.

<sup>55</sup> Demographic information included in the current report is intended to provide a basic description of the population, not necessarily to contribute to answering the question of whether the target population was served.



People can be diagnosed with multiple disorders within (primary, secondary, and tertiary; as described by APA, 2000) and across axes, thus reflecting the myriad of problems they may be experiencing. While not every participant had multiple Axis I diagnoses, all JERP participants had at least two diagnoses on Axis I and II combined, reflecting the seriousness of the population. Table 2 shows the distribution of each Axis I diagnosis for men who participated in JERP.

- The majority of JERP participants had a primary diagnosis of mood disorder.
- Secondary and tertiary diagnoses were dominated by substance abuse problems.
- A few individuals had more than three diagnoses.
  - These additional diagnoses included substance abuse, anxiety, and “other disorders typically diagnosed during childhood.”

**Table 2. Axis I Diagnoses**

	<b>Primary Diagnosis (n = 40)</b>	
	<b>Number</b>	<b>Percent</b>
<b>Mood disorders</b>	30	75.0
<b>Schizophrenic and other psychotic disorders</b>	9	22.5
<b>Anxiety disorders</b>	1	2.5
	<b>Secondary Diagnosis (n = 35)</b>	
	<b>Number</b>	<b>Percent</b>
<b>Substance-Related Disorders</b>	24	68.6
<b>Anxiety disorders</b>	7	20.0
<b>Childhood disorders</b>	2	5.7
<b>Delirium, Dementia, Amnesic, and other cognitive disorders</b>	1	2.9
<b>Mental disorders due to a general medical condition</b>	1	2.9
	<b>Tertiary Diagnosis (n =20)</b>	
	<b>Number</b>	<b>Percent</b>
<b>Substance-Related Disorders</b>	15	75.0
<b>Anxiety disorders</b>	4	20.0
<b>Childhood disorders</b>	1	5.0

Note: Not every participant had a secondary, and/or tertiary Axis I diagnosis. Percentages are based on the number of clients with that level of diagnoses and may not equal 100% exactly due to rounding (e.g., secondary diagnosis).

Table 3 demonstrates that 90 percent of all JERP participants had an Axis II disorder as well as an Axis I disorder. Personality disorders were the predominant diagnosis.

**Table 3. Axis II Diagnoses**

	<b>Number</b>	<b>Percent</b>
<b>Personality Disorder NOS</b>	18	45.0
<b>Deferred</b>	9	22.5
<b>Antisocial</b>	7	17.5
<b>Paranoid</b>	1	2.5
<b>Learning Disability</b>	1	2.5
<b>None</b>	4	10.0
<b>Total</b>	<b>40</b>	<b>100.0</b>

Data Source: ICCS Database

**Mental Health History.** Nearly all of offenders who had participated in the program had previously received either inpatient and/or outpatient mental health services. Specifically, the frequency of people who had previously received mental health services can be seen in Table 4.

**Table 4. Mental Health Services Previously Received by the Offender**

		<b>Overall (n = 36)</b>	
		<b>Number</b>	<b>Percent</b>
<b>Any Mental Health Treatment</b>		<b>35</b>	<b>97.2</b>
	<b>Outpatient</b>	25	69.4
	<b>Inpatient</b>	14	38.9

Note: Four clients were missing previous mental health service data. Inpatient and outpatient totals are not meant to be summative.

Data Source: JCMH Database

**Psychiatric Needs Score (P-Code).** As discussed previously, P-Code is a programming categorization used by the Department of Corrections to identify service needs of inmates. The codes range from 1 to 5, and JERP was intended to target offenders with a P-Code of 3 or 4. Of the 40 men in the program, 38 had a P-Code of 3. In addition, two men had a P Code of 4, reflecting a greater level of service need compared to those with a score of 3.

**Standardized Offender Assessment – Revised (SOA-R).** The SOA-R is a battery of substance abuse assessments to evaluate treatment needs of offenders in Colorado (SOA-R Training Manual, 2005). Adult offenders serving sentences across the system--probation, DOC, parole, and community corrections--are screened for substance abuse problems, and those who are found to require possible treatment are the focus of the SOA-R. The SOA-R identifies the level of treatment needed via scores that range from 1 to 5; Level 4

has four sub-levels. The following is the suggested treatment for each score level.

- Level 1 – No treatment needed
- Level 2 – Drug and alcohol education with an increase in urine analysis
- Level 3 – Weekly outpatient therapy
- Level 4a – Enhanced outpatient therapy
- Level 4b – Intensive outpatient therapy
- Level 4c – Intensive residential treatment
- Level 4d – Therapeutic Community
- Level 5 – Medical/Mental health referral

Thirty-nine of the 40 JERP participants had SOA-R scores available for analysis. Table 5 provides the SOA-R treatment levels for the men in JERP. Based on this analysis, the JERP participants had co-occurring mental health and substance abuse problems as was intended by those who designed the program. In fact, nearly 100% were assessed to need intensive treatment for substance abuse.

**Table 5. Distribution of SOA-R Scores**

SOA-R Score	Overall (n = 39)	
	Number	Percent
<b>3</b>	2	5.1
<b>4a</b>	5	12.8
<b>4b</b>	22	56.4
<b>4c</b>	10	25.6
<b>Total</b>	<b>39</b>	<b>100.0</b>

Note: One person was missing SOA-R data.  
Data Source: ICCS Database

**Current Crime.** Table 6 details the most serious current conviction crime for offenders who participated in JERP between November 1, 2005 and October 31, 2007. Offenders were most frequently convicted of drug and property crimes. Fraud was the third most frequent crime of conviction.

**Table 6. Current Crime**

	<b>All Participants (n = 40)</b>	
	<b>Number</b>	<b>Percent</b>
<b>Drug Crime: Possession/Distribution of Drug or Contraband</b>	21	52.5
<b>Property Crime: Fraud/Burglary/Robbery/Theft/MVT</b>	19	47.5
<b>Fraud: Forger/Criminal Impersonation</b>	7	17.5
<b>Crime Against Person(s): Menace/Stalk/Assault</b>	5	12.5
<b>Weapons Crimes: Concealed Weapon</b>	5	12.5
<b>Crime Against Public Order: Harassment/Vehicular Eluding</b>	4	10.0
<b>Escape – Actual</b>	3	7.5
<b>Escape – Attempted</b>	1	2.5

Data Source: DOC and ICCS Documents

**Criminal History.** Information on prior adult criminal court activity in Colorado was obtained from Court Link (<https://w3.courtlink.lexisnexis.com/cocourtdata/>), a LexisNexis website. CourtLink provides 24/7, online access to more than 200 million Federal and state court records through a single search interface. LexisNexis CourtLink has agreed to act as the agent for the Colorado Judicial Department to provide access to ICON (Integrated Colorado Online Network) to the general public and for other vendors. It allows the user to look at a Colorado name index, all of the Registers of Actions related to that name, an index to court filings, and appearance dates. As a government entity, DCJ has access to some information not available to the public. Information provided in this report refers only to Colorado activities and may be incomplete.

Through LexisNexis researchers found that all participants had an adult criminal history. The average number of previous adult arrests was 10.6 and they had an average of 5.8 convictions. An examination of the Colorado Client Assessment Record (CCAR)<sup>56</sup> data, provided by JCMH, revealed that 44.4 percent had a juvenile criminal history as well.

**Level of Supervision (or Service) Inventory (LSI).** The Level of Supervision Inventory (LSI) is part of a battery of assessment instruments used in Colorado to identify individual offender risk and program needs for the purposes of matching those needs to available services.<sup>57,58</sup> The LSI is comprised of 54 static and

<sup>56</sup> Refer to page 40-41 for a description of CCAR items.

<sup>57</sup> Andrew, D.A., & Bonta, J. L. (2003). *Multi health systems. Level of Supervision Inventory-Revised*. U.S. Norms Manual Supplement.

dynamic items across 10 domains (criminal history, education and employment, financial, family and marital, accommodations, leisure and recreation, companions, alcohol and drug problems, emotional and personal, and attitude and orientation).<sup>59</sup> Static items refer to characteristics that are typically constant or not subject to change, such as criminal history. Dynamic items are subject to change and are intended to be the focus of each offender's the treatment and case management plans. Agency guidelines for classifying risk/needs level for Colorado probationers and offenders under the jurisdiction of the Department of Corrections are provided in Table 7, along with estimated recidivism rates for categories of risk scores, according to Andrews and Bonta (2003).

**Table 7. Established LSI score categories for designation of risk/need**

<b>RISK/NEED Category</b>	<b>Probation Scores</b>	<b>DOC Scores</b>
<b>Low</b>	1-18	0-12
<b>Medium</b>	19-28	13-26
<b>High</b>	29-54	27-54
<b>LSI Total Score (Raw Score)</b>	<b>Percent Chance of Recidivism within One Year (Based on Total Score)</b>	
0 to 5	9%	
6 to 10	20%	
11 to 15	25%	
16 to 20	30%	
21 to 25	40%	
26 to 30	43%	
31 to 35	50%	
36 to 40	53%	
41 to 45	58%	
46 to 50	69%	
50 to 54	<70%	

Source: Andrews, D.A., & Bonta, J. L. (2003). *Level of Supervision Inventory-Revised. U.S. Norms Manual Supplement*. Multi Health Systems. Toronto.

The LSI is part of the assessment process when offenders enter the JERP. Table 8 shows the possible range for each sub-score, as well as the actual mean and median of LSI scores for 39 JERP participants (all LSI data were unavailable for one participant).

<sup>58</sup> See Attachment A for a copy of the LSI.

<sup>59</sup> See Attachment B for a description of each of the subscales.

**Table 8. LSI Scores at Intake (n = 39)**

		Overall		
		Possible Range	Mean	Median
<b>Overall LSI Score</b>		0-54	32.03	32.00
<b>LSI Subscale Scores</b>	<b>Criminal History</b>	0-10	6.51	7.00
	<b>Education/Employment</b>	0-10	6.13	7.00
	<b>Financial</b>	0-2	.90	1.00
	<b>Family/Marital</b>	0-4	1.87	2.00
	<b>Accommodation</b>	0-3	1.56	2.00
	<b>Leisure/Recreation</b>	0-2	1.64	2.00
	<b>Companions</b>	0-5	3.08	3.00
	<b>Alcohol &amp; Drug Problems</b>	0-9	5.13	5.00
	<b>Emotional/Personal</b>	0-5	3.67	3.00
	<b>Attitude/Orientation</b>	0-4	1.44	1.00

Note: One program participant was missing all LSI data.

Data Sources: ICCS Database and DCJ Termination Form

According to the risk rates provided by Andrews and Bonta (2003) a population with a mean LSI score of 32 (as in the JERP population) has approximately a 50% chance of returning to prison. However, these risk rates do not account for the population also having mental health problems. While the risk level of the JERP clients, on average, is relatively high, research has shown that addressing individual needs can reduce recidivism by over 30%<sup>60</sup> and JERP programming was designed to reduce recidivism.

According to O’Keefe and Hayman<sup>61</sup>, in FY 2006 the mean LSI total score for the 21,838 inmates, parolees, and community corrections offenders with substance abuse problems was 30.5 whereas the mean score for the remaining 5,535 non-abusers was 23.6. Not surprisingly, given their mental health problems, JERP clients are at a moderately higher risk of recidivism than the average prison substance abuser and a considerably higher risk of recidivism than the non-abuser.

Table 9 compares the proportion of men in the JERP with LSI scores that correspond to the reoffending rates published by Andrews and Bonta (2003, Table 20).

<sup>60</sup> Gendreau, P., French, S.A., & Taylor, A. (2002). *What works (what doesn’t work) revised 2002*. Invited Submission to the International Community Corrections Association Monograph Series Project; Landenberger, N.& Lispey, M. (2005). The Positive Effects of Cognitive Behavioral Programs for Offenders: A Meta Analysis of Factors Associated with Effective Treatment. *Journal of Experimental Criminology, 1*, 165-197.

<sup>61</sup> O’keefe, M. L., & Hayman, K. (2007). *Overview of Substance Abuse Treatment Services: FY 2006*. Colorado Springs, CO: Colorado Department of Corrections, Office of Planning and Analysis.

**Table 9. JERP LSI Scores in LSI Score Categories (n=39)**

<b>Total LSI score</b>	<b>% (#) in JERP program with this score</b>	<b>Probability of Reoffending per Andrews and Bonta (2003)</b>
<b>21 – 25</b>	7.7% (3)	40%
<b>26 – 30</b>	28.2% (11)	43%
<b>31 – 35</b>	46.2% (18)	50%
<b>≥ 36</b>	17.9% (7)	53%
<b>Total</b>	<b>100.0 (39)</b>	<b>N/A</b>

Note: One program participant was missing all LSI data.  
Data Source: ICCS Database

### **Barriers to Reaching and Placing the Target Population**

From the data presented here, it appears that those participating in JERP met the established criteria that program developers were targeting. All participants had been diagnosed with a serious mental illness and had a significant mental health history, were high-risk offenders, were paroling to Jefferson and Gilpin counties, and many had drug and alcohol abuse or dependence.

However, a significant problem surfaced regarding the target population. The JERP program had 15 beds, and in over two years only 40 men—not the expected 60 or 80--were served and available for analysis in this study. In fact, the JERP beds were filled to capacity only once briefly during the study period, reflecting serious problems in the operation of the program. Given the apparent need (i.e., the high proportion of inmates in DOC who are in need of JERP-like services in the community), it seems reasonable to question not only why JERP beds remained vacant, but why there was no waiting list for JERP.

Multiple barriers were identified as interfering with the ability of JERP to operate at its 15-bed capacity. These barriers are discussed below.

**Selection Process.** The following is the selection process included in the original grant documentation creating the program:

According to program documentation<sup>62</sup>, the referral process was as follows (for a substantial portion of the time period under study):

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<sup>62</sup> Early program documentation provided by JCMH entitled “Community Parole/Mental Health Pilot Project Program Description.” (n.d.)

1. **DOC Case Managers** identify candidates who are within 16 months of parole eligibility and who are releasing to Jefferson/Gilpin counties, and refers these cases to
2. **DOC's Division of Adult Parole and Community Corrections** who reviews cases for the specific presence or absence of the following:
  - Psychiatric and substance abuse needs (presence)
  - Institutional behavior problems (absence)
  - Motivated to change (presence)
  - Willingness to participate in the program (presence)
  - Previous treatment attempts (discretion)
  - Previous response to treatment (discretion)
  - 8 months minimum length of time left on sentence
  - Type of offense/history of similar offenses (discretion)
  - Community resources available and appropriateness of resources (discretion)
  - Escape history/risk (absence)
  - Connection to the community (presence)
  - Job history (discretion)
  - Previous compliance
  - Response to medicationsSigned offender release of information for all providers, and refers these cases to
3. **JCMH** where staff assesses the man's medical/mental health files for eligibility, and forwards the candidate to
4. The **JERP team**, who determines if the client is someone they can manage in the program and who will have the best chance for success. And then
5. ICCS reviews the case for manageability within the facility based on criminal history, current offense, institutional behavior, previous community supervision, offender needs and available resources, risk to the community, and offender attitude, and
6. The Jefferson County Community **Corrections Screening Board** reviews the case and decides if the client is acceptable for community corrections, with a representative from ICCS and JCMH present at this meeting, and
  - If the offender's criminal history involves violence or a weapon, the case then goes to the **full JeffCo Community Corrections Board** meeting for approval, and
7. If accepted, the JeffCo Screening Board notifies DOC and arrangements are made to transport the offender.



Approximately 16 percent of DOC inmates have a severe and persistent mental health diagnosis (many with co-occurring substance abuse problems). However, the complex, multi-layered acceptance process that allowed for considerable discretion by each entity to screen clients, determined many released inmates who were in need of services as ineligible for the program. While some interviewees endorsed this approach, several other interviewees thought that it may help to explain why only half of those initially referred by DOC were actually accepted into the program (see Figure 1), contributing to the problem of empty JERP beds.

**County-Specific Placements.** According to DOC policy<sup>63</sup>, placement for those deemed appropriate for specialized programs and/or at case manager's request may be referred to an alternative community corrections center from the one in which the offender intends to parole. However, and not unlike many other state community corrections boards, the original program design limited participants to those who committed their crime(s) in Jefferson or Gilpin County or who because of a job or relatives intended to release to one of those counties. One purpose of this program acceptance criterion was to ensure a smooth transition between the offender's residential treatment at JERP to the non-residential services available in the community through the partnering agency JCMH after release.

The county-specific criterion was identified in the original program design when JERP was funded primarily through a federal grant. But when JERP funding changed in July 2007 from the federal grant to state General Fund dollars that paid an enhanced community corrections per diem rate for this high-need population, some stakeholders questioned whether the program should be open to any qualifying offender paroling in Colorado, regardless of whether they have connections to Jefferson County.

During the course of the study, researchers attended many weekly staff meetings and monthly steering committee meetings in which the county-specific topic arose. Researchers also discussed eligibility criteria with JERP staff and administrators and community members, before beginning the actual interviewing process. Throughout this time, the issue of out-of-county placements surfaced as a point of contention with several stakeholders. For this reason, researchers developed interview questions to specifically address the topic. The information below summarizes the research findings.

A primary limitation to keeping the beds filled, according to interviewees and stakeholder meetings, was that the program eligibility criteria were too strict, most notably the county-specific placement requirement. Some interviewees stated that they believed that once the funding stream changed from a federal grant to state funding, offenders from across the state should be eligible to participate in this state-funded service program, such as is the case with the

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<sup>63</sup> Adult Parole, Community Corrections, and Youthful Offender System. ( 2007). Administrative Regulation 250-03, Section IV-Procedures, Part C-2.

Independence House Therapeutic Community. Lifting this restriction would substantially expand the pool of eligible program participants.

Some interviewees raised concerns that the program's future could be in jeopardy since it relied on state funding to serve those with special needs in only one local community.

Interview data revealed a range of opinions regarding the obstacles to accepting out-of-county placements. Community corrections boards and programs' philosophies of local control and county-specific placements vary across jurisdictions, and several interviewees stated that the Jefferson County Community Corrections Board was one of the most conservative boards in operation. They were seen as the major obstacle to expanding the pool of offenders from which to choose.

“Community Corrections in Jefferson County is very conservative and limited when it comes to opportunities for offenders.”

“The JeffCo Board doesn't want to accept a wide range of offenders; they are a very conservative board. The Denver Board is much more progressive.”

Another issue concerning out-of-county placements is lack of consensus on policies about whether an offender can be referred elsewhere. One administrator said offenders often choose to parole to counties that have more programs available, better public transportation, and more job opportunities. However, when researchers attended a meeting with DOC mental health supervisors and other DOC staff, a DOC policy was referenced that requires eligible inmates be referred to community corrections placements in their county of conviction. In trying to resolve this discrepancy with the Administrative Regulation cited above, researchers were unable to locate any such regulation. It appeared that professionals from various vantage points in the re-entry system were unclear as to county-specific release criteria.

Overall, out-of-county offender participation was one of the primary issues raised regarding barriers to maximizing the use of the JERP beds, and it remained unresolved during the study period.

**Medical Issues.** The refusal to accept men with medical issues was also cited as an unreasonable preclusion from participation in the program. This criterion may be related to costs associated with medical conditions, but this was never mentioned during interviews or meetings. Interviewees who saw the JERP criteria as being too stringent noted that medical issues should not prevent someone from being able to participate in the program. One offender progressed through the JERP screening process and was accepted to the program only to be returned to DOC shortly following his intake at JERP due to a medical problem that began at DOC.

**Diversion Clients.** Along with expanding the criteria to include offenders outside of Jefferson County and accepting offenders with medical issues, a few interviewees stated that the JERP should consider expanding to include Diversion offenders. This was in response to problems experienced by the program regarding the referral system breakdown, which is covered in the next section.

### Referral System

**DOC's Jurisdiction Over JERP participants.** Because the JERP serves men transitioning out of the Colorado Department of Corrections, the first step in getting an offender into the program is through a referral out of the prison system. The process of transferring inmates out of DOC and into JERP was the most prominent concern, arising in nearly every interview with JERP administrators and staff. In fact, concern about this issue was so widespread that the offenders in focus groups talked about how the problem negatively affected the program. At times when JERP beds were under- utilized, administrators instigated an alternative system to bump up capacity. ICCS administrators reviewed documentation on transition offenders serving a regular ICCS sentence looking for any who had been diagnosed with a mental health disorder. These individuals would then be transferred directly into the JERP program from ICCS. The men participating in JERP who were admitted through the standard process felt that the offenders transferred from ICCS had less severe problems and didn't really need the JERP program, thus, minimizing their experiences.

From the program's launch date in November 2005 through July 2007, DOC naturally played a major role in getting referrals into the JERP. Original JERP documentation on the referral/selection process states "The Department of Corrections staff will identify eligible inmates...." <sup>64</sup>

When the program launched, DOC appointed a lead person, Manager of Community Mental Health Services, to help get referrals to JERP. The (then) Manager of Community Mental Health Services for DOC and a contractor also assigned to assist in this process established the referral system and organized trainings on the topic for case managers in DOC who were ultimately responsible for sending names to DOC's Division of Adult Parole, Community Corrections and Youthful Offender System (hereafter referred to as the DOC's community division). They also developed a monthly IT system to track and identify potential participants for the program that involved 1) the use of DOC's management information system's time computation component to identify potential participants from each prison, and 2) a great deal of outreach to DOC case managers and other DOC staff. After identifying and screening inmates, DOC's

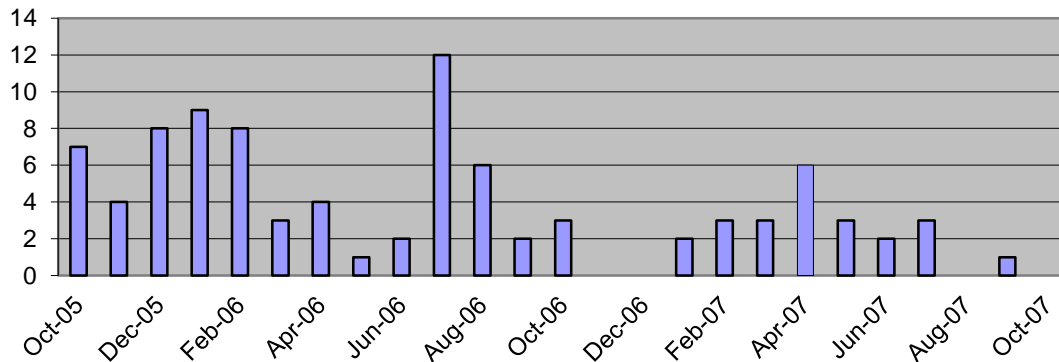
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<sup>64</sup> Early program documentation provided by JCMH entitled "Community Parole/Mental Health Pilot Project Program Description." (n.d.)

community division then referred candidates to the next step in the screening process, JCMH, for continued JERP-specific screening.

When the program moved from federal to state funding in July 2007, however, the designated referral persons at DOC were reassigned to other DOC business and were no longer available to function in the JERP referral capacity. Since JERP participants originated at DOC, the vacating of this key position effectively stalled the referral process. Figure 3 reflects the numbers of referrals made by DOC from January 2007-October 2007. It is clear that referrals, while never all that high during this time period, drop off significantly in August.

**Figure 3. Number of Referrals Emanating from DOC per Month (October, 2005-October 2007)**



Data provided by JERP Administrators

One interviewee stated that “[i]t was never DOC’s job in the first place to keep the beds full at JERP.” The same interviewee went on to clarify that DOC took on the referral role only initially, and that all the other JERP entities assumed DOC would continue to provide an employee to help facilitate referrals, yet without dedicated funding, DOC did not share this expectation.

Many administrators and staff interviewed agreed that there should be a single position or staff person dedicated to getting referrals into JERP and keeping the beds full. The process of sifting through thousands of inmates from multiple DOC facilities to find those who fit the JERP criteria requires DOC staff resources. Moving offenders through the lengthy and complex acceptance process would occur most efficiently if it was the responsibility of a specific person or position.

Despite what appears to be a cumbersome referral process where the decision to reject can be made by five separate entities, interviewees indicated that this process worked well and would continue despite the problems encountered with the initial DOC-to-JERP program “feeder” mechanism.

### **Do Other Specialized Community Corrections Programs Have Referral Problems?**

As part of the process of studying the JERP referral system, researchers examined the referral process for Independence House-Fillmore, another local community corrections facility located in Denver that also treats offenders with mental illness transitioning from DOC. Independence House was involved in a comprehensive study by the National Development and Research Institutes (NDRI) of DOC's therapeutic community (TC) programs for offenders with mental illness and chemical abuse (MICA) disorders. The study facilitated the referral process since TC participants in DOC TCs are transferred to Independence House-Fillmore.

Administrators at Independence House-Fillmore were interviewed to better understand the referral process and the organization's link to DOC. Interview data revealed the challenges of getting a solid referral system in place. Interviewees reported that it took a long time to build rapport with DOC's case managers and case manager supervisors, and that they had "growing pains for about five years". Currently the MICA researchers assist in the referral process from DOC. However, prior to the MICA study a designated Independence House staff member worked with DOC directly to get clients referred into the program. Administrators at Independence House said they think it is critical to have someone 'in-house' who is responsible for building a relationship with DOC and getting clients referred.

Researchers also interviewed four inmates in DOC who had participated in JERP but were regressed to prison. Two of the inmates interviewed confirmed that a representative from Independence House (and the MICA study) had come to DOC to talk to them about how their program could help them.

The person who originally worked with JERP to get clients referred to the program was a DOC employee, whereas Independence House-Fillmore provided their own employee for the referral process. Also, Independence House is linked to two TC programs within DOC, narrowing the relationship-building requirement to the case managers in those programs. JERP draws its referrals from the entire DOC system, and then narrows the eligibility pool with a long list of eligibility requirements. Assigning one individual to develop relationships with case managers and mental health staff from facilities across the state, not to mention meeting with individual inmates prior to release, makes a similar referral process untenable for the JERP.

### *Efforts to Eliminate Vacant Beds*

After July 2007, when a designated DOC employee screened potential JERP participants, JERP staff and the JERP Oversight Committee devoted considerable time to investigating the issues surrounding the referral problem. JERP staff members from JCMH and ICCS have worked in various capacities to

identify prospective JERP clients in DOC and get them referred into the program. Many efforts were undertaken to improve the referral process and fill beds at the JERP.

**Outreach Efforts and Case Manager Role.** In an effort to establish relationships and rapport with DOC staff directly—the method that had been valuable at Independence House--JERP staff and administrators hosted an open house for DOC case managers, case manager supervisors, and mental health staff. JERP staff traveled to DOC facilities and delivered presentations to case managers at the following locations/meetings:

- DOC Training Facility in Canon City
- Sterling Correctional Facility
- Pueblo State Hospital
- DOC Case Manager Supervisor meeting - Colorado Springs
- DOC mental health supervisor meeting – Colorado Springs

Interview data revealed a great discrepancy in opinion regarding the role of the institutional case manager and referrals to specialty programs in the community. Data from interviews and focus groups revealed that being aware of specific community program eligibility requirements for all the specialty programs in Colorado was too difficult for case managers whose main responsibilities were already overwhelming.

**Interviews with DOC case managers.** To further explore this significant issue, researchers held focus groups with 49 case managers and mental health staff from six DOC prisons across the state to obtain their perspective on the JERP program and the best way to move inmates into the program. Many of the case managers were supportive of the JERP program, understood the target population, and viewed it as their responsibility to get inmates referred into the program.

In general, DOC case managers stated that they managed an average of 70-90 offenders and are often overwhelmed with current duties without also preparing for an inmate's release to the community. Case managers overall stated that their main role was to evaluate inmates and provide case management while inmates were in the facility. When an offender exhibits mental health issues, a case manager refers the person to DOC mental health staff per DOC policy. Once the mental health referral is made, many case managers are no longer involved or informed in the inmate's treatment issues per federal confidentiality law requirements. The exception is that case managers know the P-Code of individuals on their caseload.

**ICCS 'internal' referrals.** With the significant drop in referrals since July 2007, JERP staff subsequently and informally developed an internal referral system in the latter part of 2007. ICCS staff began reviewing the transition cases referred

to ICCS for possible JERP eligibility. When a man was found to be eligible, a staff person from ICCS or JCMH would notify the DOC case manager in an effort to obtain the information necessary for a complete screening.

Several interviewees associated with the JERP stated concerns with this modified system. A Community Corrections Board Screening Committee member stated that this process is a problem because the Screening Committee often has inadequate information, making appropriate decision-making difficult. Delays in obtaining case information from DOC can also alter the review sequence. In at least one incidence, the full board considered an inmate for JERP before the referral had even been reviewed by JCMH.

An offender in one of the focus groups reported that he was aware of ICCS' effort to keep beds full, and stated that this process may result in the placement in JERP of offenders with less serious problems. While other focus group participants nodded in agreement, the man stated that identifying offenders with less serious problems and integrating them with those with serious mental health issues created tension among JERP participants. It appeared that other offenders in the focus group were in agreement with this offender's viewpoint as several were nodding in agreement while this offender was describing this dilemma. Quantitative data were not available to address this concern.

*In conclusion, the group that participated in JERP reflected the target population initially identified by program developers, but it served considerably fewer offenders than expected in the timeframe of this study. For a variety of reasons, the JERP beds were filled to capacity only once briefly during the first two years of operation. The inability to fill the JERP beds at ICCS was the subject of considerable concern among stakeholders during the study period.*

## **Question 2: Was the program being implemented as planned?**

*Yes, the program was generally implemented as planned. Much effort was invested into learning and implementing with fidelity the treatment modalities (SSIC and IDDT) selected by the program for use with this population who have a multitude of diagnoses.*

*An analysis of service hours found that JERP participants received a range of services designed to meet their individual needs. Interviews and focus groups with offenders—those who succeeded in the program and some who were returned to prison—revealed consistently positive experiences with the program. Program participants were grateful for the care and concern provided by JERP staff and reported significant relief from their treatment and medication regime.*

*Providing services on-site significantly facilitated the men's access to therapy, medication, support, education/vocational opportunities, and parole officials. Most said that they learned about mental illness and were provided cognitive tools that helped them manage their illnesses. Even those who returned to prison told researchers that they benefited from the program and that their experiences at JERP increased their ability to effectively interact with others when they returned prison. Only four offenders reported that they would not return to the program given the chance because they felt the rules of the community corrections program were in conflict with the goals of the JERP; one person cited concerns regarding the sharing of information amongst team members.*

*An important finding was the confusion and sense of overwhelm JERP men had with bus transportation, a problem plaguing many inmates' transition from prison to the community. But for those with serious mental illnesses, the problem is exacerbated. The JERP men suggested implementing a "buddy system" that would pair residents who are experienced with the bus system with those who express concern about their ability to navigate it as a way to address this area of difficulty.*

*During the study period, a written policies and procedures manual was not developed, although ICCS had a manual for their overall operations. A cooperative effort to develop a written document would clarify roles and responsibilities, particularly since multiple agencies are involved in the program, and could be used to train ICCS security staff.*

*In sum, the wrap-around service aspect of the JERP, the convenience of the on-site programming, and the care and quality of the staff were consistently mentioned by offenders and administrators as program highlights, suggesting that the program was implemented as designed. The JERP program staff and administrators were open to feedback from researchers and, in particular, were interested in training ICCS security staff so that they would be of assistance to the JERP participants.*

## **FINDINGS**

The main goal included in the original grant documentation was "to increase public safety and reduce recidivism through the continued implementation of a pilot wrap-around services program that facilitates the successful reintegration of prison inmates who suffer from serious and persistent mental illnesses and who have paroled to Jefferson County, Colorado." Grant documentation also stated this was to be achieved "through the integration of correctional supervision, mental health treatment, medication compliance, and substance abuse treatment." Twenty-eight individual interviews with professional staff either directly or peripherally involved and four focus groups across six DOC facilities including 49 case managers and clinicians were conducted to address these



targeted areas, along with offender interviews and focus groups. This section describes the study findings regarding the program's adherence to these principles.

As described previously, the JERP was designed to assist offenders with special needs transition successfully from prison to the community. Using a multi-disciplinary approach, JERP was designed to provide services to offenders with mental illness and substance abuse problems by providing transitional housing, medication management, mental health and substance abuse treatment, correctional supervision and accountability, and case management services. The JERP design centered on the collaborative effort of Intervention Community Corrections Services, the Jefferson Center for Mental Health, the Division of Criminal Justice, the Division of Justice Services in Jefferson County, and the Department of Corrections.

The program development subcommittee members of the Task Force on the Mentally Ill in the Justice System and the agency partners expressed commitment and enthusiasm for this collaborative project aimed at a high-risk, high-need offender population. The method selected for reducing the recidivism of the JERP participants was the implementation of this collaborative, multi-agency team delivering the above-described services primarily on-site designed to meet the individual needs of participants.

The findings described here address these stated objectives of the project, primarily as reported by staff, administrators, agency partners, and program participants.

#### *Collaborative, Multi-Disciplinary Structure*

The JERP's collaborative, multi-disciplinary structure was the core method of service delivery. A central component of this evaluation, then, was to ascertain the degree to which this structure was implemented as planned.

The service delivery team consisted of six professionals, and during the study period, team members met weekly to review each offender's progress and modify treatment plans as needed. Two full time JCMH therapists and one ICCS case manager delivered group and individual counseling. The community parole officer (CPO) (who also had a caseload of non-JERP clients) spent several hours each week at the facility. The nurse worked 20 hours each week providing medication monitoring and support. Originally the psychiatrist met with clients only at his office at the Jefferson Center for Mental Health, but later he also met with offenders on site, following meetings with the program team. This expedited medication adjustments and reduced the need for offenders to travel for appointments.

During interviews the JERP staff members and administrators consistently reported that the collaborative structure of the JERP was a critical and successful

component in the program design. The team members came from varied backgrounds with different agency missions, yet nearly all of these professionals consistently expressed respect for each other's opinions, positions, and backgrounds. Staff from each agency reported that they learned new perspectives from other team members. In general, this successful interaction facilitated problem solving and program development particularly during early program implementation. Therapists said they better understand the importance of community safety; parole staff and case managers said they learned more about the essential and critical nature of the therapeutic process. Team members reported that they could "agree to disagree," and regardless of personal differences, they reported that they work together toward a common goal: helping the JERP participants positively adjust back into the community.

"It's a pilot program and we learn as we go. I'm more and more comfortable as time goes on."

"We discuss issues from everyone's point of view in the group. The team then collaborates to make decisions on write-ups, discipline, treatment plans, etc."

"Roles become clearer the longer we're all together."

"The team approach works much better than having one point person when it comes to making decisions. Lots of different factors come into play when making decisions about these folks and it's good to see things from everyone's point of view."

Most team members said decisions were almost always made as a team. Yet when interviewers asked team members where ultimate authority for the program resided, or who made final decisions, responses varied. This lack of clarity regarding program authority was a consistent theme. Also, despite the positive remarks about team collaboration during interviews with researchers, personality and style differences led to staff turnover in two of the three key positions where turnover occurred over the course of the study. With a small and specialized staff, turnover can be disruptive to program operations and transition for the incoming team member can be difficult. During the study period, each of the following positions turned over:

- The ICCS case manager
- The substance abuse therapist
- The community parole officer

The struggles around key team members departing and the difficulty integrating new employees into the team reflected, in part, a lack of agreement about who was ultimately in charge. It was echoed in the inconsistent responses by interviewees to questions, discussed above, about the agency or position with the ultimate authority. The men in the program were offenders with significant

behavioral health needs, and the agencies managing the men differed in the longstanding *institutional* perspectives regarding what behaviors were acceptable, expected, and reasonable. Interview data revealed an intermittent disconnect between the philosophies of mental health and correctional agencies. At times this disconnect affected the functioning of the program team. While individually, the team members and administrators were committed to the program goal of helping the men reintegrate successfully, the lack of agreement and resolution about these fundamentals sometimes led to difficulties in program implementation and operations.

### Treatment Modality

The JERP's main program goal stated, in part, that staff from the participating agencies "will collaborate to provide individualized, comprehensive interventions that improve individuals' functioning and stability in the community." To this end, as was stated in Section Two, the JERP originally adopted the Strategies for Self-Improvement and Change (SSIC) treatment model as it is designed for those with mental illness whose pasts include criminality and substance abuse. Both therapists interviewed reported receiving training on this model and, in fact, researchers informally at the start of the program had lengthy conversations with the first two therapists regarding their experiences with the curriculum. These treatment providers invested a great deal of energy into acquiring the skills necessary to provide this service model effectively. And, for the first one and a half years of program implementation, this model was employed with all offenders in the JERP program. The therapists stated that while learning the model was intense, it was worth it because it was well suited to the JERP population. Treatment curriculum was provided and did indeed reflect that therapists were applying the SSIC principles in their service delivery to offenders.

At the request of the Colorado Division of Mental Health (DMH),<sup>65</sup> in the summer of 2007 JCMH embarked on the process of replacing the treatment model. JERP therapists and JCMH administrators once again poured a great deal of effort and resources into adopting Integrated Dual Diagnosis Treatment (IDDT, described in Section Two) as their primary treatment modality. JCMH retained a contractor with expertise in IDDT implementation that met with JCMH administrators and JERP clinicians weekly to introduce and refine the model to integrate with the current JERP structure and program. These weekly clinical trainings continued for several months, and technical assistance continues to be provided on an on-going basis. Therapists reported that the IDDT framework provided them with new tools for addressing offender's dual diagnoses.

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<sup>65</sup> The Colorado Division of Mental Health has oversight responsibility for mental health centers operating in Colorado. DMH concluded that mental health centers must select one of three approved evidence-based programs in their work with consumers. IDDT was determined to be the best fit for the JERP population.

### JCMH Services

“Continuity of treatment and access to medication during the transition out of prison and into the community, combined with team case management efforts to ensure appropriate structure and support” were part of the grant documentation program plan. As intended, many services and interventions were available to JERP participants. According to program documentation provided by JCMH, these services were primarily provided in the following formats:<sup>66</sup>

- Group Therapy
- Individual Counseling for more than 30 minutes (per session).<sup>67</sup>
- Individual Counseling for less than 30 minutes (per session).<sup>68</sup>
- Case Management with Clients
- Case Management without Clients
- Case Management with Clients on the Phone

JERP participants were required to attend all eight group sessions offered by the program each week while in their first month in the program during which time they were not allowed to leave the facility. This time period was intended to facilitate offender’s adjustment to life outside prison walls. Thereafter, when they were required to either job-hunt, work, or volunteer at the JCMH Summit Center (described in Section Two) they were required to attend one group session with each therapist per week and attend one individual session with their assigned therapist.

### Written Policies and Procedures

Written policies and procedures were in place for the umbrella ICCS facility, but there were currently no official policies and procedures specific to the JERP program. The Division of Criminal Justice’s Office of Community Corrections (OCC), the oversight agency for all the halfway house providers in the state, promulgates standards that require halfway houses to implement and retain a policies and procedures manual for their programs. ICCS is in compliance with the DCJ’s OCC standard requiring a policies and procedures manual, yet a specific set of written policies and procedures pertaining to JERP are also critical given the interagency aspect of the program. In addition, development of such a manual would likely lead to common ground and a sense of cohesion that would benefit program staff, stakeholders, and program participants.

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<sup>66</sup> Note that other services were provided, but these are the services provided most often. For exact times spent in each service, please see next subsection entitled “What outcomes were achieved by offenders at the time of program discharge?”

<sup>67</sup> Note that Individual counseling often included drug and alcohol assessments.

<sup>68</sup> See footnote 9.

Interview data revealed that it was hard to implement policies and procedures in the first two years because the program was in development. One administrator said that the time required to develop written policies and procedures was a barrier to accomplishing the task.

No single person or agency has been made responsible for documenting existing policies and procedures for JERP. Yet, this is a task that requires significant collaboration among administrators and program staff from each agency. Given the importance of ensuring that all agencies agree on the standard operating procedures, this task requires that the group work together to develop an outline, discuss, and agree on each procedure. Clarifying roles and responsibilities facilitates the decision making process, and ensures consistency over time. Given the conflicting perspectives that surfaced during interviews regarding agency authority and decision making responsibilities, and the impact these issues had on the core method for delivering the program—the multidisciplinary team—the development of written policies and procedures is an essential next step for JERP.

### Offender Views of Program Functioning

One of the goals of this research was to determine if the JERP was operating as designed. Researchers conducted in-depth interviews and focus groups with both current and former JERP participants. Researchers held a total of three focus groups with 16 JERP participants who were both on residential and non-residential status. Individual interviews with eight former JERP clients who completed both successfully and unsuccessfully; four of these men returned to prison and were interviewed there.

During the focus groups and individual interviews, the attitude of the offenders toward the program was overwhelmingly positive, with a few exceptions (discussed below). Most of the men interviewed said they would participate in JERP again if they had the chance. Almost all of the men said they couldn't have successfully made the transition back into society if it weren't for the JERP program. Two offenders from the focus groups and two offenders who were returned to DOC said that they would not participate in the program again if given the chance. Reasons provided by these offenders are discussed below.

**Program Strengths.** When asked about the strengths of the program, participants described the following the key themes:

- Abundance of resources
  - Appropriate medication for illness
  - Group treatment—frequency and type
  - Individual sessions with therapists
  - Variety of programming

- Access to vocational opportunities (Red Rocks Community College, The Gateway Program)
- Excellent Staff
  - Complementary roles and styles
  - Dedication
  - Caring
  - Desire to see offenders succeed
- Skill-building Efforts
  - Confidence building
  - Learned about mental illness, and how to manage it
  - Coping skills

Offenders repeatedly stated that they were amazed at the level of caring by the key staff people and other JERP participants. They reported that this was the key motivating factor for their progress through the program. Many reported this caring was in stark contrast to anything that they had experienced before. Several offenders stated that they were very angry, guarded, and mistrustful when they arrived. In fact, these same offenders reported that due to their inability to feel confident enough to talk and make eye contact, it would have been very difficult for them to participate in the research study as interviewees or focus group participants if contact with researchers had been closer to their program entry date.

Focus group participants had the following to say about their experiences with the staff and programs:

“Without [the two therapists] I’d be back in prison.”

“I’m a totally different person than I was and I give that 99% to [the therapist].”

“[The nurse] is great. A lot of times they’ll forget to check our meds in and [the nurse] will stay late and make sure that everything is good for us and we’re situated.”

“The education [cognitive and substance abuse treatment] has been great. I’ve learned an amazing amount about how to live life, how to deal with my thoughts, feelings and emotions.”

“They give you all kinds of life skill tools that are invaluable.”

“This is a tremendous staff. \_\_\_\_\_ is the most incredible case manager. The accessibility is great. You can’t talk to case managers on the other side (regular ICCS) without making an appointment. \_\_\_\_\_ lets you just drop in.”

“I’d come back if I had it to do over again. I want to be a mentor for guys coming in. I’d even like to go to DOC and talk to case managers or work as a liaison to get other guys brought in here.”

“If I hadn’t have come here I would’ve gone straight to the homeless shelter.”

**Program Weaknesses.** One offender expressed discomfort with the perceived lack of confidentiality among members of the JERP program team; he felt this seriously impeded his ability to discuss his concerns in treatment. Others identified the following problems with the program:

- The JERP staff was available only during regular work hours, Monday through Friday, but the mental health needs of the clientele occurred round-the-clock.
- ICCS security staff had no understanding of mental health problems, creating considerable problems for the JERP participants.
  - This created important problems with the medication distribution.
- The JERP men were co-mingled with the general population, even though the administration made efforts to limit interaction. Some JERP participants said they felt vulnerable because their JERP status was known to more hardened offenders.

**Offenders Returned to Prison.** Most offenders who regressed to prison also reported positive experiences with the program. Most stated that they learned skills while participating in JERP that helped them better accommodate to the demands and stressors of the prison environment. The following are some of the comments made by these offenders regarding program strengths:

“I learned tools there that have helped me back in prison this time around. I’m more comfortable with people now.”

“I got a lot out of it and I really understand my mental illness and thinking patterns now.”

“I got great skills; I didn’t realize how sick I was. Now I realize why I was so dysfunctional. I used to think I was a piece of \_\_\_ but the program built me back up to believe in myself. My treatment helped me change my view of myself. I learned how to change my thinking.”

“I tell everyone that the program is the best thing going right now.”

“You think JERP can’t be for real until you get in there. They want to see you strive, succeed and move on. The little time I was there I got a lot of treatment, support and love. When I was there it was successful, it wasn’t a waste. It’s a wonderful program.”

In sum, then, the overwhelming response from offenders, including those who failed the program and returned to prison, was that the JERP was a positive experience for them, significantly helping them learn about and manage their illness and improve their ability to function.

**Therapeutic Community Elements.** While the JERP doesn't operate under a Therapeutic Community (TC) model, there are elements of a TC in the program that offenders said they found very beneficial. Most of the JERP participants reported feeling a bond with each other that they had not experienced in prior programs or facilities. Some men said that from the moment they got off the bus from DOC, a fellow JERP client was there to help them, tell them what the program was about, and assist them in beginning the transition process.

“The peer support was the best part. Someone in our group meetings was always ‘the rock’ and we would fill that role for each other. Someone was always there for me or any of us to keep us straight.”

“This program has facilitated all of us to help each other and take care of each other and through being together and caring for one another we learn that much more about our problems.”

Overall, offenders--current and previous, successful and unsuccessful--reported that the program was a lifeline for them in ways that they had never experienced before. They found the programming to be inclusive of their needs, supportive of their progress, complete in what was offered, and delivered in a caring manner. They resoundingly reported that they were thankful that they participated in the program, even though it presented them with many challenges along the way.

**“One-Stop-Shop” Wrap-Around Services.** As discussed in the introduction, the goal of this program is to increase public safety and reduce recidivism through the implementation of a wrap-around services program. Offenders were to be assessed, evaluated and programmed for services at a centralized location (ICCS) by a multidisciplinary team consisting of a case manager, parole officer, and mental health professionals who would also provide substance services.

To this end, the JERP included a combination of offender services in one central location at the ICCS facility. Services included the following:

- case management,
- individual and group therapy (both mental health and substance abuse),
- nursing services to help with medication needs,
- psychiatrist consultations for diagnosis and prescribing medications,
- access to the community parole officer, and
- educational/ vocational training.



Almost everyone interviewed, clients as well as staff, agreed that one of the most positive elements of the JERP was the wrap-around service model. JERP clients said it was very helpful that everything they need and are required to participate in is in one building. Many offenders said they often go to more groups than are required simply because they are so convenient to attend.

“It’s helpful that everything is in the building. You can roll out of bed and make group. Not having to go out and face the world sometimes is a good thing. The groups would be much harder to attend if they weren’t in-house.”

“The JERP concept can really give these guys support they couldn’t get anywhere else.”

“Team treatment in a confined setting is far and away the best thing about this program.”

“The psychiatrist makes sure your meds are right and you’re stable. The therapist helped get me emotionally stable. The case manager helps with your job search program.”

“I know all the people working with me are also talking to each other about my case to make sure I get through.”

Furthermore, program staff reported being deeply committed to the JERP mission. Team members said they often go beyond what would be considered ‘normal’ duties to help JERP clients succeed. The community parole officer (CPO) reported that it was important to help program participants avoid situations that cause stress. For example, non-JERP ICCS clients are required to find their own transportation but, when possible, the CPO drove JERP clients to appointments because navigating the bus system can be overwhelming for them. One of the program therapists took a JERP client to his mother’s home for a visit, something that was really important to him at one point during his treatment. Another therapist reported helping offenders obtain new identification cards, birth certificates, Social Security cards, and Social Security benefits.

One offender, however, reported a problem with the team approach. He expressed discomfort with what he believed was a lack of confidentiality. He said he wanted to be really honest with his therapist, but doing so would result in the therapist disclosing information to the CPO that could get him in trouble.

**Medication Management.** A major JERP component is psychiatric stabilization through effective assessment and implementation of an individualized medication regime. Accomplishing this objective was a core aspect of the JERP design. Program developers intended that offenders be properly assessed and diagnosed, and receive prescriptions for medications necessary for effective

symptom management. Each individual's response to the medication regime would be monitored and, if necessary, reassessed.

Medication needs varied by offender, and nearly all of the participants in JERP were prescribed and taking psychotropic medications. In addition, staff worked with the men to help them understand their mental illness and the role of medications in reducing symptoms. The evidence below suggests that this medication management component of JERP was well implemented.

Offenders were usually transferred from the Department of Corrections to the JERP facility with the medications that they had been prescribed while in prison. During the first month in the program, the men were scheduled for an intake interview and evaluation with the JERP psychiatrist. A nurse also worked with offenders to monitor the effects of the medications. The nurse consulted with the psychiatrist and recommended adjustments when necessary.

Focus group and interview data found that a majority of offenders felt that considerable time and attention was given to their medication management. Offenders reported that the nurse role was essential to their success and that the person filling this role was very dedicated to their overall wellbeing. They also reported that the psychiatrist carefully worked with them to make sure they were taking the right medications at the proper dosage. One man stated that his medications were tailored to his needs in JERP in comparison to the medications he received in prison which were barely helpful. These findings suggest that the assessment and medication monitoring—a core JERP service according to program description materials—was implemented as planned.

“My medication regime is finally stable.”

“I've got good meds. I'm sleeping now. The combo of meds and therapy is working wonders for me.”

“Without this program I couldn't afford my meds.”

**Medication Distribution.** Medication management was the responsibility of the JERP staff, and ICCS security staff handled the daily medication distribution activity. In general, the men reported concerns about the method of medication distribution. Issues surrounding medication distribution surfaced in two of the three focus groups with JERP clients. The concerns centered the security staff's lack of knowledge about mental health issues and the role medication plays in treating this specific offender population.

The following are some of the situations described by JERP clients that caused them concern:

- A focus group participant said he was five minutes late to the distribution window and the line-staff refused to let him have his medication.
- Another man said that he had problems with the line staff regarding a drug he was taking that was prescribed with directions to “take as needed.” When he requested the medication, staff told him that since it was not a required medication, he should come back later in the day during the designated medication distribution time.
- A man had medicine with directions to “take with food.” He said the security staff would not give him anything to eat when he took his pills.
- A man reported embarrassment when a line-staff worker who was distributing his medication asked loudly when others were present, “What is *that* one for?” The man said he felt singled out for his mental illness in the presence of non-JERP offenders.
- A focus group participant stated that he was denied his medication and subsequently suffered an anxiety attack. The staff did not understand his behavior, and the offender received a write-up for the incident.

Security staff showed the researchers the medication distribution area and explained in detail the procedures. Researchers were shown computerized logs where medications were tracked and received descriptions about the scrutiny under which the distribution process occurs. It became clear that one potential pitfall of the process was the lack of documentation at the distribution window of all the medications the men were taking. Consequently, each man was required to approach the window and tell staff what medications he needed to take. Unfortunately, this system required the person with mental illness to correctly remember his medication regime. This can be particularly problematic during the period that one’s illness is in the process of being stabilized, i.e., when cognition and emotional functioning may be compromised. In addition, given the lack of privacy in this arrangement, the approach had the potential of violating federal confidentiality and privacy laws since other ICCS offenders were within earshot of the distribution window. These procedures require further examination by JERP administrators.

Researchers discussed with JERP program administrators the concerns identified above by the clients. Specific incidents were investigated and one staff member who seemed to be linked to many of the incidents was let go. Administrators also planned to conduct training with security staff on the importance of proper psychotropic medication distribution and confidentiality regulations.

In general, then, the medication distribution procedure was found to be problematic, but the JERP program administrators were responsive when made aware of problems. Administrators and program staff may want to implement

procedures that, during intake and throughout the residential stay, actively encourage clients to report problems related to medication or other service interventions.

**Physical Facility/Co-Mingling of Populations.** As stated earlier, the JERP exists within the ICCS halfway house. While many aspects of the JERP operate independently of the halfway house, the fact that it is co-located with non-JERP clientele creates specific challenges, according to offender focus groups and staff interviews. The JERP offenders stated that the constant interaction with the general population at ICCS was detrimental to their progress in the program. According to information obtained during the focus groups, many of the non-JERP offenders were operating within the anti-social “convict code” which was in conflict with the mental health and substance abuse treatment they were receiving. Also, some JERP clients said they felt vulnerable because they were identified to the non-JERP population as having a mental illness.

Both offenders and staff also reported that a separate program facility would allow for the entire staff—treatment and security—to be trained in mental health issues.

“It always seemed like a tug and push between ICCS and JERP. If I needed to see the doctor the JERP people would say okay, but then ICCS wouldn’t allow it. It was frustrating.”

*Many populations are co-mingled.* The JERP population was designed to target men transitioning to the community from DOC. The ICCS population, like many community corrections facilities across the state, is made up of both men and women and includes not only offenders transitioning out of DOC, but offenders who are court ordered to serve a community corrections sentence in lieu of prison. Previous studies of community corrections conducted by the Division of Criminal Justice’s Office of Research and Statistics (ORS) underscore significant differences among the transition and diversion offender populations.<sup>69</sup> Also, the use of coed facilities was criticized in an earlier ORS study.<sup>70</sup>

The JERP program offices were located in a wing of the ICCS building that was separate from the general population staff offices. However, both the JERP and the general population were housed in the same locations in the facility and they

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<sup>69</sup> Diversion offenders are younger, less likely to be married, often less motivated to change than their transition counterparts, are adjusting to increase in structure rather than a decrease in structure, are less likely to successfully complete the program, and are more likely than transition offenders to escape/abscond from the halfway house (Hetz-Burrell, N., & English, K. (2006). *Community corrections in Colorado: A study of program outcomes and recidivism*. Denver, Colorado: Office of Research and Statistics, Division of Criminal Justice, Department of Public Safety, also available at: [http://dcj.state.co.us/ors/pdf/docs/Comm\\_Corr\\_05\\_06.pdf](http://dcj.state.co.us/ors/pdf/docs/Comm_Corr_05_06.pdf)).

<sup>70</sup> Woodburn, S.G., & English, K. (2002). *Community corrections in Colorado: A report of findings*. Denver, Colorado: Office of Research and Statistics, Division of Criminal Justice, Department of Public Safety, also available at: [http://dcj.state.co.us/ors/pdf/docs/Comm\\_Corr\\_05\\_06.pdf](http://dcj.state.co.us/ors/pdf/docs/Comm_Corr_05_06.pdf)).

used the same line staff security office to check into and out of the facility, participate in urinalysis tests, obtain medication, and engage in other security-related activities. Both populations also share the lunchroom, a courtyard for leisure activities, and the hours and space for educational programming. Offenders reported that this can make it much more difficult for them to resist the negativity and criminal thinking that existed with many of the diversion residents. These differences can make substantial differences in an individual offender's ability to adhere to house rules and maintain a pro-social attitude.

While the JERP staff understood mental health issues, the regular ICCS staff was not trained in this area of specialization. The JERP staff was available to the offenders from Monday through Friday, 8am to 8pm. The remainder of the time only ICCS staff worked at the facility. JERP clients said they felt that their mental health needs were taken care of very well during the week but that in the evenings and on the weekends they were "on their own." Both JERP clients and some JERP staff stated that the security staff (ICCS) was not interested in mental health and so treated the JERP clients as "a number."

"JERP staff members understand us but the ICCS staff members don't. The JERP staff is therapeutically minded but the ICCS staff is more punitive."

"The JERP staff is tremendous, unfortunately from 8pm to 8am and on the weekends there's no one for us to talk to."

"Ideally there should be a 24-hour mental health person on staff if it's a mental health focused program. I'm bi-polar and I can forget stuff but its all medication related. I got seven write-ups in nine days. If you have a meltdown and there's no JERP staff here, you're screwed."

When researchers interviewed staff at Independence House, another community corrections agency with a similar population, the issue of co-mingling different populations was discussed. Interviewees said that when they originally started treating offenders with mental illness they, too, housed many different populations in the same building: offenders with mental illness, women, men, transition, and diversion clients.

"Our escape rates were really high in the beginning (when our general population and mental health population were mixed). The program flourished and escape rates went down when the mental health offenders had their own facility."

According to interviewees, every employee at Independence House who comes into contact with offenders (from security staff up to administrators) has had mental health training and many have a specialized background in mental health, providing for a cohesive and consistent approach to the issues common to this

population of offenders. Independence House operates this component of the program as a therapeutic community, which is not a goal of JERP. Nevertheless, JERP offenders and staff both reported that having 24-hour, 7 days per week, mental health coverage would be of significant benefit to program participants.

When these findings were discussed with JERP administrators, they agreed with the need for training and creativity in housing options.

**Transportation.** Offenders in focus groups identified navigating the bus system as a major obstacle for them. For this reason, they stated that not being able to leave the facility for the first month of their stay in the program was a good policy. While previous community corrections studies have found transportation barriers to be a struggle for offenders returning to the community,<sup>71</sup> these offenders described the significant difficulty they experienced with the over-stimulation of the experience itself.

Many reported receiving assistance from the case manager to read the route maps before leaving the facility, but the actual experience remained overwhelming and disorienting. The noise, visual stimulation, and confusion, combined with a lack of confidence, made travel an extremely negative experience. One offender reported that he rode to Brighton—90 minutes away--before he realized he was headed in the wrong direction. While this confusion can occur to anyone using the bus system for the first time, these offenders stated that their mental illness affected their ability to successfully interact and communicate with others to solve problems, adversely affecting their ability to effectively manage the common problem of transportation. This is especially evident in unfamiliar settings with unknown people in contexts where there is a great deal of activity. Further exacerbating threats to their success, these offenders' inability to effectively seek assistance can result in being late to appointments or in late returns to the facility, oftentimes resulting in significant problems for the offender.

*Buddy System.* JERP participants suggested instituting a buddy system for the first weeks in the program for individuals using public transportation. They stated that this could ease offenders into what some considered was the most overwhelming experience in the program: using the bus system. A buddy system for their initial trips into the community, they felt, would improve their confidence and help them learn to manage their overwhelming experience and navigate the system on their own.

*Fraternization.* While the men strongly recommended the buddy system, they discussed the primary barrier that rendered the idea impossible: the parole condition that prohibits them from interacting with fellow JERP participants, past or present, outside the confines of the actual facility. One offender reported that he was given permission to have a fellow JERP participant accompany him off-

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<sup>71</sup> Ibid.

grounds “once or twice,” but this was a special exception because of his severely debilitating circumstances. They talked about the fact that they develop strong bonds of support amongst each other while in the program, which is all part of the program. But once they leave they are denied this access except on group nights, and with the unpredictability of their triggers, planned group nights were sometimes not enough.

Thus there appear to be two key challenging junctures: 1) after leaving prison, entering the half-way house, and actually penetrating society, and 2) when they leave the half-way house for a more independent living arrangement. At each point, they are disallowed the support they experience while in the program that encourages success once they are on their own. Offenders mentioned two program participants in particular that they felt really could have benefited from the support of their program peers, but instead made bad decisions and ended up back in prison. They stated that this is the key parole condition that they would like to see reevaluated to allow for discretionary circumstances, such as participation in the JERP program.

*In conclusion, the program was generally implemented as designed. Deliberate processes were in place to deliver the selected therapeutic interventions with high fidelity. Offender participants felt that the staff was caring, professional and effective at what they did. Several programmatic issues were noted by offenders and staff that program staff was open to discuss and consider.*

### **Question 3: What outcomes were achieved by offenders at the time of program discharge?**

*The successful program completion rate for the JERP program in its first 27 months of operation was 48.5 percent. While this rate did not meet the targeted rate of 56 percent stated in grant documentation, it is an impressive rate for a start-up program, especially when considering the degree of seriousness of the JERP population. Positive relationships were found between program participants on all but one of the CCAR variables examined, regardless of whether they successfully completed the program. Perhaps most notable is that all participants who volunteered at JCMH’s Summit Center (described below) successfully completed the program.*

## **FINDINGS**

This section presents outcomes in several domains of achievement including program completion, mental health, substance use, education, and employment/volunteering, for those 33 individuals who had completed the program by December 31, 2007. Data are often reported by those who successfully

completed the program and those who did not in order to compare the groups and reveal any significant differences that may inform later programming. All quantitative findings should be interpreted with caution because of the small number of participants included in this portion of the study.

Program Completion

As was stated in Section One of this report, the primary grant goal outlined in the original grant application was a 56 percent successful termination rate for this high risk population. Table 10 indicates that, for those terminating within the first 27 months of the program, the successful termination rate was 48.5 percent.

**Table 10. Program Completion and Termination Reason**

	<b>Number</b>	<b>Percent</b>
<b>Successful Termination</b>	16	48.5
<b>Escape</b>	5	15.1
<b>Technical Violation</b>	12	36.4
<b>Total</b>	<b>33</b>	<b>100</b>

Data Source: DCJ termination data.

Overall Educational Hours

Educational programming included, among other things, reading, math, computer skill development, writing, and GED preparation. As can be seen in Table 11 below, that while the group that succeeded received on average approximately 16 more education hours than the group[ that failed, this difference was not statistically significant.

**Table 11. Average Number of Educational Hours Received**

	<b>Successes (n = 14)</b>	<b>Failures (n = 17)</b>	<b>Overall (n = 31)</b>
<b>Mean</b>	56.3	39.9	47.3
<b>Median</b>	30.0	26.5	29.0
<b>Range</b>	2 - 193	4 - 177	2 - 193

Note: Two success cases were missing education data. No statistical differences were found.  
Data source: ICCS Database



## Mental Health

The Colorado Client Assessment Record (CCAR) is a well-researched instrument that originated in 1978 and is currently required of all admissions and discharges to the Colorado Public Mental Health System (Colorado Department of Human Services, Division of Mental Health, 2008). This includes the men who were admitted to JERP and treated by the Jefferson Center for Mental Health (JCMH). The purpose of the CCAR is to monitor the performance of mental health centers by examining the changes in patients' mental health functioning.

Areas of clinical interest were measured by comparing the intake and last scores of those who were successfully discharged to those who failed. Scores were measured on a nine-point Likert scale (1 = no problems observed in this area, 9 = severe/inhibiting problems observed in this area<sup>72</sup>). Note that the CCAR was to have been updated every six months during JERP participation, however, this did not always occur. The "last" score may have been at discharge or simply the final update. Only those that had multiple CCAR scores were included in the analysis.

Table 12 shows the average intake and last scores, as measured by the nine point CCAR scales, for those that were successfully terminated from JERP in comparison to those that failed. The following definitions, directly from the CCAR instrument, help explain the meaning of the terms used and domains reported in Table 12:

- Cognition: The extent to which a person performs cognitive tasks and experiences symptoms such as, but not limited to, confusion, poor problem solving, and impaired judgment.
- Alcohol Use: The extent to which a person's use of alcohol impairs daily functioning.
- Drug Use: The extent to which a person's use of legal or illegal drugs impairs daily functioning.
- Socialization: The extent to which a person's conduct deviates from cultural and/or social norms.
- Overall Symptom Severity: The rate of the severity of the person's mental health symptoms.
- Social Support: The extent to which a person has relationships with supportive people who will contribute to recovery.
- Empowerment: The extent to which a person uses available resources that contribute to personal health, welfare, and recovery. This includes knowledge and understanding of symptoms, treatment options, and resource alternatives.
- Overall Recovery: The extent to which a person is involved in the process of getting better and developing/restoring/maintaining a positive and meaningful sense of self.

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<sup>72</sup> See [http://dcj.state.co.us/ors/pdf/docs/Anita\\_Appendix\\_F.pdf](http://dcj.state.co.us/ors/pdf/docs/Anita_Appendix_F.pdf) to view full CCAR.

- Overall Level of Functioning: The extent to which a person is able to carry out activities of daily living, despite the presence of mental health symptoms.

**Table 12. Differences in Domain Score Averages (Mean) at Intake and Last Assessment**

Domain Scale	Successes (n = 13)		Failures (n = 18)	
	Average Intake	Average Last	Average Intake	Average Last
Socialization	2.71	2.79 <sup>a</sup>	3.12	5.59 <sup>a</sup>
Cognition	3.07	2.57 <sup>b</sup>	3.00	2.71 <sup>b</sup>
Alcohol Use	3.00	2.36	2.41	3.00
Drug Use	3.64	2.57	3.41	3.76
Overall Symptom Severity	5.29	4.57 <sup>c</sup>	5.41	5.41 <sup>c</sup>
Social Support	4.86	4.21	4.29	3.18
Empowerment	4.79	2.79 <sup>d</sup>	6.94	5.88 <sup>d</sup>
Overall Recovery	5.36	4.71	5.35	4.24
Overall Level of Functioning	4.64	3.57	5.12	4.12

Note: Lower scores reflect lower needs; higher scores reflect higher needs. CCAR data was unknown for two successes; means were calculated with only known information. The following p-values indicate whether the statistical differences between success and failures were significant: <sup>a</sup> $p < .0001$ , <sup>b</sup> $p = .08$ , <sup>c</sup> $p = .09$ , <sup>d</sup> $p < .0001$ .

Thirty-one JERP participants were assessed multiple times. A correlation analysis was conducted to determine if intake scores were predictive of later scores within the same domains. Only the relationship between intake and last scores for socialization was *not* found to be predictive of later scores (data not presented).

As presented in Table 12, of those individuals that were assessed multiple times, score differences were found to exist between those who were successfully discharged and those who failed:

- Average Socialization scores got worse for all participants, but were significantly worse for those who failed in comparison to those who succeeded.
- Cognition was found to be marginally better for those that succeeded in comparison to those that failed.
- Overall Symptom Severity was marginally better for those that succeeded than those that failed.
- Average levels of Empowerment scores improved for both successes and failures but those who succeeded had significantly better scores than those who failed.

Lastly, a marginal correlation was found to exist between the number of prior psychiatric hospitalizations and success/failure status. Specifically, JERP participants who succeeded were previously hospitalized for psychological issues on average 1.93 (N=15) times compared to .24 (N=17) times for those who failed (data not presented).

Substance Use

Table 13 presents drug and alcohol usage by those who have failed the program based on the most recent urinalysis results prior to their termination. It can be seen that failures were using alcohol and illegal substances such as amphetamines, cocaine, opiates, and marijuana at a fairly limited rate. Not surprisingly, no urinalysis results indicated use by those who successfully completed the program.

**Table 13. Substance Use, Most Recent Urinalysis Results: Program Failures**

Drug	Frequency Using at Last Assessment	
	Failures (n = 17)	
	#	%
Amphetamines	4	23.5
Barbiturates/Sedatives/Tranquilizers	0	0.0
Cocaine/Crack	1	5.9
Alcohol	2	11.8
Hallucinogens	0	0.0
Heroin	0	0.0
Inhalants	0	0.0
Other Opiates/Narcotics	1	5.9
Marijuana	1	5.9

Note: Because JERP is intended to treat addiction (typically drug and/or alcohol), this is an important aspect to consider. Last assessment scores were used (rather than first assessment scores) as a way to determine the usefulness of the drug treatment program. CCAR data were unknown for one failure; percentages were calculated with only known information. Furthermore, while some offenders were not using any substances others may have been using more than one concurrently, thus percentages do not add up to 100%.

Data source: CCAR

### Service Use

While the average length of stay was comparable for both those who successfully completed the program and those who did not, as can be seen in Table 14, JERP clients did not use available services equally.

**Table 14. Average Length of Stay (Days)**

	<b>Days (average)</b>
<b>Successes (n = 15)</b>	167.9
<b>Failures (n = 15)</b>	118.5
<b>Overall</b>	<b>143.2</b>

Note: Length of Stay was known for only 30 individuals.  
Data source: ICCS Database

The primary services received, as well as the mean number of hours spent in each service, can be seen in Table 15 below. Differences in the mean number of overall service hours received were found between those that succeeded and those that failed the program. The overall mean number of service hours received (including both JERP specific and non-JERP specific services) was significantly greater for those who succeeded than for those that failed the program (M = 334.8 hours and M = 109.3 hours, respectively).

Specifically, men who succeeded received more of each of the following services:

- Direct services (individual therapy, group therapy, and case management<sup>73</sup> with the client),
- Indirect services (case management without the client),
- Extraneous services, including time at JCMH's H.A.F., and
- House (residential facility) and the Summit Center, (recreational and vocational assistance program), and time at Teller House (residential facility).

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<sup>73</sup> Case management included activities such as setting up appointments, contacting service providers, and making arrangements so that participant needs are met.

**Table 15. Mean Total Hours Spent in Each JERP-Specific Service**

		Successes (n = 13)			Failures (n = 17)		
		Mean Hours	Range	N	Mean Hours	Range	N
<b>Direct Services</b>	<b>Individual Therapy</b>	37.3	1.0-84.3	16	26.2	3.3-54.4	17
	<b>Group Therapy</b>	113.1	2.0-316.6	16	77.0	3.0-322.9	7
	<b>Case Management with Client</b>	14.5	.7-63.1	15	3.8*	.7-10.9	17
<b>Total Direct Service Time</b>		164.0	3.0-454.2	16	107.0	7.75-371.5	17
<b>Indirect Services</b>	<b>Case Management without Client</b>	6.1	.3-16.8	13	2.4	.5-10.8	12
<b>Extraneous Services</b>	<b>Extraneous Service</b>	24.3	12.5-36.0	2	1	1-1	1
<b>Other</b>	<b>Teller House Time</b>	4.0	1.5-12.6	6	1.3	.3-5.5	7

Note: Service data was unknown for two success cases. Extraneous services included time at the H.A.F. House as well as recreational time at the Summit Center.

\*Mean differences were statistically significant for case management with the client ( $p=.02$ ).

Data Source: ICCS Database

Furthermore, as would be expected, the longer a participant was in the residential portion of the program (as measured by days) the more time they tended to spend receiving services. In fact, approximately 16 percent of service hours could be accounted for by length of stay.

### Employment and Volunteering

It is not surprising to see in Table 16, below, that successes received more service time than failures (services include direct and indirect services as referred to in the previous table). However, it may be surprising that those who volunteered received many more services hours than those that neither worked nor volunteered ( $p=.01$ ). Also noteworthy in Table 16 is that all eight of the individuals that volunteered (volunteered only and worked and volunteered) successfully completed JERP. While conceptually and practically one may conclude that the interaction of volunteering at the Summit Center (a program for individuals with mental illness) and a high number of service hours leads to success, no statistical tests can be conducted to demonstrate this due to the low number of cases and the lack of a comparison group (no volunteers failed).

**Table 16. Average Number of Service Hours (Direct and Indirect) Received for those that Did or Did Not Work or Volunteer (n=10)**

	<b>Successes</b>	<b>Failures</b>	<b>Overall</b>
<b>Worked and Volunteered</b>	220.5 (n=2)	N/A (n=0)**	220.5
<b>Worked only</b>	121.9 (n=6)	124.7 (n=9)	123.6
<b>Volunteered only</b>	252.9 (n=6)	N/A (n=0)**	252.9*
<b>Neither Worked nor Volunteered</b>	18.9 (n=2)	91.9 (n=8)	77.3*
<b>Overall</b>	<b>170.5</b>	<b>109.3</b>	<b>138.9</b>

\*Comparison between those that volunteered only and those that neither worked nor volunteered revealed a statistically significant difference of  $p < .010$ .

Note: Service hours include time spent receiving only direct and indirect services.

\*\*None who volunteered failed.

Data source: ICCS and JCMH Datasets

A logistic regression was performed to determine if work (employment or volunteer time), service hours (direct and indirect), education hours, and length of stay were related to success. Although length of stay and service hours were found to have an effect on success, work (paid employment or volunteer time) was found to have the most significant effect ( $p < .05$ ) (*data not shown*).

What was it about these individuals and/or the volunteer experience that was so strongly predictive of success? After examining differences in mean LSI scores, mean service hours received, mean educational hours received, and mean length of stay, the biggest difference was found in length of stay: both volunteers and those with paid employment had significantly longer lengths of stay than non volunteers/workers (*data not shown*).

*In conclusion, volunteer experiences seemed to have a significant positive impact on program success. All who volunteered received more services and successfully completed the program. Longer lengths of stay were correlated with those who volunteered and/or worked.*

*Program interventions also had a significant impact on improvements in levels of cognitive functioning, particularly for those that succeeded, as measured by selected CCAR domains. These domains included Cognition, Empowerment and Overall Symptom Severity. Socialization levels worsened for both those who succeeded and those who failed, but more so for those that failed.*

## **SECTION FIVE: SUMMARY OF FINDINGS**

### ***Question 1: Did the program serve the target population?***

**Yes and no.** The evidence suggests that the men who participated in the JERP met the established criteria identified by program developers. The group had serious mental health or substance abuse problems, or both. However, an inadequate number of men participated in the program because the beds were not filled to capacity. Therefore the process of referring and accepting individuals into the JERP became an important part of answering this research question, along with determining if the characteristics of the men were consistent with the target population identified in the program design.

Like all Colorado halfway house referrals, movement from prison into Colorado's Community Corrections system requires the participation of and approval from multiple entities. JERP clients were transitioning from prison, requiring the Department of Corrections to initiate all referrals. In addition, JERP stakeholders identified a specific population for treatment participation who would meet the following basic criteria:

- 16 months from parole eligibility
- Convicted of a nonviolent crime
- No medical problems
- Acceptable behavior while in prison (in terms of disciplinary violations)
- Original crime occurred in Jefferson or Gilpin Counties
- Moderate psychiatric problems and co-occurring substance abuse problem

The information presented below shows that all program participants were diagnosed with a serious mental illness and nearly all had serious problems with drug and alcohol abuse or dependence. Further, the clients were paroling to Jefferson or Gilpin Counties, and were convicted of non-violent crimes. Information on prison disciplinary infractions and medical problems were not available for analysis.

However, the DOC struggled to identify and refer the number of clients necessary to fill the JERP beds at ICCS, particularly in the second year of operation. Of those referred, many were screened out by the program partners, which also contributed to empty beds. In part, especially in the first year, this can be attributed to common program development and start-up processes. Nevertheless, many of the beds remained unfilled for the duration of the study. This became a consistent issue of concern and discussion amongst the JERP Oversight Committee.

Nearly half (43 of 99) of the inmates referred to JERP by DOC case managers were denied by decision makers at the various screening points. DOC's community corrections division rejected 13 of the 42. Another 10 inmates were rejected by the community corrections screening board, and three were rejected by the Jefferson Center for Mental Health who reviewed the DOC medical/mental health files to ensure that each individual's clinical needs could be met through JERP services. Finally, ICCS denied 14 inmates, presumably for disciplinary problems while in prison (again, the reasons for rejection were not available for analysis), and another two inmates refused to participate in the program. Data on specific reasons for rejection by any of the entities were not available. This study identified the need to clarify and perhaps expand the criteria for acceptance into the program.

Ironically, although hundreds of DOC inmates with mental health and substance abuse problems were presumably in need of community treatment, the beds in the JERP program were only filled to capacity briefly at one point in time in these first two years of operation. Multiple problems seemed to contribute to the lack of clients:

- The acceptance criteria for program participation was extremely narrow, making many DOC inmates in need of community services ineligible for the program. In fact, only half of those referred by DOC and meeting the most basic program criteria were accepted into the program.
- The referral process seemed extremely cumbersome and men could be rejected by at least five separate entities for a variety of reasons
- . The in-county participation criterion was consistently mentioned as a barrier to maximizing the use of JERP beds.
- A significant lack of referrals from DOC and an acceptance rate of about 50% of referrals prevented the program from operating at capacity, particularly after federal grant funding was replaced with state funding in July 2007. DOC received none of the state funds directed to program operations and Interviewees consistently referred to this deficit as adversely affecting DOC's ability to review and refer qualified offenders While vacant beds were a problem prior to the change in funding from federal to state dollars, it was at this point that referrals to the program significantly plummeted.

Many case managers reported that making referrals was especially difficult due to the high number of community referrals they made on a daily basis and the lengthy specific criteria for all the different community programs.

These referral issues and the problem of vacant beds were identified as primary JERP program operational problems and they remained unresolved during the study period.



In sum, then, the group that participated in JERP reflected the target population initially identified by program developers. However, too few men received services during the study period to support a finding that the full, appropriate population was served.

***Question 2: Was the program being implemented as planned?***

Yes, the program was generally implemented as planned. Much effort was invested into learning and implementing with fidelity the treatment modalities (SSIC and IDDT) selected by the program for use with this population who have a multitude of diagnoses.

An analysis of service hours found that JERP participants received a range of services designed to meet their individual needs. Interviews and focus groups with offenders—those who succeeded in the program and some who were returned to prison—revealed consistently positive experiences with the program. Program participants were grateful for the care and concern provided by JERP staff and reported significant relief from their treatment and medication regime.

Providing services on-site significantly facilitated the men's access to therapy, medication, support, education/vocational opportunities, and parole officials. Most said that they learned about mental illness and were provided cognitive tools that helped them manage their illnesses. Even those who returned to prison told researchers that they benefited from the program and that their experiences at JERP increased their ability to effectively interact with others when they returned prison. Only four offenders reported that they would not return to the program given the chance because they felt the rules of the community corrections program were in conflict with the goals of the JERP; one person cited concerns regarding the sharing of information amongst team members.

An important finding was the confusion and sense of overwhelm JERP men had with bus transportation, a problem plaguing many inmates' transition from prison to the community. But for those with serious mental illnesses, the problem is exacerbated. The JERP men suggested implementing a "buddy system" that would pair residents who are experienced with the bus system with those who express concern about their ability to navigate it as a way to address this area of difficulty.

During the study period, a written policies and procedures manual was not developed, although ICCS had a manual for their overall operations. A cooperative effort to develop a written document would clarify roles and responsibilities, particularly since multiple agencies are involved in the program, and could be used to train ICCS security staff.

In sum, the wrap-around service aspect of the JERP, the convenience of the on-site programming, and the care and quality of the staff were consistently

mentioned by offenders and administrators as program highlights, suggesting that the program was implemented as designed. The JERP program staff and administrators were open to feedback from researchers and, in particular, were interested in training ICCS security staff so that they would be of assistance to the JERP participants.

***Question 3: What outcomes were achieved by offenders at the time of program discharge?***

The successful program completion rate for the JERP program in its first 27 months of operation was 48.5 percent. While this rate did not meet the targeted rate of 56 percent stated in original grant documentation, it is an impressive rate for a start-up program, especially when considering the degree of seriousness of the JERP population.

Positive relationships were found between program participants on all but one of the CCAR variables examined, regardless of whether they successfully completed the program. These domains included Cognition, Empowerment and Overall Symptom Severity. Socialization levels worsened for both those who succeeded and those who failed, but more so for those that failed.

Perhaps most notable was that all participants who volunteered at JCMH's Summit Center successfully completed the program. Volunteer experiences seemed to have a significant positive impact on program success. All who volunteered received more services and successfully completed the program. Additionally longer lengths of stay were correlated with those who volunteered and/or worked.

**It is worth noting that given the gap in time between the study period and the release of this report and the evaluation feedback delivered to program staff throughout the study, significant progress has been made in several domains presented in this report. For example, the statistics for FY '11 show JERP operating at about 14 occupied beds, which exceeds the currently funded capacity. It would appear that efforts invested in addressing the problem of unfilled beds have been met with success.**

## **APPENDIX A**

### ***DIAGRAM OF PARTICIPATING AGENCIES***

