
# Preliminary Review of Administrative Data for the Proposed Study of the Justice and Mental Health Collaboration Program

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October 2020

## Introduction

The UNM Institute for Social Research (ISR) has been contracted by Bernalillo County to provide research services for the Bernalillo County Health Initiative, including an evaluation of the Resource Reentry Center (RRC) and a separate but connected evaluation of the federally funded Bureau of Justice Assistance Justice and Mental Health Collaboration Program (JMHCP). The JMHCP funding was awarded to enhance the Reentry Resource Center program by adding case managers and is described in more detail later. We begin by broadly describing the scope of work associated with the evaluation of the JMHCP portion of the RRC program, focused on our proposed study of the funded case managers. This brief report emphasizes our preliminary review of individual level data maintained by the program with the goal of assessing the feasibility of conducting a study to evaluate the impact of the program on clients.

In February 2015, the Bernalillo County Commission (BCC) and voters approved a new gross-receipts tax (GRT) expected to generate between $17 and $20 million each year, to improve access to care throughout the County and to develop a unified and coordinated behavioral health system in the County and surrounding area (CPI, 2016). This behavioral health gross receipts tax funds the County's Behavioral Health Initiative [BHI]. The BHI oversees a wide variety of programs including the Reentry Resource Center (RRC), which opened in June 2018. The RRC is the first stop for the vast majority of individuals released from the Metropolitan Detention Center. The goal of the RRC is to improve transition planning and improve linkages of inmates released from custody to community-based services to improve public safety and reduce crime and recidivism. In the first few days after release, individuals returning to the community are at high risk for drug use, homelessness, and other problems that may lead to reoffending (Jannetta et al., 2011). There are two primary components of the RRC; the first is transition planning for clients at the Bernalillo County Metropolitan Detention Center (MDC). The design focuses on transition planners who target high-risk inmates, administer risk/needs assessments, create transition plans with varying levels of detail depending on the intensity of need, begin implementation of the transition plan as timing dictates, and coordinates with case managers at the RRC to facilitate uninterrupted care and take the first positive steps toward implementing a transition plan. The second component focuses on the Re-entry Resource Center. The RRC provides an immediate opportunity for temporary shelter, brief interventions, connecting with family or community providers, and access to service information. For a subset of individuals flagged by the transition planners at the MDC, case managers are in place to engage them at the Center and oversee the hand-off to community-based services more directly. The RRC design allows for additional services to be provided on site by community-based providers and Medicaid Managed Care Organizations.

In December 2018 Bernalillo County was competitively awarded funds from the federal Bureau of Justice Assistance (BJA) Justice and Mental Health Collaboration Program (JMHCP) to fund navigator positions to link justice-involved individuals with community-based behavioral health services. These navigators are boundary spanning case managers working in the Reentry Resource Center (RRC) with individuals releasing from the MDC with mental illness or co-occurring disorders. Because the number of releasing inmates from the MDC is much greater than the number that can be case managed by the JMHCP case managers the RRC uses data from the Intake Screen Risk Framework that is designed to screen inmates for risk to target releasing inmates most in need.

Our study of the JMHCP funded portion of the RRC has several research tasks. These tasks are briefly described below and this review focuses on 2.

1. Intake Screen Risk Framework. Review the use, reliability, and validity of the Risk Framework (Intake Screen) used to score individuals booked into the MDC. The generated scores are used to help the RRC program target individuals most in need of services that include the JMHCP funded case managers.
2. JMHCP research. Plan and implement a pre- and post-study that involves a sufficiently large number of clients in a combined retrospective/prospective study that tracks individuals for a time period before admission into the JMHCP program to discharge and follow up for a minimum of one-year. The study involves the use of administrative data, which may include MDC data, treatment data maintained by the MDC contracted treatment provider, court data, emergency room data maintained by the New Mexico Department of Health, and health data maintained by the Health Information Collaborative. Analysis of Bernalillo County's System for Serving People with Mental Illness and Criminal Justice Involvement.

The overall goal of the JMHCP is to provide case management and services that achieve the following:

1. Reduce the number (and percentage) of people who have mental illnesses who are booked into jail.
2. Reduce their average length of stay in jail.
3. Increase the percentage of people who have mental illnesses who are connected to treatment.
4. Reduce their recidivism rates.
5. Decrease the number of visits to hospital emergency departments.

The remainder of this brief report describes our preliminary review of available data to determine the feasibility of completing a pre/post study of the impact of JMCHP funded case managers on the goals mentioned above using available historical data to identify clients served by the case managers and related services they received.

## Study Population

The study population includes all individuals booked into the Bernalillo County Metropolitan Detention Center (MDC) since February 2019, who were administered a screening and receiving form at booking that includes the validated tools use to create a risk score, and were case managed by a case manager hired as part of the JMHCP program.

**Risk Framework**

Each person booked into MDC is administered an intake receiving screening form intended to triage higher-risk inmates into the programs and interventions targeted for their needs, without spending unnecessary resources on low-risk offenders who are not likely to return to jail. The process allows scarce resources to be targeted to the offenders who have the greatest needs. This process follows the National Institute of Corrections Transition from Jail to Community initiative guidelines for screening and assessment. The MDC screening receiving form contains validated screens for risk to reoffend (Proxy Risk Triage Screener), suicide (Columbia Suicide Severity Risk Screening Tool), alcohol use (Audit-C), drug use (DAST-10), behavioral health (Brief Jail Mental Health Screen), and an opioid risk tool (Opioid Risk Tool).

Individuals who screen positive for suicide risk, drug or alcohol withdrawal, mental illness, or any serious medical need should be further assessed by a qualified medical professional and monitored immediately. These screening tools are used to calculated a score of low, medium, or high for criminogenic risk, substance abuse needs, and mental illness needs. These three scores are combined to assign a risk/needs group from 1 to 8, with a 1 indicating low risk and needs and an 8 indicating the highest risk and needs. This framework was developed by a County staff member, has not been studied or validated, and is the subject of study as part of the research associated with the JMHCP funding, but is not directly part of this review and associated study.

**JMHCP Case Managed Clients**

To identify RRC clients in general and JMHCP clients in particular the only data source available is a file called the Risk Needs Assessment, which can be exported from SharePoint. While SharePoint is highly configurable, usage varies substantially among organizations and it is currently used by the RRC as its primary data management system. SharePoint is primarily sold as a document management and storage system and it is not designed to function as a database. SharePoint was originally intended to be used temporarily and not as the primary electronic platform for data collection. This is the primary reason it is difficult to identify clients served by JMHCP funded case managers and services provided to clients.

To review the available data for conducting the study described above we completed a number of steps described next.

First, we reviewed the information available as part of the Risk Needs Assessment from SharePoint for inmates releasing to the RRC between July 1, 2019 through June 30, 2020[1]. As part of this process we collected missing MDC person IDs where possible and removed a small number of cases with missing data. There were 4,362 records, each theoretically representing a unique arrival at the RRC of a released individual from the MDC. A few records (6) were excluded because of a missing name or MDC person ID, an additional 119 records were removed because they had an invalid or missing MDC ID. The remaining 4,234 records represented 3,519 unique individuals. The most recent record for each individual was selected, leaving 3,505 inmates on the Risk Needs Assessment list. A list of JMHCP staff was provided by County staff to which to match these 3,505 individuals to determine which of these individuals had contact with JMHCP staff. Of the 3,505 inmates, 3,336 or 95.1% had contact with JMHCP staff.

Second, the Intake Screen Risk Framework scores, described earlier, were matched to the Risk Needs Assessment list. The Intake Screen Risk Framework responses and scores are stored in an electronic record through Sapphire Health, a company that provides electronic healthcare management. While these scores are not stored historically, the responses can be used to calculate an approximate score as needed. For this reason, ISR staff exported each individual's answers to the Risk Framework and Receiving Screening assessments in order to calculate their group score.

When the Intake Screen Risk Framework score was matched to the Risk Needs Assessment list, 60 of the 3,336 individuals who had contact with JMHCP staff (boundary spanners, the UNM CHW staff, Pathway Navigators, and UNMH TPTs) and did not have a score available, which left 3,276 cases in the sample.

[1] Cleaning the file required collection MDC id's and excluding a small number of instances where there was insufficient data

Services that qualify as case management by JMHCP staff fall into one of 9 categories: behavioral health, medical, benefits, identification, food and shelter, legal, transportation and property, case management – long term support, and vocational (see Table 1). A small 3% random sample of the JMHCP clients were selected for detailed review of the data available on services provided.

**Table 1. JMHCP Case Management Services**

| **BEHAVIORAL HEALTH** | **FOOD & SHELTER** |
|---|---|
| Mental Health/Counseling/Psychiatric | Food Pantry |
| Special Accommodations* | VISPDAT completed |
| SA/Alcohol Treatment | Housing (i.e. ABQ Housing, Bernco Housing Authority, Sec 8, Apt rental application, etc.) |
| Detox Services | Motel Voucher (one referral per client/year) |
| Sober Living | Transitional Living |
| DWI information packet | Westside Shelter information |
| Narcan Education & Distribution | Westside Shelter Pick-Up |
| Methadone referral/access | Shelter Referral (other) |
| Suboxone referral | **LEGAL** |
| **MEDICAL** | Pre-Trial District |
| Dental/Vision referral | Pre-Trial Metro |
| Medical referral | Probation & Parole |
| Prescription Access/Coordination | Legal (LOPD, attorney, court information, etc.) |
| **BENEFITS** | **TRANSPORTATION & PROPERTY** |
| Referrals to SSCs for Medicaid Reinstatement (client has appt within 72 hours of release) | Monthly Bus Pass |
| # of Medicaid verifications through portal | Travel Assistance (Outside of ABQ) |
| Medicaid only application completion | **CASE MANAGEMENT-LONG TERM SUPPORT** |
| SNAP application only | Translation Services/Interpreter |
| Cash Assistance (includes TANF) | ICM Referrals |
| Medicaid and SNAP (and/or Cash assistance); multiple service application | Boundary Spanners |
| SSI/SSDI/SSN | Case Management (Other Agency) |
| **IDENTIFICATION** | Managed Care Organization (MCO) Care Coordinator (Presby, Western Sky, BCBS) |
| Driver's License/ID | Veteran Services |
| Birth Certificate | **VOCATIONAL** |
| | Education |
| | Employment |

## Data Analysis

While the Risk Needs Assessment file includes some information on potential services received, this information is not clearly organized and is incomplete. Of the 3,276 MDC inmates released through the RRC with contact with JMHCP staff a small sample (100 or 3.1%) was selected for review. The Risk Needs Assessment file was reviewed to determine what services were received. Of the 100 individuals in the sample, 56 received no services (see Table 2). Sixteen received one service, 7 of which were a connection to PTS, 4 had a connection to probation/parole, 2 were given information on a referral to substance abuse or alcohol treatment, and 3 completed a VI-SPDAT. The remaining 28 in the sample received multiple services including completing a VI-SPDAT, SNAP applications, referrals to case management or substance or alcohol abuse programs, and housing among others.

In some instances, it was difficult to determine if an individual received services. The service details are listed across multiple variables, some of which are text fields and are not required to be completed by the service provider. These variables do not always supply sufficient detail to allow a determination on whether services were received. For instance, one note indicated the transition planner tried to help the inmate call the EBT hotline, but the inmate got angry and did not completed the conversation. In this instance, this would not qualify as a provided service. These comments are time consuming to review and it is not always completely clear what services were provided.

**Table 2. JMHCP Client Sample**

| Services Provided | Count | Percent |
|---|---|---|
| Total Unique Inmates on RRC List as JMHCP clients | 3,276 | |
| Inmate Sample for Review | 100 | |
| No Services Provided | 56 | 56.0% |
| One Service Provided | 16 | 16.0% |
| Connection to PTS | 7 | 7.0% |
| Connection to Probation/Parole | 4 | 4.0% |
| VI-SPDAT | 3 | 3.0% |
| Referral to SA or Alcohol Treatment | 2 | 2.0% |
| Multiple Services Provided | 28 | 28.0% |
| Total JHMCP Client Sample | 100 | 100.0% |

ISR staff was advised that the transition plans, where available, could be used an alternate source of data on services received that were not listed in the Risk Needs Assessment file. These plans were manually reviewed. For 59 of the 100 inmates there was no transition plan that could be located and for an additional 14 there were no services listed on the transition plan.

For the 56 individuals with no JMHCP services received, 39 (69.6%) had either no transition plan or a plan with no services (see Table 3). Of the 17 (30.4%) with services, a variety were provided including the VI-SPDAT, and referrals to housing or treatment among others.

**Table 3. Transition Plans for JMHCP Clients with No Services.**

| Transition Plan Details | Count | Percent |
|---|---|---|
| No Transition Plan or No Services on Plan | 39 | 69.6% |
| Services Listed on Plan | 17 | 30.4% |
| Total | 56 | 100.0% |

Of the 100 individuals reviewed of the 3,276 MDC inmates released through the RRC with contact with JMHCP staff, 56 had no indication of having received services. Of the 44 who received services 16 received one service and 28 received two or more services, which included completing a VI-SPDAT, SNAP applications, referrals to case management or substance or alcohol abuse programs, and housing. In addition, we reviewed a second source for services for the 56 individuals who had no services recorded in the Risk Needs Assessment file. Of these 56 individuals 17 or 30.4% showed having received services in their transition plan.

In total 61 or 61% of the sample had an indication of receiving services in either the Risk Needs Assessment file or in the Transition Plan file. There was limited information on these services and it appears some of these services may be more clearly classified as referrals. If additional detail would have been available it may have revealed more about these services. Services that may more clearly be classified as referrals includes connections to PTS and Probation/Parole and referral to substance abuse or alcohol treatment. A large minority (39%) of the individuals had no indication of receiving any services and of those that did some of these services were limited to "connections" and "referrals" and all the services lacked detail.

## Conclusion

The study of the JMHCP includes several research tasks. This brief report describes the research task to conduct a pre- and post-study of JMHCP clients. An initial review found available historical data on the program clients is often unavailable and when service information is available it lacks detail on the services received.

To conduct a study as proposed in the original response to the JMHCP Request for Proposal and our contracted scope of work we will need to conduct a prospective study and not a historical study. First, this primarily occurs because historical information of sufficient quality does not exist to conduct a study of this type. Second, and related to the first, the preliminary review suggests and discussions with County staff supports the view that the group of case managers who served the clients in the historical data did not operate as described in the funded proposal. This means the program was not implemented as designed and hence the expected outcomes would not be expected to be realized. Third, the County discontinued the prior contract with the agency employing the case managers and has hired new case managers who are now County employees and who will be focused to providing the services as described in the initial proposal and based on best practices for this type of case management. Fourth, the COVID-19 pandemic has caused delays in implementing the redesigned program with County employed case managers.