A Promising Approach to Coordinated Community-Based Reentry Services

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OVERVIEW

Los Angeles (LA) County has the largest jail system in the world, housing over 12,000 people daily in 2023.[1] In an effort to divert people from incarceration and support formerly incarcerated individuals when they are released, LA County's Board of Supervisors established the Office of Diversion and Reentry within the LA County Department of Health Services in September 2015. In November 2022, the board centralized preexisting justice reform efforts in LA County—including pretrial and reentry services as well as jail closure work, with an emphasis on the nonclinical components of this work—by establishing the Justice, Care, and Opportunities Department (JCOD). The original Reentry Division within the Office of Diversion and Reentry—hereafter referred to as the Reentry Division—transferred as an entire unit, (that is, all the division's contracts, programs, funding, and staff), to JCOD in November 2022.

Evidence for coordinated reentry—or the coordination of services from multiple community providers—shows that it is a promising approach to support individuals with mental health or substance use disorders who are released from correctional facilities. Recognizing the role that community-based organizations can play in securing access to services, the Reentry Division built a countywide system of programs that aim to increase access to housing, primary care and hospital, mental health, substance use disorder, and employment services (among others) are intended to reduce criminal legal system involvement. One such program is the Reentry Intensive Case Management Services (RICMS) program. Through a network of 29 community-based providers located across LA County, the RICMS program links individuals with prior criminal legal system involvement to community health workers—most of whom have lived experience with the criminal legal system, housing instability, or mental health issues. For about one year, the community health workers provide care coordination and help clients navigate the many services and supports available to them.

This report describes findings from a process study and outcomes study of the RICMS program that are based on analyses of administrative records and management information system data for individuals who enrolled in the program between April 2018 and March 2021; a survey of program staff and managers in April 2022; and semistructured interviews with program managers, staff, and participants that were conducted between June 2019 and August 2022.[2] The study used a quasi-experimental approach (propensity score matching) to compare the health and criminal legal system outcomes of individuals who enrolled and participated in the RICMS program with those of individuals in a matched comparison group who enrolled but did not participate in the program. Propensity score matching is a powerful analytic tool to generate a comparison group when a randomized controlled trial is not possible. This analysis provides some information about the differences in outcomes that could be due to participation in the

1. Vera Institute of Justice, "Care First L.A.: Tracking Jail Decarceration." Accessed May 8, 2023, website: https://www.vera.org/care-first-la-tracking-jail-decarceration.

2. The study defines clients as individuals entered into the CHAMP management information system for the RICMS program. Participants are individuals who received services from a community health worker for at least 30 days after enrollment and had a care plan recorded in CHAMP.

program. However, it cannot determine with certainty whether a causal relationship exists between the program and observed outcomes. It is possible that unobserved characteristics may have influenced the patterns of which individuals participated in the program and which ones did not.

Overall, the results suggest that RICMS is a promising program for improving the life experiences of its clients, especially for reducing future contact with the criminal legal system. More specific findings include:

- **The location of enrollment appears to have important implications for participation in the program.** Clients reached the RICMS program through a variety of referral sources, including jails within LA County. Most individuals enrolled in the RICMS program after they were released and had returned to live in their communities, but some individuals enrolled in the RICMS program between the date of their booking and date of release. Of the individuals who enrolled while they were in jail, 13 percent participated in the RICMS program, while 30 percent of individuals who enrolled while living in the community participated.
- **Participants and nonparticipants from both enrollment locations had similar demographic profiles.** The majority of clients were men, with more than 40 percent identifying as Hispanic and 41 percent identifying as Black. Participants and nonparticipants used LA County outpatient mental health services, and inpatient treatment, at similar rates. The groups differed most in terms of how recently their members had contact with the criminal legal system. Nonparticipants had more recent contact with the criminal legal system than participants. For example, nonparticipants were more likely to have been arrested or convicted than participants in both enrollment groups.
- **Over half of all RICMS participants were enrolled in the program for six months or less.** However, individuals who enrolled while in the community tended to participate for longer periods of time than those who enrolled while in jail. Participants who were interviewed consistently spoke about the importance of their connection with their community health worker; some even described them as "family."
- **Multiple contextual factors created barriers to program implementation and participation.** The inaccessibility or unavailability of housing was a pervasive issue. Stable housing can support an individual's success in the substance use recovery process, facilitate positive physical and mental health, and support the ability to maintain employment. The amount of communication between jail-based staff and RICMS program staff varied depending on the provider or staff member, so it was sometimes challenging to support individuals as they prepared for release and returned to the community. The fact that the Los Angeles County Sheriff's Department restricted access to potential clients in the jail facilities exacerbated this challenge. The COVID-19 pandemic prompted providers to adjust their service delivery approaches.
- **RICMS is a promising program that appeared to reduce contact with the criminal legal system during the two years of follow-up. It also appeared to reduce the use of emergency medical services for individuals who enrolled while living in the community.** Because the pool of individuals who enrolled while in jail (1,619) was so much smaller than the number of individuals who enrolled while in the community (13,429), the quasi-experimental analyses were focused on the latter group.
    - In nearly all the outcomes measured—including arrests, incarceration, convictions, and probation revocation—the participant group had better outcomes than the comparison group; those

findings are statistically significant. RICMS program participants had fewer convictions, arrests, incarcerations, and probation revocations than the comparison group. They also had spent fewer days in jail at both the one-year and two-year mark after program enrollment.

- RICMS program participants were also less likely to visit the emergency room at both time points than comparison group members.

While the quasi-experimental matched comparison group analysis yields stronger evidence than simply comparing outcome levels of unmatched groups, it should be interpreted with some caution. The RICMS study finds that this approach to coordinated community-based reentry is a promising approach to supporting individuals with criminal legal system involvement. The relationships between participants and community health workers—and the supports community health workers provided—were central to the successful reentry of participants. An upcoming cost study will further explore these findings and document the total costs of the RICMS program.

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The Authors

INTRODUCTION TO THE PROGRAM AND THE STUDY

Los Angeles (LA) County has the largest jail system in the world, housing over 12,000 people daily in 2023.[1] In recent years, the LA County jail system has seen an increase in the number of individuals with complex clinical needs, in part because these individuals face a lack of affordable housing and difficulties navigating and accessing primary care, hospital, and behavioral health services in the community.[2] In 2015, LA County's Board of Supervisors established the Office of Diversion and Reentry within the LA County Department of Health Services, with the primary goals of diverting people with serious mental health, physical, or behavioral health needs away from LA County jails and into community-based care, and supporting individuals after their interaction with the criminal legal system. In 2022, the LA County Board of Supervisors consolidated various efforts to support communities that are system-impacted by creating the new Justice, Care, and Opportunities Department (JCOD). The original Reentry Division within the Office of Diversion and Reentry—hereafter referred to as the Reentry Division—transferred as an entire unit (that is, all its contracts, programs, funding, and staff members), to JCOD in November 2022. With funding from the Safe Neighborhoods and Schools Act (Proposition 47)—administered by the California Board of State and Community Corrections—and the California Community Corrections Performance Incentives Act of 2009 (Senate Bill 678), the Reentry Division has launched a number of programs that are intended to improve well-being and prevent future system involvement.

Evidence for coordinated reentry into the community—or the coordination of services from multiple community providers—shows that it is a promising approach to support individuals with mental health or substance use disorders who are released from correctional facilities.[3] Recognizing the role that community-based organizations can play in securing access to services, the Reentry Division built a countywide system of programs that aim to increase access to housing, primary care and hospital, mental health, substance use disorder, employment, and other services that are intended to reduce involvement in the criminal legal system. This system of services includes the Reentry Intensive Case Management Services (RICMS) program.[4] Through a network of community-based providers located across LA County, the RICMS program links individuals with prior criminal legal system involvement to community health workers (CHWs) who provide care coordination and help clients navigate the many services and supports available to them.

1. Vera Institute of Justice (n.d.).
2. Hunter and Scherling (2019).
3. Umez, De la Cruz, Richey, and Albis (2017); Corrigan et al. (2017).
4. The Reentry Division also developed an interim housing program for individuals in early recovery from substance use disorders, with the goal of providing a safe housing environment that equips clients with support that can help them stay sober. Some RICMS clients were referred to this program. For more information about this program and its implementation, see Appendix E.

MDRC leads the RICMS evaluation as part of the Los Angeles County Reentry Intensive Services Project (LA CRISP), a multiyear, multistudy evaluation of the Reentry Division's reentry programs. The study was executed as part of a Proposition 47 grant to LA County.

To evaluate the RICMS program, the LA CRISP research team conducted a process study, an outcomes study, and a cost study. This report presents findings for the process and outcomes studies.[5] The remainder of this introductory section briefly describes the RICMS program. The process study findings are described in the next section, followed by a presentation of the outcome study's findings one year and two years after clients enrolled, depending on the time of enrollment. The final section concludes the report with recommendations for local, state, and national policies and practices.

Study Design

The research team used qualitative and quantitative methods to examine the program models, goals, and implementation, as well as the client outcomes. The process study examined how RICMS program activities aligned with the logic model (shown in Figure 1) and how the program was implemented, including what services were provided and what role the Reentry Division (and coordinating agencies and contracted providers) played in delivering and coordinating services. The theory of change underlying the RICMS program assumes that centralizing the coordination of reentry services, and connecting individuals to others with similar experiences, will lead to improved health and well-being outcomes and reduced contact with the criminal legal system. The outcomes study assessed whether the program achieved its proposed goals. To this end, the evaluation measured RICMS participants' use of LA County primary care and hospital services, mental healthcare, and substance use disorder treatment services, as well as their criminal legal system outcomes.[6] The outcomes study used a matched comparison group quasi-experimental design to assess whether the services may have resulted in improved client outcomes. See Appendix A for information about data sources and methodology.

The study of the RICMS program examined administrative data for individuals enrolled in RICMS between April 2018 and March 2021. Interviews with program staff and program participants, conducted between June 2019 and August 2022, provided qualitative information

5. Findings from the cost study will be published separately when that analysis is finished.

6. Participants are clients who received services from a community health worker for at least 30 days after enrollment and had a care plan recorded in LA County Department of Health Service's management information system—known as Comprehensive Health Accompaniment and Management Platform (CHAMP). Participants were considered to be enrolled in the RICMS program until their CHWs removed them from CHAMP. This happened when participants achieved their goals, declined further services, stopped responding to CHW outreach attempts, moved out of the county, or were reincarcerated.

FIGURE 1. The Reentry Intensive Case Management Services (RICMS) Logic Model

INPUTS

Coordinated agencies
- Reentry Division
- Correctional Health Services
- Community-based providers
- Sheriff's Department
- Probation Department
- Division of Adult Parole Operations

Program staff
- Community health workers
- Correctional Health Services staff
- Medical case workers

Eligible participants
- Adult felony probationers (Senate Bill 678)
- Individuals with mild to moderate substance use or mental health disorders who are also involved in the criminal legal system (Proposition 47)

Evaluation enhanced resources
- Training for RICMS staff on using risk-need-responsivity principles to drive service referrals and case management

ACTIVITIES IMPLEMENTED

System-level coordination
- Reentry Division service agreements
- Reentry Division quality assurance
- Provider implementation based on standard operating procedures

Recruitment and screening
- Triage community referrals
- Triage in-jail referrals

Intake and assessment
- Use of validated assessment tool
- Case plan based on risks and needs
- Documentation in administrative management information system data

Client engagement
- Regular outreach by staff
- Warm handoffs and referrals to services
- Help getting to appointments and support during them
- Social support

Case management
- Case plans regularly updated
- Case conferencing with partner staff
- Coordinate supports before and after release

OUTPUTS

Enrollment
- Number of successful enrollments

Service receipt
- Number of referrals for services
- Social support provided
- Benefits enrollment

Service quality
- Alignment of service receipt with identified needs
- Client-staff relationships
- Client satisfaction

OUTCOMES

Outcomes at 12 months
- Improved health and well-being
- Reduced arrests
- Reduced convictions
- Reduced incarceration admissions
- Reduced incarceration days

System optimization
- Improved access to services for clients
- Number and types of trainings for providers
- Provider adherence to protocol

about program implementation.[7] A survey of program managers and direct service staff was administered in April 2022.

Program Snapshot

This section contains a brief description of the RICMS program.

Program Structure and Staffing Model

The RICMS program was delivered by 29 community-based providers that were contracted by the Reentry Division.[8] (See Table A.1 for more information.) Each provider has a team that comprises a program manager and one or more CHWs who work directly with clients.

CHWs are a key component of the RICMS model; they conduct outreach to engage clients, identify their needs, and help them access needed services. Each CHW maintains a caseload of approximately 30 clients who are enrolled while they are living in their communities, plus a "jail caseload" (also referred to as a pre-release caseload) of up to 60 individuals who are pending release.[9] As part of their contract with the Reentry Division, RICMS providers committed to hiring CHWs who have "lived experience" with the criminal legal system—which means they have been personally affected by the criminal legal system (for example, by having been arrested or incarcerated) or affected by others close to them (for example, by having family members or close friends who have been arrested or incarcerated).

Connection with the LA County Reentry System

For the RICMS program, the Reentry Division established a referral pipeline from LA County's Correctional Health Services team—which provides prerelease health services to individuals in the LA County jail system—to RICMS providers. The Reentry Division also educated other LA County programs and agencies—such as the Innovative Employment Solutions workforce program and the Probation Department's Resource Utilization Unit—about RICMS to encour-

7. Clients who were interviewed for the RICMS process study were recruited through community-based providers and were participating in the program at the time of the interview. Researchers were not able to solicit feedback from clients who had enrolled but were not engaged with the RICMS program.

8. After the launch of this study, four RICMS providers stopped providing program services, bringing the total number of providers to 25. This report focuses on all 29 providers, since they delivered services for most of the study period.

9. Individuals who enrolled in the RICMS program while living in the community were those who had already been released from jail at the time of enrollment. Individuals in the jail caseload had a RICMS enrollment date that fell between their booking date and release date (including enrolling on their date of release), as recorded in the Comprehensive Health Accompaniment and Management Platform (CHAMP). While they were still in jail, information about them was sent to the community provider in the area where they would be released to facilitate recruitment and enrollment. To date, CHWs have not had the opportunity to interact much with these individuals before they are released.

age referrals to the program.[10] The Reentry Division also established the Interim Housing program as a supplement to the housing resources offered by RICMS providers. (The program is described in Appendix E.) The Reentry Division provides technical assistance and training to help providers connect with programs and resources across the county. (See the next section, "Program Implementation and Participation Patterns," for further discussion of the Reentry Division's role in program monitoring and technical assistance.)

PROGRAM IMPLEMENTATION AND PARTICIPATION PATTERNS

This section describes how the RICMS program was implemented and presents program participation patterns for people who enrolled in RICMS between April 2018 and March 2021, with a minimum follow-up period of one year from the time of enrollment. The process study examined how the RICMS program was implemented and managed, including its service provision and coordination with other agencies. The research team seeks to answer the following overarching research questions:

- What organizational factors, policies, and other external factors may have shaped the design, implementation, and outcomes of the RICMS program?
- Who was served by the RICMS program and what were their service needs?
- What is the service delivery system of the RICMS program and how is the program implemented?
- How do participants experience the RICMS program, and does it meet their needs?

The process study draws on analyses of administrative management information system data from the LA County Department of Health Service's management information system—known as Comprehensive Health Accompaniment and Management Platform (CHAMP)—along with surveys of staff at each community-based provider. Qualitative data include interviews with a subset of staff from the community-based providers, Reentry Division staff, and program participants, as well as an analysis of official planning and program documents shared with the research team. See Appendix A for more information about the implementation research data sources and methods.

10. The LA County Innovative Employment Solutions program (INVEST), funded through California Senate Bill 678, is designed to address the complex range of employment and supportive service needs that individuals on felony probation may have and support them in pursuing their employment and career goals. It is the subject of a separate MDRC evaluation.

Context of Program Implementation

When interviewed, staff working within RICMS programs described multiple contextual factors that created barriers to program implementation and participation. These factors also represented opportunities to improve client engagement with the program. They are described below.

Release Process

While CHWs were expected to make efforts to communicate with individuals who were referred from LA County jails before their release date, the research team found that the extent of this communication varied by provider and staff member. During interviews, CHWs reported that release dates were unpredictable and were not communicated directly by the jail, which meant it could be hard to know when to begin preparing to engage an individual in planning for reentry. For example, it was common for a referred client to be suddenly released, without communication to the CHW, months before the release date that was scheduled in the jail data system. Another reported challenge was that the LA County Sheriff's Department put restrictions on CHWs' access to potential clients in the jail facilities. However, some CHWs described instances when they successfully collaborated with medical case workers inside jails to set up phone calls or meetings, though interviewees reported that medical case workers could be hard to reach. Other CHWs said they developed alternative strategies to reach these clients, such as sending letters or setting up a process to receive collect calls. CHWs described the California Department of Corrections and Rehabilitation's referral process as more synchronized, since its staff actively coordinated with CHWs around an established release date that was communicated by the correctional agency and was unlikely to change suddenly. Staff members who were interviewed reported that because of the challenges reaching these clients, they tended to focus their efforts on engaging clients who came from referral sources other than the county jails. One CHW said that individuals who were referred from sources other than jails were more engaged. Especially for individuals who were referred before their release date, staff said that a lack of contact information was a common reason they were unable to successfully engage clients. Staff described attempting to reach other points of contact (such as family members), or, in some cases, seeking individuals at locations where they were known to spend time.

The COVID-19 Pandemic

The COVID-19 pandemic prompted organizations to change the ways that they approached service delivery and internal operations. While many internal operations went remote in March 2020, some staff and program managers who were interviewed described their organizations as having "boots on the ground"—that is, staff who worked in the field to provide services directly to clients in need. One staff member added that most of the staff who were active in the community during the height of the pandemic contracted COVID-19. Many of the organizations tried to continue in-person service delivery throughout the pandemic, closing temporarily when a staff member became sick. A program manager summarized one organization's remote COVID-19 policies: "[We work] remote where we can . . . [but] pretty much the show goes on." This seemed to reflect the way many RICMS organizations responded to the pandemic.

Housing Availability

Service provider staff members and participants consistently brought up the unavailability and inaccessibility of housing in LA County. A lack of housing presented challenges to service delivery; many provider staff members who were interviewed suggested that access to housing was often necessary for a participant to succeed in employment and substance use recovery, achieve better physical and mental health, and develop prosocial behaviors associated with reentry (for example, "staying out of trouble," or not being exposed to social environments that could encourage negative patterns or habits). One participant said,

> Because I was in jail, my kids were taken away. The court won't give me my children without having housing. Housing won't give me housing because I don't have my children. So that's like a loop . . . I'm struggling right now.

One CHW explained a challenge of the housing application process:

> I have a client right now. It took him over a year to get his housing. We went through one of the emergency housing [voucher programs]. We duplicated proof of income three or four times. We duplicated homeless history just as many, if not more . . .
>
> And the client finally got his Section 8 voucher. [We] helped the client find a beautiful apartment, filled out the application. The manager loves the client, the owner loves the client. [He's] ready to move in. We sent the voucher back to the housing authority. He needs $3,500 to move in. Okay?
>
> Now $3,500 was needed. That is just as taxing, as depressing as you can get after you've been through all this, and the client will say they don't want you to get housing. "How can I get housing when I can't get this money? Where do they expect me—who's been homeless for the last 15 years—to get this money? Am I just supposed to have this money?" So if the Reentry Division had a flex fund, had something that I could tap into to help this client get this money, it would save a lot.

Incidentally, the Reentry Division developed the Interim Housing program, using Proposition 47 funds, for individuals in early recovery from substance use disorders who have an immediate need for housing. The first location, a 20-bed house for male clients, is operated by Christ-Centered Ministries. The program slots are available to other reentry programs in LA County, but RICMS participants account for most referrals to this short-term housing option.

Gaps in Services

CHWs said that some participants may have been uncomfortable with the types of services that were offered—such as shared housing arrangements—due to concerns about their safety or the lack of autonomy offered in those spaces. In other situations, CHWs reported that some neighborhoods or areas were unsafe for certain participants due to their history in those areas. In

order to adequately serve participants, programs need to be able to help them navigate complex circumstances while maintaining a sense of safety and meeting their unique needs.

Trust

Staff said that some participants may not have been ready to engage with the RICMS program or its referral services. CHWs described the efforts they had to undertake to earn the trust of participants. Many participants were suspicious of LA County systems because they had experienced harm or trauma in the criminal legal system, expected that anything they shared with the CHW would be reported, or were disappointed with other agencies that had failed to help them or adequately understand their needs. One CHW explained,

> People who've been incarcerated have a good degree of distrust and suspicion of other people, especially people coming from "the system." So, generally, when I first meet someone, I give them a chance to talk. I tell them who I am; what I do. And let them know I'm here to only help them for what they want to do, not what I want to do. And I ask them, "How can I help you?" And that's how I start: By giving them the permission or giving them an opportunity to express their need and their desires.

Clients Served by the RICMS Program

The RICMS program was designed to have a "no wrong door" approach to enrollment, allowing clients to engage with the program at any point after interacting with the criminal legal system. During the study period, the RICMS program enrolled willing adults who were charged with or convicted of a crime, and who were identified as having mild to moderate mental health or substance use disorders.

Referrals to the RICMS Program

Clients reached the RICMS program through a variety of referral sources, including jails within LA County, other reentry programs led by the Reentry Division, the Probation Department, the California Department of Corrections and Rehabilitation, and RICMS providers within their communities.[11] All client information was entered into CHAMP at the point of enrollment.

Recruitment approaches varied among providers depending on the kinds of partnerships they established, their level of outreach in the community, and the programs they offered beyond RICMS. For example, some CHWs described having strong partnerships with medical or substance use disorder organizations that sent them referrals, while others described visiting local social service offices to do direct outreach by speaking with potential clients. Multiple CHWs

11. At the start of the RICMS study, the program accepted referrals from the California Department of Corrections and Rehabilitation of clients who were being released on parole from state prisons. Due to issues related to eligibility under Proposition 47 grant funding, the Reentry Division stopped accepting referrals from that department.

said they established relationships that centered on recruitment with local probation offices; they received referrals from individual probation officers who knew about their organization.

Once a client was referred to the RICMS program, providers were expected to make at least five attempts to reach the client within 30 days. Clients who were recruited from LA County jails were enrolled into the RICMS program by Correctional Health Services staff before their release. Then Reentry Division staff distributed those referrals to providers located in the communities where the clients would be released. These clients were considered part of a jail caseload, which was monitored by provider staff so that service planning could be continued after the client's release. However, as noted earlier, CHWs met challenges doing so.

As it turns out, the location of enrollment—whether the client was in jail or in the community—appears to have important implications for a client's participation in RICMS services. Individuals who enrolled while they were living in the community were more likely to participate in the RICMS program than those who enrolled while they were still in jail. (See Table 1.) While the exact reason for this difference is not known, challenges communicating with individuals while they were in jail—as described earlier—likely played a part. Of the 1,619 clients who enrolled while they were in jail, only 211 (13 percent) became participants, whereas 4,089 of the 13,429 clients (30 percent) who enrolled while living in the community became participants. This important finding motivated the study team to analyze data for these two referral streams separately.

TABLE 1 Participation Outcomes by Enrollment Location

Outcome	Jail Enrollment	Community Enrollment
Participated in RICMS program (%)	13.0	30.4
Mean days participated	174.3	225.6
Median days participated	151	190
Sample size	1,619	13,429

SOURCE: Calculations based on data from the CHAMP management information system.

NOTES: Participants are RICMS clients who were enrolled in the program for at least 30 days and had a care plan recorded in CHAMP.

"Jail enrollment" indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

"Community enrollment" indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

Characteristics of RICMS Clients

Table 2 presents characteristics of RICMS clients who participated in program services and RICMS clients who were enrolled but ultimately did not participate in the program, for both the

TABLE 2 Characteristics of RICMS Participants and Nonparticipants, by Enrollment Location

Variable	Jail Enrollment		Community Enrollment		All Enrollment	
	Participants	Nonparticipants	Participants	Nonparticipants	Participants	Nonparticipants
Demographics						
Age (mean number of years)	39.8	39.9	41.1	40.3	41.0	40.3
Age (%)						
18-24 years	3.8	4.5	5.2	4.6	5.1	4.5
25-34 years	36.0	35.0	31.6	33.5	31.9	33.7
35-44 years	31.3	30.1	27.9	29.4	28.1	29.5
45 or more years	28.9	30.3	35.2	32.4	34.9	32.2
Gender (%)						
Female	33.6	31.9	26.8	18.7	27.2	20.4
Male	63.5	67.5	71.7	80.2	71.3	78.6
Genderqueer	0.5	0.1	0.0	0.1	0.1	0.1
Trans female	0.9	0.4	1.1	0.8	1.1	0.8
Trans male	0.9	0.1	0.3	0.1	0.3	0.1
Race/ethnicity (%)						
White	36.5	41.9	23.5	43.5	24.1	43.3
Black	28.9	29.6	41.6	30.2	41.0	30.1
Hispanic/Latinx[a]	52.6	44.2	42.6	43.5	43.1	43.6
Asian	3.3	2.1	1.2	1.5	1.3	1.6
Pacific Islander	0.0	0.3	0.6	0.6	0.6	0.5
Native American	0.9	1.0	1.1	1.0	1.1	1.0
Multiracial	5.2	4.5	3.7	3.8	3.8	3.9

(continued)

TABLE 2 (continued)

Variable	Jail Enrollment		Community Enrollment		All Enrollment	
	Participants	Nonparticipants	Participants	Nonparticipants	Participants	Nonparticipants
Service planning area (%)						
1. Antelope Valley	4.3	8.4	3.8	7.2	3.8	7.3
2. San Fernando Valley	10.9	15.3	13.8	16.8	13.7	16.6
3. San Gabriel Valley	18.0	11.5	12.3	10.2	12.6	10.4
4. Metro	19.4	22.0	13.4	24.4	13.7	24.1
5. West	2.8	4.3	2.3	4.6	2.4	4.5
6. South	19.9	15.2	39.5	15.0	38.5	15.0
7. East	13.3	8.9	6.4	9.0	6.7	9.0
8. South Bay	10.0	13.6	7.9	11.8	8.0	12.1
Contact with the criminal legal system						
Ever convicted of a misdemeanor (%)						
In the two years before enrollment	53.6	62.7	29.3	51.1	30.5	52.6
Between two years and seven years before enrollment	50.7	60.4	34.8	50.5	35.6	51.8
Ever convicted of a felony (%)						
In the two years before enrollment	64.0	58.5	32.4	50.2	34.0	51.3
Between two years and seven years before enrollment	39.3	49.6	30.6	42.5	31.0	43.4

(continued)

TABLE 2 (continued)

Variable	Jail Enrollment		Community Enrollment		All Enrollment	
	Participants	Nonparticipants	Participants	Nonparticipants	Participants	Nonparticipants
Median number of days between most recent conviction and enrollment[b]	67.5	78.0	315.0	84.0	286.0	84.0
Mean number of days incarcerated						
In the two years before enrollment	173.9	197.7	61.5	161.5	67.1	166.2
Between two years and eight years before enrollment	150.3	218.0	106.0	193.6	108.2	196.8
Ever arrested (%)						
In the two years before enrollment	99.5	99.6	54.6	84.7	56.8	86.7
Between two years and eight years before enrollment	77.3	85.7	59.4	73.1	60.3	74.8
Medical care						
Primary care and hospitalization						
Mean number of primary care visits in the two years before enrollment	0.6	0.6	0.7	0.6	0.7	0.6
Mean number of emergency services in the two years before enrollment	0.7	1.0	0.5	1.0	0.5	1.0
Mean number of hospital admissions in two years before enrollment	0.1	0.1	0.1	0.2	0.1	0.2

(continued)

TABLE 2 (continued)

Variable	Jail Enrollment		Community Enrollment		All Enrollment	
	Participants	Nonparticipants	Participants	Nonparticipants	Participants	Nonparticipants
Mental health (%)						
Ever had inpatient mental health admission within the previous three years	12.8	16.3	7.5	14.3	7.8	14.6
Ever had outpatient mental health service within the previous three years	43.6	43.0	33.9	41.9	34.3	42.0
Ever had substance use disorder as recorded in mental health data within the previous three years	35.1	27.4	19.9	27.5	20.6	27.5
Sample size	211	1,408	4,089	9,340	4,300	10,748

SOURCES: Calculations based on data from the CHAMP management information system and InfoHub.

NOTES: Participants are RICMS clients who were enrolled in the program for at least 30 days and had a care plan recorded in CHAMP. Nonparticipants are similar individuals who were enrolled in—but not participating in—RICMS services. Age data are missing for 5 people, gender data are missing for 8 people, ethnicity data are missing for 432 people, race data are missing for 294 people, and service planning area data are missing for 118 people.

"Jail enrollment" indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

"Community enrollment" indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

[a]Racial demographic percentages represent a combination of race and ethnicity data from the CHAMP management information system. Self-reported Hispanic ethnicity and Latinx race were combined into the "Hispanic/Latinx" variable shown in the table. As such, percentages in this section will not add up to 100.

[b]Conviction data were available for the seven-year period before client enrollment.

jail and community referral streams. The majority of RICMS participants were men. Overall, 43 percent of participants identified as Hispanic; 41 percent identified as Black. About 34 percent of participants had used LA County outpatient mental health services at some point in the three years before RICMS program enrollment, and 8 percent received inpatient treatment from the Department of Mental Health. Overall, the characteristics of clients were similar for the two enrollment locations.

Both groups differed most in terms of how recently their members had contact with the criminal legal system: On average, nonparticipants had more recent contact with the system. Among clients who had enrolled while in the community, around one-third of participants were convicted of a felony in the two years before RICMS enrollment, compared with one-half of nonparticipants. On average, nonparticipants were more likely to have been arrested or convicted than participants in both enrollment groups. Nonparticipants also spent more time incarcerated than participants. See Box 1 for more detailed examples of RICMS client backgrounds.

Case Management Services and System Navigation

After a client was enrolled in the RICMS program, CHWs completed a comprehensive assessment of client needs. This assessment was used to form a care plan, which included goals for the client to work on. Due to challenges communicating with individuals who enrolled while in jail, the assessment typically did not happen until after they were released and living in the community. Care plans addressed service domains such as physical health, mental and behavioral health, housing, transportation, benefits enrollment, and employment. Care plans also included other client goals, such as obtaining identification and legal documentation and fulfilling court mandates. Staff reported that they used an initial conversation to identify the client's primary goals and motivations and then built out the care plan over time.

Staff at RICMS providers described their approach to serving clients as meeting them "where they were at." This style of engagement means acknowledging that client progress often is not linear, and that setbacks can and do happen. When a setback—for example, relapse or reincarceration, an emotionally or physically distressing situation, or losing access to housing—occurred, staff emphasized the necessity of having a nonjudgmental reaction and disposition. The phrase was also meant literally, as in physically meeting clients where they were located or working to remove any barriers that could make it hard to meet in person. One CHW summarized meeting a client "where they were at" as follows:

> We're not here to judge the client. We're here to help them, no matter how many times they fall; it doesn't matter. As long as we're there to help you get up. Getting up is gonna have to be a struggle. But at the end of the day, we'll do it together.

The Role of Lived Experience in the Community Health Worker–Client Relationship

Since RICMS providers were committed to hiring CHWs who had lived experience with the criminal legal system, MDRC spoke with CHWs and program participants about how they perceived and understood the role that lived experience may play in both service delivery and the

BOX 1

In Their Own Voices: RICMS Participants Describe Their Life Experiences

In Recovery from Substance Use Treatment

In interviews, the research team asked RICMS participants about their histories of substance use and treatment for substance use disorders. One participant had a long history of addiction, relapse, and recovery, which at times overlapped with his experiences with incarceration and parole. Before being interviewed, he had lived with a partner for seven years and was addicted to crack cocaine, alcohol, methamphetamine, and heroin.

> [After] many years of using alcohol and drugs, I was just tired of it. And this last time around, being addicted to crack cocaine was horrible . . . I was hallucinating a lot, and I was hearing voices. I was going crazy. I wasn't happy.

The participant had checked himself into rehab multiple times in the past. At the time of the interview, the participant was in recovery and on probation following his release.

Navigating Employment with Weak Social Ties

The ability to tap into personal social networks for help accessing crucial resources like housing, employment, or emotional support can make all the difference when navigating reentry. For some RICMS clients, however, such networks or social ties were not available—and in some cases, never were. One participant described never having a strong support system while growing up:

> I grew up without [a] family, you know what I'm saying? My dad is the same . . . I never had nobody care for me and I never asked for help from nobody.

Unlike other RICMS clients who were able leverage their social networks to find a place to stay—or a job—shortly after their release, another participant had no such network to call upon, which is why he felt the help provided by his CHW was so crucial. For this participant, the relationship that developed between the two of them represented a social bond that felt more familial than the ones he had with his family growing up:

> Everybody in here . . . it's like a family I never had. [They've] done more than my family, you know? It's something I'm never going to forget.

By working with a CHW, this participant was able to access medical and employment services that ultimately led to him getting a much-needed eyeglasses prescription and eventually to finding stable employment as a forklift operator.

Medical Needs Related to Physical Health

One RICMS participant, like many, had been incarcerated for many years—in his case, 48 years. After his release, he faced many challenges related to reentry, such as trouble acclimating to new forms of technology and communication, and mental and physical health needs associated with aging. After release, this participant had trouble getting some of the medications he needed, such as a monthly injection to help with the absorption of vitamins. Because he didn't have adequate income or access to insurance that would pay for this treatment, he ended up missing two doses in two months.

> I went almost two months without any B12 injection. At what point do I continue to become damaged, irreparable damage?

development of relationships between CHWs and participants. While not all CHWs had lived experience with the criminal legal system, most did: The staff survey found that 71 percent of CHWs and other staff members directly serving a client caseload had experienced someone close to them being incarcerated, and 52 percent had direct experience with incarceration. (See Table B.1.) The study team also examined whether CHWs—and other staff carrying caseloads of RICMS clients—were demographically similar to clients.[12] The study team found that clients and these staff members shared some characteristics, such as racial and ethnic identity (41 percent of clients and 48 percent of staff identified as Black, and 43 percent of clients and 55 percent of staff identified as Hispanic), but their gender identity differed (64 percent of case-carrying staff and 27 percent of clients reported their gender identity as female).[13]

The majority of CHWs who were interviewed agreed that lived experience (specifically with incarceration and addiction) enhanced their capability to empathize with and understand clients' experiences, and the everyday challenges and obligations they face after release. Some CHWs noted that their own experiences allowed them to pick up on subtle behaviors, patterns, or attitudes that their clients displayed that they may not have noticed—or placed as much importance on—if they did not have lived experience in similar situations. One CHW spoke about lived experience:

> It helped me connect with people who probably would not have accepted this type of help before, because they were able to connect with me because of my previous experience. I had a client before who thought, "How did you get this job?" And so when I told her a little bit about my history, she was floored. She couldn't believe I had been to prison and that I [had] an office job and that I was a case manager. And I told her, "You can do the exact same thing I'm doing." So when I told her about my story, all her walls fell down and I was able to kind of get in and help her.

CHWs disclosed their lived experience to clients strategically. While many CHW interviewees reported that they were upfront with their clients about their relatable personal histories, others withheld some or all their lived experiences from clients until they felt it would serve a strategic function. For example, one CHW described how sharing personal experiences with incarceration helped with uncooperative clients:

> From my personal experience, when I have a client who's like, "You don't know what I've been through," and I allow them to vent and I allow them to let me

12. Some program managers reported that they carried a caseload of clients in addition to their managerial duties.

13. Race and ethnicity are different dimensions of identity, though they're sometimes related. Race often tends to be distinguished based on physical characteristics, especially skin color. Ethnicity is often distinguished by cultural characteristics, including—but not limited to—language, history, and religion. However, these concepts are often conflated. In this report, the research team has generally presented race and ethnicity separately. In the RICMS program's client data and in the staff survey conducted by MDRC, clients and staff could indicate multiple races, and separately indicate whether they identified as Hispanic or Latino.

> know that they're frustrated—I feel like it's the most rewarding feeling to be able to be like, "Listen, I spent the majority of my 20s in prison. So yes, I do know how it feels." You know what I mean? And I feel like sometimes when a client hears that and they see the position I'm in and I'm rocking a county badge. . . . I used to transfer drugs across the border. Nine years ago, you would never tell me I would be in this position. And when I have the chance to tell a client who's desperate for help but does not know the steps, and I let them know, like, "Check this out; whatever you want in your life, it is possible," and then I give them a brief description of what I've been through—that's the most rewarding thing. So I feel like it does help when you have those clients who wanna be difficult and [say], "You don't know how it feels . . . no one wants to hire me."

CHWs' lived experiences were an important tool for establishing trust and rapport with clients. The relationships between CHWs and their clients were fortified and deepened through the intentional sharing of such experiences. For participants, believing that their CHW truly and meaningfully understood them felt very important. This mutual understanding facilitated a level of trust that many participants didn't have with other staff in criminal legal institutions or service providers, and for some participants, a level of trust that they couldn't find even within their own networks of family and friends. One RICMS participant explained why it was useful for a CHW to have similar lived experiences:

> I think they connect with me because some of them have been in similar . . . they might not have done time or anything like that, but they've dealt with the system and they know . . . how the system can put up roadblocks to prevent you from moving forward, especially with a record, you know. They're able to relate in finding jobs, you know, having an income, things like that . . . having a drug addiction, having alcohol addiction. They're able to relate in those ways, you know. And I think that makes them better caseworkers because they're not just giving us words or [being] self-serving.

Another participant expressed a similar opinion:

> I feel that the other case worker that I had, she kinda related to me with certain, like, personal things that I've went through. . . . Since the first day she met me, she was worried about my well-being when I told her that I just wanna be a good mother to my baby when my child comes. And I know that she's a mother herself, and she wanted to help me because she knows the struggle as a woman, as a mother, you know.

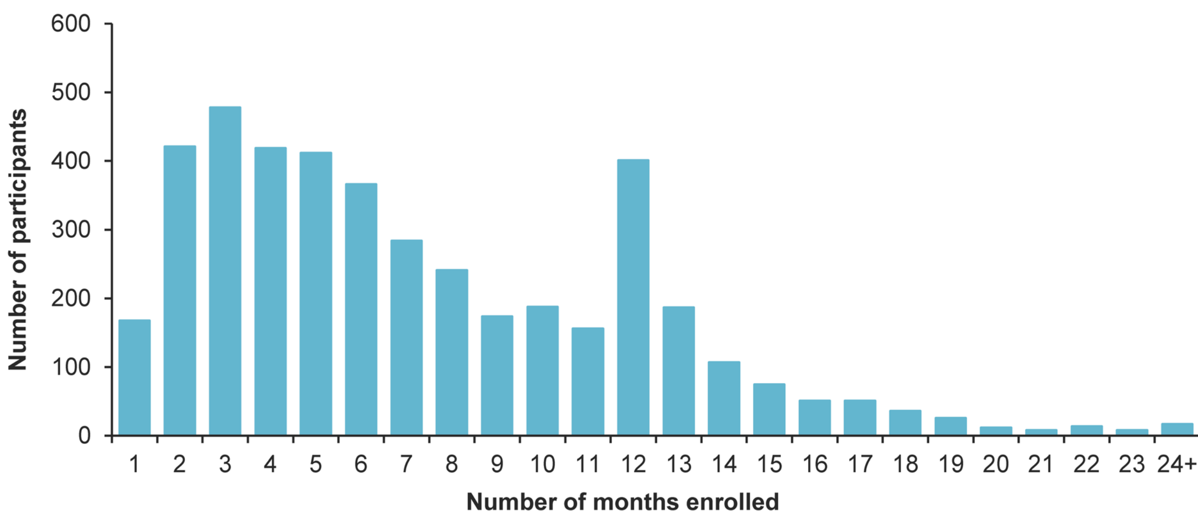
Engagement in the RICMS Program

Based on analysis of the management information system records (see Table 1), only 30 percent of clients who enrolled while living in the community participated in the RICMS program, meaning that they received services for at least 30 days after enrollment and had a care plan re-

corded in CHAMP; 13 percent of the individuals who enrolled while in jail met this participation threshold. Once enrolled in the RICMS program, clients received case management services for up to 12 months. In some circumstances, participants participated for longer than 12 months if they needed more support. Staff periodically reviewed caseload assignments to assess whether participants were successfully meeting their goals and conducted case reviews after six months to determine whether participants needed more time to address the needs documented in their care plans.

Figure 2 shows the number of months that participants were enrolled in the RICMS program (regardless of enrollment location). Fifty-three percent of participants were enrolled in the program for 6 months or less, 34 percent were enrolled for 7 months to 12 months, and 14 percent were enrolled for more than 12 months.

FIGURE 2. Participant Enrollment in the RICMS Program



SOURCE: Calculations based on data from the CHAMP management information system.

NOTE: Participants are RICMS clients who were enrolled in the program for at least 30 days and had a care plan recorded in CHAMP.

Furthermore, individuals who were enrolled while living in the community participated for longer periods of time, on average, than individuals who were enrolled while in jail. Participants who were enrolled while in the community spent an average of 51 more days as active RICMS participants. The median number of days participants who enrolled while living in the community spent in the program was 190 days—39 more days than the median for participants who enrolled while in jail (as shown in Table 1).

Types of Services and Supports

As described earlier, RICMS providers used various approaches to connect clients to services, which were offered in-house or through referrals to other LA County programs or community-based organizations. Services—and approaches to meeting service needs—varied among providers, depending on the resources they could offer, other available resources in their geographic regions, and the boundaries established by staff members when attending to client needs. Box 2 shows participants' perspectives on the role persistence played in navigating reentry. The sections below describe the services and supports that were commonly discussed by participants and CHWs.

BOX 2

Participant Persistence While Navigating Reentry

Participants described their attitudes—toward the future, their goals, or challenges they faced or anticipated facing as they reentered their communities—as positive and optimistic. One participant spoke about navigating reentry: "[I]t's a battle. It's turmoil. I'm not gonna lie about it. It's very challenging. But . . . through it all, I know something great is in store for me." This sentiment, one of positive future orientation, reflected the perspectives of other participants who were interviewed. Another participant acknowledged that the process required perseverance, explaining, "I have my days where I don't want to do anything . . . [but] I need to do it; nobody's gonna do it for me."

Additionally, many participants felt that a certain degree of persistence and grit was crucial to reaching their goals. For example, one participant said, "I stopped blaming the system . . . I stopped blaming people for the things that I do. I caused this for myself . . . I can't blame anybody for things that I did." In interviews where participants talked about their attitudes toward their incarceration and reentry, their relationships with CHWs appeared to reinforce their positive future orientations, and ultimately encouraged perseverance in dealing with the many challenges they faced.

Housing. When asked which services were hardest to access, nearly all the CHWs who were interviewed said that providing housing was the greatest challenge. Access to affordable housing is in particularly high demand in LA County and varies depending on local jurisdictions. Staff observed that housing availability had improved over time, though staff in some service planning areas of LA County, such as the San Gabriel Valley, reported having fewer options to meet housing needs than other service planning areas.[14] To help alleviate some of the housing pressure, the Reentry Division developed the Interim Housing program for individuals in early recovery from substance use disorders who had an immediate housing need. Program slots were made available to all Reentry Division programs, but RICMS clients accounted for almost all referrals.

14. Service Planning Areas are geographic designations of LA County's Department of Public Health.

Primary care, hospital, and mental health services. Participants said their physical and mental health status presented challenges to navigating reentry. Some participants experienced physical conditions, such as learning disabilities or limited mobility due to injury, or mental health conditions, like depression or issues with anger management. However, these challenges were compounded by other factors, such as a participant's socioeconomic status and access to insurance or financial assistance. Participants said that the ability to access medical services within one organization was very beneficial. Furthermore, to effectively connect clients to behavioral or mental health services, it was valuable for CHWs to "make a warm handoff" within the organization—that is, to connect the participant with a specific person the CHW knew. This approach was particularly helpful for participants who felt hesitant to try therapy due to fear or concern about a social stigma.

Substance use disorder treatment. Participants' histories of substance use were another theme that emerged from interviews. Most of the participants who discussed their relationship to substance use had experiences characterized by phases of recovery that were punctuated by relapses. Some of these participants struggled with addiction to multiple substances, including alcohol and illicit drugs. Their attempts to recover were compounded by other factors, such as their housing status or socioeconomic status. For example, one participant explained that, while she experienced homelessness, one of her only options for housing was with a friend who played a major role in facilitating her alcohol relapse.

Court-mandated programs. During interviews, participants and CHWs often described how provider services that could help a participant fulfill court-mandated requirements were extra motivators for engagement. For example, some RICMS providers offered programs that, in some cases, would satisfy court-mandated requirements for clients on parole. Watts Labor Community Action Committee, for instance, provided access to free court-mandated classes about anger management and domestic violence that some participants needed to attend to meet legal requirements. One participant said that the free programs significantly reduced that client's financial burdens and alleviated stress.

Crisis response. Some CHWs shared anecdotes about helping clients during times of acute distress or urgency. CHWs would drop what they were doing to pick up a client in an emergency, provide support when a client faced eviction, or help with transportation if a client could not get to work.

Social support. Social networks, when available, could be a crucial external resource that participants used to navigate the challenges associated with reentry. In some cases, a participant's strong social ties with friends or family afforded access to crucial information and resources shortly after release, like job leads or transportation. For example, one participant was able to quickly buy a car from a close family member for $1,000. Access to such resources so soon after release appeared to have powerful downstream impacts. The participant who was able to purchase a car right after being released from prison was then able to find stable employment independently. At the time of the interview, this participant was enrolled in a vocational training program for solar panel installation. While it is impossible to know what might have happened under different circumstances, it is reasonable to assume that without quick access to reliable

transportation via a social network, this participant may have had a much harder time finding a job in solar panel installation, since one of the job requirements was owning a car.

The utility of strong social ties and networks was not only demonstrated through direct access to resources, but also through access to social and emotional support during and after incarceration. One participant had family and friends who visited her regularly during her long prison sentence. She emphasized how crucial that social-emotional support was for her well-being during and after her incarceration. Additionally, many people in her immediate social network had experience being incarcerated and navigating reentry. One close relative was even a social worker who had experience helping formerly incarcerated individuals. Upon release, this participant was able to use her social network's knowledge to find programs and services that worked well for her:

> I've learned about it through my sibling having been in the . . . jails and stuff. . . . We've been involved, incarcerated and stuff, since before [we were] 18.

Ultimately, strong social ties and social networks were an important resource that some participants possessed and used to navigate challenges associated with reentry. These participants were able to independently access resources and information that other participants, who lacked these social ties, needed to get from CHWs. However, the majority of participants who were interviewed did not have robust social networks. In some cases, participants had extremely frayed social networks, to the point where they had very few—if any—family or friends they felt they could ask for help. For these participants, their CHWs appeared to fill an important social void; their relationships with their CHWs were one of the few (and for one client, the first) to be characterized by unconditional support. See Box 3 for further discussion of participant perspectives on the quality of their relationships with CHWs.

One of the major strengths of the RICMS program was that the CHWs provided essential social support and capital to participants who had few—if any—people they could rely on unconditionally. This form of support seemed both implicitly and explicitly essential to participants identifying and reaching their goals following release. It also seemed to make participants more enthusiastic about engaging with the RICMS program.

Referrals for Services

The organizations operating the RICMS program offered a range of other services and therefore CHWs across different organizations had varying levels of access to resources. It was often necessary to provide external service referrals to help clients. When surveyed about providing referrals to services inside or outside their organizations, staff reported that they most frequently referred clients to other organizations for things like children's services, primary care and hospital services, and substance use disorder treatment. Within their own organizations, CHWs most frequently connected clients to things like mental health treatment, employment services, and education services.

BOX 3

Participant Satisfaction with the RICMS Program

Participants who were interviewed for the RICMS evaluation were asked to share how satisfied they were with their CHW and the services they accessed through the program. Nearly all interviewees had positive feelings about their experience with the RICMS program. Some interviewees said they had a strong relationship with their CHWs, describing the emotional support the CHWs provided. A common refrain from participants, when reflecting on their feelings towards their CHWs, was that their CHWs were like family—and for some, the family that they never had.

> She's helped me all the way around, where it's just like, "Damn, like, she did a lot more for me than my own family did for my child."

> Everybody is kinda open and understanding. It feels like family. For somebody like me, this is one of the only connections I have without having family out here.

> That's why I told her . . . you guys have done more than my family, you know . . . it's something I'm never going to forget.

Participants also described a strong appreciation for the CHWs' proactive outreach to them, their follow-through in securing services even when the process felt slow and complicated to navigate, and the effort they put in. One participant described the communication and effort from the CHW:

> I can be straight up and honest with her because that's the way she helps me, when I'm honest with her, you know? I think [she is] way different. I don't see her like my social worker or my enemy. . . . She's really polite, and she really does help me and hear whenever I have [a problem] . . . and she checks up on me all the time. Like, if I don't call her for a week, she does call me. And she does check up on me to see, like, "What's going on? Are you okay? Do you need something?" You know? And I appreciate that, because not a lot of people do that, or agencies.

Sometimes participants expressed frustration with the constraints and limitations around services, such as the types of housing available or the hoops they felt they had to jump through to get support. However, they said they trusted that their CHWs were working hard to help them. One participant discussed a situation where his CHW was trying to help him meet his healthcare needs, but it was taking some time to sort out:

> I believe everything is happening. It might not be happening as fast as I need it to happen, you know what I mean? But I see it happening. I have no problem with it.

Table 3 shows service referrals made for RICMS participants in the year after their enrollment (which occurred between May 2020 and March 2021).[15] It separates participants by enrollment

15. CHAMP was updated in May 2020 to enable systematic recording of service referrals. This update added a new module to CHAMP where each service referral could be logged as its own specific record, with designated fields that included referral date, type of service referred to, and whether the referral was for one-time or ongoing services. Prior to this update, CHAMP could only record service referrals in open-text case notes. This text field was used for many purposes (not just for logging referrals). Further, the case notes fields could not be extracted from CHAMP, meaning that it was not possible to analyze them for the evaluation.

TABLE 3 Service Referrals for RICMS Participants After One Year of Follow-Up, by Enrollment Location

	Jail Enrollment		Community Enrollment		All Enrollment	
Outcome	Percentage	Mean Number of Referrals	Percentage	Mean Number of Referrals	Percentage	Mean Number of Referrals
At least one referral for ongoing services:						
Employment services	10.6	0.1	18.9	0.3	18.4	0.3
Housing services	28.2	0.4	34.5	0.6	34.2	0.5
Legal services	10.6	0.1	13.4	0.2	13.3	0.2
Mental health services	14.1	0.2	17.8	0.3	17.6	0.2
Physical health services	8.2	0.2	9.3	0.1	9.2	0.1
Substance use disorder services	16.5	0.3	7.7	0.1	8.2	0.1
At least one referral for one-time services:						
Assistance with food	9.4	0.1	22.6	0.6	21.9	0.6
Basic necessities (clothing, hygiene kit, phone charger, etc.)	17.6	0.2	18.0	0.3	18.0	0.3
Education	2.4	0.0	9.2	0.1	8.8	0.1
Employment (job applications, resume building, etc.)	5.9	0.1	16.1	0.3	15.5	0.2
Housing (SPDAT)[a]	1.2	0.0	3.7	0.0	3.6	0.0
Legal services	10.6	0.2	12.0	0.2	11.9	0.2
Other supportive services	17.6	0.2	29.5	0.5	28.8	0.5
Social services (CalFresh, Medi-Cal, etc.)[b]	22.4	0.3	15.2	0.2	15.6	0.2
Transportation services (gas cards, ride share rides, etc.)	10.6	0.1	15.5	0.3	15.2	0.3
Voter education or registration services	2.4	0.0	12.9	0.1	12.3	0.1
Referred to one or more distinct service categories	69.4	--	84.5	--	83.6	--
Referred to two or more distinct service categories	45.9	--	67.7	--	66.4	--

(continued)

TABLE 3 (continued)

	Jail Enrollment		Community Enrollment		All Enrollment	
Outcome	**Percentage**	**Mean Number of Referrals**	**Percentage**	**Mean Number of Referrals**	**Percentage**	**Mean Number of Referrals**
Referred to three or more distinct service categories	31.8	--	46.2	--	45.4	--
Referred to four or more distinct service categories	21.2	--	28.1	--	27.7	--
Sample size	85		1,379		1,464	

SOURCE: Calculations based on data from the CHAMP management information system.

NOTES: This table includes RICMS participants who enrolled from May 2020 through March 2021. Documented referrals in CHAMP may represent a floor or minimum, rather than an exact accounting. In other words, at least the number of participants shown in this table were referred to the services shown, but it is possible that more received referrals to these services.

Participants are RICMS clients who were enrolled in the program for at least 30 days and had a care plan recorded in CHAMP.

"Jail enrollment" indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

"Community enrollment" indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

[a]SPDAT = Service Prioritization Decision Assistance Tool.

[b]CalFresh is California's Supplemental Nutrition Assistance Program. Medi-Cal is California's implementation of the federal Medicaid program.

location: jail or community enrollment. Referrals fall into two categories: (1) referrals for ongoing services, such as a series of employment workshops, and (2) referrals for one-time assistance, such as securing basic necessities like clothing. For participants who enrolled while living in the community, the most commonly documented referrals to ongoing services were for housing services (35 percent), followed by employment services (19 percent) and mental health services (18 percent). The most commonly documented referrals to one-time services for these participants were for assistance with food (23 percent), assistance with basic necessities (18 percent), and assistance with other supportive services that were not categorized in CHAMP (30 percent).

Referrals for participants who enrolled from jail indicate they had different priorities: The most common referrals to ongoing services were for housing (28 percent), substance use disorder services (17 percent), and mental health services (14 percent). The most commonly documented referrals for one-time services were for social services (22 percent), basic necessities (18 percent), and other supportive services that were not categorized in CHAMP (18 percent).

A caution when interpreting these referral numbers: The documented referrals in CHAMP may represent a floor, or minimum, rather than an exact accounting. In other words, at least the number of participants shown in Table 3 were referred to the services shown, but possibly more received referrals to these services. Table 3 also shows that 84 percent of all RICMS participants had at least one documented service referral. Based on qualitative interview data and the staff survey, nearly all RICMS participants should have received referrals to some type of service. One potential reason why participants may not seem to have received referrals is that in some instances, staff may not have used the service referral functionality introduced in May 2020 and instead may have continued to document some services in case notes, as was the practice before introduction of the service referral tracking function. Still, even with this potential undercounting of service referrals, these data give a sense of the relative frequency with which RICMS participants were referred to different service types.

In interviews, program managers and staff also described using other funding sources outside of the RICMS program to help clients with additional needs, such as transportation. Providing clients with bus passes, for example, was a common practice. Many CHWs personally gave their clients rides to various appointments and obligations.

In interviews, CHWs described tailoring their approach to connecting clients with services to the clients' level of engagement, explaining that some clients were more likely to reach out proactively and pursue goals independently, while other clients needed more hands-on assistance. Feedback shared by participants and staff members suggests that their relationship, once established, contributed to participants' satisfaction with services and sense of connection to the program. (See Box 3 for further information.) CHW interviewees discussed the importance of being perceived by their clients as dependable and consistent. It was important for clients to trust that they would always answer or return their calls, that CHWs would follow up consistently, and, among other things, that CHWs could be depended on when urgent needs arose.

> I think a big thing is following through. That's number one. Never promise anything that you yourself cannot deliver. So even though I can say, "This is how

> the housing works," or "This is how this program works"—I can explain that to you, but I'm not the one running that program; I'm not the one funding that program. I can't tell you for sure [what] is going to happen. All I can say is this is usually the process, and this is how you usually get there. If I tell you, "Hey, I've got some clothes," because I know I've got them here, and I'm like, "Yeah, here's some socks," you know, then I know that's on me. But I can't say, "Oh, yeah, we're gonna get you those socks. I'm gonna find you this week," if I don't know that I'm gonna be able to pull that off. Because I don't wanna ever add to mistrust. I don't want them to ever feel a sense of, like, "Wow. You're just like everyone else. You're giving me a bunch of crap."

In interviews, CHWs emphasized the importance of holistic approaches to client engagement, where the services provided—and the nature of the CHW-client relationship—go beyond reentry goals and services. For example, CHWs checked in with clients about their medical histories (a last doctor or dentist visit), or personal relationships (with children, family, and so forth) as a way to look at the "whole person." One CHW said:

> We deal with the whole person. We don't want you to just think better, we want you to feel better and look better while you're going through this change. So we deal with the mental, the emotions, the body.

As important as it was to be perceived as available and dependable, CHWs also talked about the importance of establishing boundaries with their clients, which they felt ultimately facilitated trust and rapport. Some CHWs were adamant about a clear "9-to-5" workday, and only engaged with clients after they were "off the clock" during absolute emergencies.

Program Monitoring and Quality Assurance Practices

The Reentry Division conducted training and quality assurance testing to ensure that the network of RICMS providers implemented the program according to established policies and procedures. Each RICMS provider was assigned a Reentry Division program manager. Program managers at the local providers and the Reentry Division representatives met once or twice a month to review CHW caseloads, discuss case management strategies, monitor care plans in CHAMP, and help address gaps in service needs. The Reentry Division program managers also conducted in-person site visits at RICMS agencies to assess the effectiveness of service provision.

The Reentry Division arranged training for CHWs and program managers, with topics including program procedures, effective case management practices, and other professional development topics. Provider staff who were surveyed found the training valuable, with 90 percent or more of staff survey respondents rating each training session they attended as being helpful or very helpful. Providers also helped CHWs learn the job through on-the-job training. Nearly all staff members who were interviewed felt they received enough training and professional development

opportunities.[16] CHWs interviewees also discussed the importance of learning from their peers. Before the COVID-19 pandemic, the Reentry Division hosted quarterly peer learning events with all RICMS providers to offer ongoing training and technical assistance, as well as to foster collaboration and share best practices. The in-person meetings were discontinued during the pandemic and were conducted virtually instead, with less frequency. Peer learning events were well received by provider staff, who frequently said, in interviews, that they were valuable opportunities to build relationships, identify resources, and share tips.

To support data quality assurance and monitor compliance with CHAMP data entry requirements, the Reentry Division conducted training with providers, developed materials to inform staff members of system changes, and reviewed individual cases with providers. Program managers who were interviewed also described reviewing data in CHAMP with CHWs to ensure they recorded program activities. Staff members' feedback on CHAMP indicates that staff attitudes toward CHAMP improved over time as the system functionality changed. Staff members who were interviewed in 2019 (before changes were implemented to CHAMP) reported lower satisfaction than staff interviewed after 2021, since the system gained features that were more useful for staff members in their workflow.

PROGRAM OUTCOMES

The theory of change underlying the RICMS program posits that centralizing the coordination of reentry services and connecting clients to individuals with similar lived experiences will lead to improved health and well-being outcomes and reduced criminal legal system contact. To unpack whether this theory translates into positive change for participants, the RICMS evaluation took a quasi-experimental approach to comparing the health and criminal legal system outcomes of individuals who enrolled and participated in the RICMS program with those of individuals in a matched comparison group who enrolled in the RICMS program but did not participate. This approach amasses less confidence about estimates of program effectiveness than, for example, a well-implemented randomized controlled trial. However, conducting a randomized controlled trial to test the efficacy of RICMS was not possible at the time of this evaluation, since the program had the capacity and desire to serve everyone who was interested

16. CHWs received training on the "risk-need-responsivity" (or RNR) model. The RNR model assumes that the risks and needs of an individual should determine the strategies chosen to address that individual's criminogenic factors, or the factors that have a direct link to future criminal activity and can be changed. This training occurred only one time, and the concept of applying the RNR model did not seem to take a strong hold among the providers.

and eligible.[17] In the absence of a randomized controlled trial, the quasi-experimental analyses provide some initial descriptive information about the differences in outcomes that could be due to the RICMS program.

Research questions for the outcomes study included the following questions:

- Do participants' county-provided emergency healthcare utilization rates differ from those of nonparticipants?
- Do participants' county-provided inpatient and outpatient healthcare utilization rates differ from those of nonparticipants (such as primary care and hospital, mental health, and substance use disorder treatment services)?
- Do participants experience fewer rearrests, new reconvictions, and incarcerations than non-participants?
- Among clients on probation supervision, do participants experience fewer revocations than nonparticipants?

Analysis Approach

The outcomes analysis used propensity score matching to construct matched comparison groups.[18] Drawing on the full sample of individuals who enrolled in the RICMS program between April 2018 and March 2021, this approach used background characteristics—including demographics, prior criminal legal system involvement, and previous receipt of county services—to construct participant and nonparticipant groups that were as similar as possible. The propensity score matching approach based on available background characteristics yields stronger evidence than simply comparing outcome levels of unmatched groups. A potential limitation of analyses that rely on propensity score matching is that there may be unobserved characteristics or unmea-

17. Randomized controlled trials of services are particularly appropriate when there is an excess demand for services that cannot be met by the program. That is, when programs are oversubscribed, with more potential clients interested in services than the program's capacity and resources to serve them. When this happens, and the benefits of the services for clients are not yet known or evaluated, a randomized controlled trial can be implemented as a fair and unbiased way to determine who receives services among interested and eligible clients. See Finkelstein and Taubman (2015) for a discussion of excess demand and service rationing as they relate to randomized controlled trials.

18. Propensity score matching is a quasi-experimental method that uses statistical techniques to construct an artificial control group by matching each individual who enrolled and participated in RICMS (program unit) with someone who enrolled but did not participate in RICMS (comparison unit) with similar characteristics (such as age, race, gender, past use of county services, or past interaction with the criminal legal system at program entry). The propensity score is the probability that a unit will enroll in RICMS based on observed characteristics. Then program units are matched to comparison units based on propensity scores. The method assumes that comparison units can be compared with program units, as if access to the program has been fully randomized, conditional on some unobservable characteristics. Propensity score matching seeks to mimic randomization to overcome issues of selection bias found in nonexperimental methods.

sured factors (for example, factors for which the team does not have data) that could predict membership in the research groups (that is, participant or nonparticipant) or the outcomes. The research team has a rich data set containing multiple LA County agencies' records for RICMS clients, including demographic information and their histories with various government services and systems (the same systems and agencies from which the team's outcome measures are derived) dating back several years.[19] However, these data are not exhaustive, and it is possible that unobserved characteristics are present that would threaten the validity of the results. For instance, the team does not have data on transportation access or whether participants had children, which could be important factors in program participation.

Given the fact that clients who enrolled in the RICMS program while living in the community were more than twice as likely to participate in RICMS services than clients who enrolled while in jail (see the earlier discussion about the data in Table 1), the propensity score matching process was conducted separately for the two groups. The sample sizes for these two groups were also quite different: During the analysis period, the number of participants who enrolled in the RICMS program while in the community was 19 times larger than the number who enrolled while in jail (4,089 participants and 211 participants, respectively). As such, the main body of this report focuses only on the outcomes findings for the larger group of participants who enrolled while in the community. Appendix C presents outcomes findings for the smaller group of individuals who enrolled while in jail. Appendix C also presents unmatched descriptive outcomes for the full sample of RICMS participants and nonparticipants as a reference.[20]

The matching process yielded comparison group matches for 85 percent of RICMS program participants who enrolled while in the community, meaning that outcomes analyses conducted on the matched group reflect outcomes for the majority of participants served by the RICMS program.[21] Appendix A presents more detailed information about the propensity score matching process and results. It also presents findings from sensitivity tests, which provide additional information about the robustness of the estimated differences in the outcomes analysis and how likely findings are to change under different assumptions and parameters. Overall, the results of the sensitivity checks were consistent with the outcomes analysis and did not diminish the team's confidence in the findings for clients who were enrolled while in the community. Had the sensitivity test results shown changes in observed differences once the tests were applied, the team would have had less confidence in the findings.

Outcomes were examined for a one-year period following RICMS program enrollment for all RICMS clients in the study sample. Outcomes over a two-year follow-up period are shown for

19. One exception: county substance use disorder services, which were not available for the time periods before program enrollment due to agency limitations on what data could be provided to researchers.

20. The full unrestricted sample in Appendix C includes the 15 percent of RICMS community enrollment program participants for whom no matching comparison was found among nonparticipants. It also includes all comparison group members, including comparison group members who did not match to a RICMS program group member.

21. The match rate for participants who enrolled in the RICMS program while in jail was 99 percent.

RICMS clients with enrollment dates before March 2020. Differences in outcomes were estimated using linear regressions.[22]

One- and Two-Year Outcomes for Clients Who Enrolled While Living in the Community

This section presents service use outcomes for substance use disorder treatment, mental healthcare

TABLE 4 Summary of One- and Two-Year Outcomes: Community Enrollment

Outcome Area	One Year	Two Years
Substance use disorder service use	4 outcomes examined, 0 significant estimated effects	4 outcomes examined, 0 significant estimated effects
Mental healthcare service use	3 outcomes examined, 2 significant estimated effects	3 outcomes examined, 3 significant estimated effects
Primary care and hospital service use	6 outcomes examined, 5 significant estimated effects	6 outcomes examined, 4 significant estimated effects
Criminal legal system contact	10 outcomes examined, 7 significant estimated effects	10 outcomes examined, 7 significant estimated effects

treatment, and primary care and hospitalization, followed by criminal legal system outcomes. Outcomes for both RICMS participants and nonparticipants (or the comparison group) are presented for clients who enrolled while living in the community. A summary of the findings is presented in Table 4. Detailed findings for each set of outcomes are in Appendix C.

Substance Use Disorder Treatment

There were no statistically significant differences in admissions to LA County–provided substance use disorder services between the RICMS program participants and the comparison

22. Generalized linear regression models were also run on binary outcomes and produced similar results. See Appendix A for a list of covariates and a discussion on covariate selection.

group members.[23] As shown in Table C.1, among both research groups, about 7 percent of clients were admitted to LA County–provided substance use disorder services during the first year after RICMS enrollment. By the end of the two-year period, about 10 precent of both research groups had been admitted to LA County–provided substance use disorder services.

Mental Health Treatment

RICMS program participants were more likely to receive services from LA County Department of Mental Health providers than comparison group members. However, these findings should be interpreted with caution, since sensitivity checks showed they may be sensitive to unmeasured bias. (See Appendix A.) Specifically, as shown in Table C.2, RICMS participants were 5 percentage points more likely to receive mental health services during the first year after enrollment.[24] By the end of the two-year follow-up period, the difference between groups was 3 percentage points. Specifically, this difference in the receipt of mental health services was driven by RICMS participants being more likely to receive outpatient mental health treatment. By contrast, at the of the second year, RICMS participants were less likely to have received inpatient mental health treatment.

Primary Care and Hospitalization

RICMS program participants were less likely to visit an emergency room than comparison group members. To examine whether the RICMS program group members differed from comparison group members in receipt of primary care and hospital services, the analysis measured primary care visits, inpatient hospital admissions, and emergency room visits. Table C.3 shows that RICMS participants were about 4 percentage points less likely to be admitted to an emergency room during the two-year follow-up period than their comparison group counterparts.

Criminal Legal System Contact

RICMS program participants were less likely to have interactions with the criminal legal system than comparison group members. They were less likely to experience an arrest, be incarcerated in jail, have a new conviction, or have a probation revocation. As shown in Table C.4, during the first year after program enrollment, about 72 percent of program participants did not experience an arrest or incarceration in jail, compared with 66 percent of comparison group members, an estimated difference of 6 percentage points. These differences persisted into the second year. On average, RICMS participants spent 8 fewer days in jail during the one-

23. The threshold for statistical significance used in this study is a p-value below 0.10. A p-value is the probability of obtaining a difference at least as extreme as the calculated difference between groups in a situation where there is no real difference between groups. For example, a p-value of 0.10 indicates that there is a 10 percent chance of observing a difference at least as extreme as the one observed when there is no real difference between groups. The p-values associated with each difference are represented in exhibits using asterisks, where "*" indicates a p-value less than 0.10, "**" indicates a p-value less than 0.05, and "***" indicates p-value less than 0.01. No asterisk indicates that the difference between groups is not statistically significant. That is, in a situation where there is no real difference between groups, the chance of observing a difference at least as large as the one observed is greater than 10 percent. See Wasserstein and Lazar (2016) for additional discussion of statistical significance.

24. Outpatient care does not require a patient to stay at the hospital for care. Inpatient care requires a patient to stay in the hospital for care.

year follow-up period than comparison group members who did not participate in the RICMS program and 13 days fewer by the end of the two-year follow-up period.

Though neither of the research groups were likely to experience new convictions during either the first or second year after RICMS enrollment, RICMS participants experienced slightly fewer new convictions than comparison groups members. The difference in having a new conviction between the research groups was 3 percentage points during the first year and grew to 4 percentage points by the end of the second year. This difference in convictions was primarily driven by differences in misdemeanor convictions.

To examine differences in probation status (whether an RICMS client was on probation supervision) and probation system interactions between RICMS participants and comparison group members, the team measured yearly probation status, revocations, terminations, and extensions. RICMS program participants on probation experienced fewer probation revocations than comparison group members on probation. As shown in Table C.4, 19 percent of the comparison group had their probation status revoked during the two-year period after their enrollment in RICMS, compared with 11 percent of RICMS participants. Comparison group members were also more likely to have probation terminated (a 1 percentage point difference between the groups).

The differences observed in arrests and incarceration are greater in both magnitude and statistical significance than most recidivism effects recorded in the literature for comparable reentry programs. A meta-analysis of 53 studies on reentry programs found that, on average, reentry programs reduce recidivism by 6 percent, compared with a 17 percent difference seen in the RICMS program.[25] A meta-analysis of 9 reentry programs and a separate study of 12 reentry programs across the United States found small and statistically insignificant differences in rearrest rates between program participants and comparison group members—between 30 and 65 percent of the observed differences in the one-year arrest and one-year incarceration rates in the RICMS analysis.[26] One of these two studies also measured reincarceration rates and found no statistically significant differences in reincarceration rates for the reentry program participants.[27] Two caveats in making comparisons to these prior studies are that (1) the target population in these studies was somewhat different from that of the RICMS program and (2) the researchers

25. Ndrecka (2014). RICMS program differences in the percentage points shown earlier were converted to percent difference for comparison purposes. Furthermore, measures were inverted (for example, the team's "no arrest" measure, with a rate of 72 percent, was converted to an "arrested" measure with a corresponding rate of 28 percent) for calculating the percent difference, as the papers in Ndrecka's meta-analysis and much of the literature in the field rely on percent calculation (rather than percentage point differences) relative to measures like arrests (rather than "no arrest").

26. Berghuis (2018); Lattimore and Visher (2013).

27. Lattimore and Visher (2013).

used various research designs in their analyses.[28] Therefore, a strictly "apples-to-apples" comparison is not possible. Still, these studies provide valuable information for contextualizing the RICMS findings in the broader research literature.

CONCLUSIONS AND RECOMMENDATIONS

The RICMS program is founded on the premise that coordinating reentry services and connecting participants to individuals with similar lived experiences could lead to improved health and well-being outcomes and reduce criminal legal system contact for participants. The findings from this report have implications for local, state, and national organizations that are thinking about service structures for individuals with criminal legal system involvement.

Both CHWs and RICMS participants who were interviewed as part of the RICMS study discussed the value of the workers' lived experience and how it facilitated stronger connections between staff and participants. The CHW-client relationship appears to be vital to engaging participants and connecting them with the services and supports they need to be successful. However, successfully connecting clients to needed services depends on the social service delivery system in the county. LA County services are highly fragmented due to the complexity of its governance and social service delivery system. Clients living in service areas with fewer community resources may experience greater barriers to achieving their goals, since CHWs have fewer options available or there may be long wait lists for in-demand services like housing. The Reentry Division was able to address some housing gaps by funding the Interim Housing program to supplement the resources available through the RICMS program, which shows how integrating services can help bolster the success of an individual program. While program managers and CHWs expressed the value of peer learning and relationship building among the 29 RICMS providers, the support the network offered all CHWs appears limited. Some CHWs said they had to secure service connections on their own or within their individual organizations, rather than with the support of the Reentry Division as a coordinating body. The different approaches to building a network of service referral options likely resulted in variation in service provision across providers depending on their unique cultures, approaches, and set of organizational resources.

Regardless of the challenges in connecting clients to needed services, the quantitative findings suggest that the RICMS program structure is potentially successful for individuals with criminal legal system involvement. The results of the analysis indicate that RICMS is a promising program for reducing future contact with the criminal legal system and emergency medical services for

28. For instance, many of the programs included in these other studies only served people who were being released from prison, and, in many cases, only men. By contrast, the RICMS program serves men and women and a wider population of people with criminal legal system involvement, including people who have recently been released from jail or prison and people who have criminal legal system contact but have not recently been released. In terms of study design, Lattimore and Visher's work used a nonexperimental design, Berghuis relied only on randomized controlled trials in the meta-analysis, and Ndrecka's meta-analyses included both randomized controlled trials and nonexperimental design studies.

clients who enrolled while living in the community. Findings regarding reduced contact with the criminal legal system among the participant group were consistent across measures of arrests, incarcerations, convictions, and probation revocations. The magnitude of these differences is similar in scale to those of more comprehensive reentry programming.[29]

That said, a substantial number of clients who enrolled in the RICMS program, regardless of their enrollment location (in jail or in the community), did not actively engage in services. It is hard to know the reason for this, though, without future study. One possibility is that individuals who enrolled ultimately decided they did not need the services that RICMS staff offered, which could suggest that there is an opportunity to target enrollment efforts differently. Another factor in the low take-up of services could be the limited interaction between the jails and the RICMS program staff, particularly about communicating up-to-date information about release dates and contact information. This suggests an opportunity to strengthen the relationship and system of communication between jail-based staff and RICMS staff to better support the individuals preparing for and being released.

An upcoming cost study will further explore these findings and document the total costs of the RICMS program. To support further learning about the reentry landscape in LA County, and how its lessons can inform efforts across the country, the research team is conducting additional impact, outcomes, implementation, and cost studies of other reentry programs in LA County that are managed by the Justice, Care, and Opportunities Department.

29. For example, see Barden et al. (2018) and Redcross, Millenky, and Rudd (2012).

APPENDIX

A

Data Sources and Methods

DATA SOURCES

The Reentry Intensive Case Management Services (RICMS) process study relied on multiple qualitative and quantitative data sources.

Semistructured Interviews with Program Staff

The study team interviewed a total of 27 community health workers (CHWs) and 14 program managers from 15 of the 29 RICMS providers in 2021 and 2022. See Table A.1 for a list of all RICMS providers. Interviews lasted approximately one hour each and took place over Zoom or in person. Topics included:

- staff lived experiences
- how staff built relationships with participants
- client interactions
- general experiences working as a CHW
- organizational characteristics of the agency
- integration of service delivery systems
- performance management
- broader policy and social context that agencies were embedded in

Semistructured Interviews with Program Participants

The study team interviewed a total of 26 individuals who participated in services from 10 RICMS providers in 2021 and 2022. The team selected participants from these providers in particular because they represented a range of service planning areas (or locations within Los Angeles County), common referral sources, and alternate services. Interviews lasted approximately 30 minutes and took place primarily in person. Topics included:

- experiences with release from prison or jail
- goals and needs after release
- service receipt and participant satisfaction
- participant's relationship with staff

APPENDIX TABLE A.1 Profiles of Programs in the RICMS Study

Organization Name	Other Services Provided	Service Planning Area (SPA)	Participated in Staff Survey	Staff Participated in Interviews	Participants Interviewed	Additional Context
A New Way of Life	Housing, legal services, family reunification	6	✓			Focuses on supporting women.
Amity Foundation	Housing, substance use disorder treatment, family reunification	4, 6	✓	✓	✓	Referrals come from jail, the community, and California Department of Corrections and Reentry (CDCR).
Ascent	Housing	8	✓	✓	✓	Focuses on young adults ages 18 to 24.
Asian Youth Center	Food distribution	3	✓			Also provides youth and family services for at-risk young people on probation.
Catalyst Foundation	Countywide benefits entitlement services	1	✓	✓	✓	Focuses on youth on probation and their families. Referrals come from jail, the community, and CDCR.
Center for Employment Opportunities	Employment services	4				Did not accept referrals from LA County jails. RICMS contract expired June 30, 2022.
Center for Living and Learning	Employment services	2	✓	✓	✓	Focuses on job readiness for disadvantaged adults and young people.
Champions in Service	Tattoo removal, gang intervention, violence prevention, employment services, education supports	3	✓			Wrap-around services include supports for victims of trauma.
ChapCare	Federally qualified health center	3	✓			Assigns patients to a physician in ChapCare's network, where they work closely with a team to receive comprehensive care, regardless of ability to pay

(continued)

APPENDIX TABLE A.1 (continued)

Organization Name	Other Services Provided	Service Planning Area (SPA)	Participated in Staff Survey	Staff Participated in Interviews	Participants Interviewed	Additional Context
Christ-Centered Ministries	Housing	6	✓	✓		Provides transitional community-based recovery housing for formerly incarcerated individuals and those experiencing homelessness. Contracted to provide interim housing for RICMS clients.
East Valley Community Health Center	Federally qualified health center	3	✓	✓	✓	Has CalAim contract.[a]
Exodus Recovery	Substance use disorder treatment, mental health, homeless outreach, housing	4, 8	✓	✓		One of the larger RICMS programs. Has CalAim contract.
Flintridge Center	Employment services	3	✓			Prepares formerly incarcerated and gang-impacted individuals for careers in union construction trades through an apprenticeship preparation program.
Francisco Homes	Reentry support, housing					Provided reentry support and housing only for men on parole from long-term incarceration, mostly life sentences. Did not take jail referrals. RICMS contract expired June 30, 2022.
Heluna Health	Linkages health services	3	✓			Provides support for various health needs, such as chronic disease and aging, communicable diseases, and mental health and addiction.
Homeboy Industries	Education, legal services, mental health, vocational training and other workforce development, tattoo removal	4	✓			Comprehensive gang intervention, rehabilitation, and reentry services.

(continued)

APPENDIX TABLE A.1 (continued)

Organization Name	Other Services Provided	Service Planning Area (SPA)	Participated in Staff Survey	Staff Participated in Interviews	Participants Interviewed	Additional Context
Homeless Health Care Los Angeles	Housing, substance use disorder treatment, mental health	4	✓	✓	✓	One of RICMS' newer programs. Started in 2019.
Homeless Outreach Program Integrated Care System	Housing, mental health, employment services, legal services	6	✓			Largest housing and homeless service agency in SPA 6.
PATH	Homelessness prevention, housing navigation, employment	4	✓			Focuses on affordable housing and supporting those without housing. Operates interim housing site.
Paving the Way	Housing, substance use treatment, veterans affairs, housing, domestic violence	1	✓			Also provides low-income assistance, as well as housing for veterans and the AB 109 population.[b]
SHIELDS for Families	Employment services, housing, court-mandated domestic violence and anger management classes	6	✓			Emphasizes culturally sensitive service models. Staff has lived experience with substance use disorder, gang involvement, and incarceration.
Southern California Health and Rehabilitation Program	Mental health, rehabilitation	6, 7	✓	✓	✓	Referrals come from jail, the community, and probation department. There are also interdepartmental AB 109 referrals.
St. John's	Transgender services, physical health, mental health, employment services, legal services	4, 6	✓	✓	✓	Has CalAim contract.

(continued)

APPENDIX TABLE A.1 (continued)

Organization Name	Other Services Provided	Service Planning Area (SPA)	Participated in Staff Survey	Staff Participated in Interviews	Participants Interviewed	Additional Context
St. Joseph's Center	Housing, mental health, substance use disorder treatment, food distribution	5	✓	✓	✓	Emphasizes street outreach to individuals experiencing homelessness.
Tarzana Treatment Centers	Mental health, substance use disorder treatment, domestic violence and anger management classes, parenting classes, court services	2, 8	✓			Community-based organization that operates a psychiatric hospital, residential and outpatient alcohol and drug treatment centers, and family medical clinics.
Turning Point Alcohol and Drug Education program	Substance use disorder classes	7	✓			Temporary and permanent housing support, mental health services, and drug and alcohol education.
Via Care	Federally qualified health center	7				Emphasizes delivering health care services in a culturally and linguistically competent manner.
Volunteers of America	Employment services, substance use disorder treatment	3, 7	✓	✓		Has CalAim contract.
Watts Labor Community Action Committee	Domestic violence and anger management classes, employment services, family source center, food distribution	6	✓	✓	✓	Has referral system with the probation department. Does not take jail referrals.

SOURCES: Reentry Division records, interviews with program staff, and study team records.

NOTES: Some RICMS programs were awarded Enhanced Care Management contracts to provide clinical and nonclinical supports to their enrollees with the most needs.

[a]CalAim (California Advancing and Innovating Medi-Cal) is California's effort to reform its Medicaid program.

[b]The AB 109 population includes individuals convicted of nonviolent, nonserious, and nonsexual offenses.

Staff Survey

A survey was administered to RICMS program managers and community health workers in April 2022. Surveys were sent to staff at every RICMS provider. A total of 94 staff responded from 27 of the 29 RICMS providers. The survey asked program staff to provide information about their roles and responsibilities, their backgrounds, the ways they supported clients and connected them to services, and trainings or procedures that guided their activities.

CHAMP

The Comprehensive Health Accompaniment and Management Platform (CHAMP) is a case management system operated by the LA Department of Health Services. It tracks client enrollments, consent forms, assessments, demographic characteristics, needs, goals, and referrals to services.

The outcomes study relied on two data sources: RICMS case management data and administrative records from several LA County agencies.

InfoHub

The LA County Chief Information Office, which sits in the LA Chief Executive Office, manages InfoHub, an administrative data repository that merges service-use data from multiple county information systems. Of the many county service systems that provide data to InfoHub, the Chief Information Office provided data from six LA County agencies for this report: the Department of Mental Health, Substance Abuse Prevention and Control, the Department of Health Services, the LA County Sheriff's Department, the LA Superior Court, and the LA Probation Department.

QUALITATIVE ANALYSIS

Interviews were recorded and transcribed. The files were imported into Dedoose, a web-based, mixed-methods analysis software package, to systematically code the data in a multistep process; program staff and program participant transcripts were analyzed separately. The development of the coding scheme involved several stages. First, structural codes—based on the topics that were intentionally included in most interviews (that is, following the semistructured questions and topical probes of the protocols)—were created *a priori* to reflect the theory of change.[1] These broad codes (for example, "CHW and client relationship" or "reentry system integration") essentially served as an indexing device. They were used to evaluate the consistency of the interviews (how commonly the code was covered) and the richness of the data collected (the extent to which topics were covered in the interviews). Second, a more detailed coding structure that included

1. Saldaña (2009).

subcodes under structural codes—as well as additional codes for emerging topics—was created based on the coding team's review of the first level codes. This was an iterative process; some codes were identified in advance, but many were data-driven and developed during the process to accommodate new and emerging themes.

PROPENSITY SCORE MATCHING PROCESS

The outcome analysis used quasi-experimental propensity score matching to create comparable research groups out of the pool of RICMS participants and nonparticipants.[2] The propensity score is the probability that a unit, or individual, will participate in RICMS based on observed characteristics such as race, gender, or past contact with the criminal legal system. Each unit (or individual) in the sample received a propensity score that predicted how likely each was to participate in the RICMS program. Each program unit (a person who enrolled and participated in RICMS, or "participant") is matched to a comparison unit (a person who enrolled but did not participate in RICMS, or "nonparticipant") with similar propensity scores. This process mimics randomization, conditional on unobservable characteristics, to create two groups: the participant group and the comparison group. This process ensured that the research groups were substantially similar with regards to their propensity to participate in the RICMS program. It also created the best available comparison group by taking into account many characteristics of each individual in the sample, which increases confidence in any effects on measured outcomes that were estimated during the outcomes analysis phase.

Propensity scores were created separately for people who enrolled in the RICMS program while in jail and people who enrolled while in the community. This was done because of the observed difference in service participation between the two groups: People who enrolled while in the community were twice as likely to participate in services as those who enrolled while in jail. (See Table 2.) Results are presented separately for these two groups.

To create the propensity scores, the analysis team used logistic regression to assess whether a series of characteristics were predictive of an individual participating in the RICMS program. In selecting covariates, the team followed the research literature on propensity score matching, which indicates that covariates known to be predictive of research group assignment (in this case, participant or nonparticipant) or outcomes should be included in the model.[3] And including additional covariates that are thought to be predictive of research group or of outcomes is likely not harmful. Therefore, covariates were selected based on findings from past research

2. The study defines participants as individuals who received services from a community health worker for at least 30 days past initial enrollment and had a care plan recorded in CHAMP. Nonparticipants are individuals who were entered into the CHAMP management information system for the RICMS program but did not have services recorded for 30 days after initial enrollment, or a care plan.

3. See Stuart (2010) and Guo, Fraser, and Chen (2020).

on predictors of criminal legal system involvement for justice-involved people.[4] The research team also included measures of prior county service usage and prior contact with the criminal legal system, since past usage and interactions may have predictive power for future outcomes.[5] Multiple imputation was conducted for missing covariates. Below are the variables that were used as covariates:

- gender
- age
- race[6]
- ethnicity
- month and year of enrollment
- indicator for whether the client enrolled in RICMS before or during the COVID-19 pandemic (measured as on or after March 16, 2020)
- probation status at time of enrollment
- Service Planning Area
- ever convicted of a misdemeanor in the two years before enrollment
- ever convicted of a misdemeanor between two years and seven years before enrollment

4. For instance, a recent meta-analysis conducted by Goodley, Pearson, and Morris (2022) found that prior incarceration, prior convictions, prior arrests, a history of mental illness, and being male were consistently shown to be associated with recidivism among adults who were convicted and sentenced to custody. This meta-analysis also found being Black to be a predictor, due to the institutional racism in law enforcement and the judicial system. A meta-analysis by Bechtel, Lowenkamp, and Holsinger (2011) found that age, number of jail incarcerations, prior conviction, prior felony, and prior misdemeanors were all predictive of rearrest among people awaiting trial. In one of the few studies that exclusively focused on people released from jails, Sheeran (2020) found that gender, race, ethnicity, age at release, criminal record, risk score, and time served were found to significantly influence an individual's likelihood of receiving a new charge, conviction, or incarceration term within three years after release. Last, a study by Lebenbaum, Kouyoumdjian, Huang, and Kurdyak (2022) found that among individuals released from provincial correctional institutes in Ontario, Canada, the utilization of mental health services prior to incarceration was associated with higher rates of recidivism, higher rates of hospitalization, and lower rates of outpatient care.
5. For instance, one outcome in the analysis was whether clients were admitted to emergency rooms. Therefore, the team included the number of emergency rooms visits that individuals had experienced in the two years leading up to RICMS enrollment.
6. Race was missing for many cases in the initial data. As a first step to addressing this absence, a comparison of race and ethnicity variables was conducted. It revealed that, in most cases when race was missing, ethnicity was indicated as Hispanic. Rather than impute race, the research team combined race and ethnicity into a single race variable and indicated "Hispanic" as the race in these cases.

- ever convicted of a felony in the two years before enrollment
- ever convicted of a felony between two years and seven years before enrollment
- number of days between client's most recent conviction and the client's enrollment date
- number of days client spent in jail in the two years before enrollment
- number of days client spent in jail between two years and eight years before enrollment
- ever arrested in the two years before enrollment
- ever arrested between two years and eight years before enrollment
- number of primary care visits in the two years before enrollment
- number of ER visits in the two years before enrollment
- number of inpatient hospital admissions in the two years prior to enrollment
- ever received county-provided inpatient mental health services in the three years prior to enrollment
- ever received county-provided outpatient mental health services in the three years prior to enrollment
- ever flagged for substance abuse while receiving a county-provided mental health service in the three years prior to enrollment

The logistic regressions produced coefficients that represent the relationship between each predictor and the likelihood that a client would participate in RICMS. Clients' individual characteristics and factors were then multiplied by these coefficients to create a score between 0 and 1, where a score of 0 meant that the client was estimated to be completely unlikely to participate in RICMS and a score of 1 meant that the client was estimated to be certain to participate.

The research team used one-to-one nearest neighbor matching to match program participants to nonparticipants with similar propensity scores. This means that each program participant was matched to the closest unmatched score in the nonparticipant pool, that is, the person with the closest set of characteristics. The team ran the match without replacement, meaning that each client could only be matched once; once they were matched, the client was taken out of the selection pool. To ensure that program participants were only matched with nonparticipants with a somewhat similar likelihood of program participation, the research team used a caliper of 0.2. Using a caliper of this size prohibits the team's statistical computing software from matching two individuals together who have propensity scores greater than 0.2 units apart on the 0-to-1 scale. The caliper size was chosen based on recommendations in the literature and established

MDRC practice.[7] The matching process produced a 98 percent match rate for the RICMS participants who enrolled while in jail and an 85 percent match rate for the RICMS participants who enrolled while in the community. In the jail enrollment group, 416 total participants and nonparticipants were matched, compared with 6,976 total in the community enrollment group. A larger sample size results in more statistical power, which means that the research team can be more confident that the community enrollment group effect estimates are accurate than the effect estimates for the jail enrollment group.

Any matched comparison group will differ slightly from the study sample. However, it can provide an estimate of participant outcomes for the population of people enrolled in programs like RICMS who did not receive services.[8] See Table A.2 for characteristics of the matched jail enrollment participants and Table 2 in the main report text for characteristics of all jail enrollment participants (including matched and not matched).

Program participants who enrolled while in the community and who were matched were more likely to have been convicted of a misdemeanor in the two years prior to enrollment, compared with the full community enrollment sample (34 percent versus 29 percent) and more likely to have been convicted of a misdemeanor in the three to seven years prior to enrollment (37 percent versus 31 percent). Matched community enrollment participants were also more likely to have been arrested in the two years prior to enrollment (63 percent versus 55 percent). On other measures, the matched and full sample of community enrollment participants were similar. See Table A.3 for characteristics of the matched community enrollment participants and Table 2 in the main report text for characteristics of all community enrollment participants (including matched and not matched).

Matching Sensitivity Checks

To assess the strength of the matching process, the research team used a variety of visual and statistical sensitivity checks at each stage of the analysis. Each sensitivity check was conducted separately for the two enrollment streams. The team used three methods to assess covariate balance: means comparison, logistic regression, and an average standardized difference love plot. First, the team compared the covariate means for the two research groups in each stream to ensure that they were substantially similar. Table A.2 shows the covariate means for the jail enrollment group and Table A.3 shows the covariate means for the community enrollment group. The means for both analysis streams were substantially similar across the research groups.

Second, the team performed a logistic regression on the matched research groups to see if there were any statistically significant differences between them. In the jail enrollment group, there

7. Austin (2011).

8. A weighting approach based on propensity scores, in lieu of matching, was also given consideration. However, the team felt that a matching approach was clearer to understand and more transparent, in the sense that it is easy to compare the differences in characteristics of the resulting matched analysis sample with the characteristics of the overall unmatched sample, also presented in this report.

APPENDIX TABLE A.2 Characteristics of RICMS Participants and Nonparticipants: Jail Enrollment

Variable	Participants	Nonparticipants
Demographics		
Age (mean number of years)	39.8	40.1
Gender (%)		
Male	63.9	66.4
Female	34.1	32.7
Trans male	0.5	0.0
Trans female	1.0	1.0
Genderqueer	0.5	0.0
Race/ethnicity (%)		
Black	29.3	27.9
Multiracial	4.8	6.3
White	38.0	35.1
Hispanic/Latinx[a]	52.4	49.5
Asian	2.9	6.3
Native American[b]	--	--
Pacific Islander	0.0	0.0
Enrolled during COVID-19 pandemic (%)	49.0	51.9
Contact with the criminal legal system		
Ever convicted of a misdemeanor (%)		
In the two years before enrollment	53.9	56.7
Between two years and seven years before enrollment	51.0	52.4
Ever convicted of a felony (%)		
In the two years before enrollment	63.9	69.7
Between two years and seven years before enrollment	38.9	36.1
Average number of days between most recent conviction and enrollment[c]	256.6	243.4
Average number of days incarcerated		
In the two years before enrollment	173.7	178.5
Between two years and eight years before enrollment	152.1	142.9
Ever arrested (%)		
In the two years before enrollment	99.5	99.5
Between two years and eight years before enrollment	77.4	78.9
On probation at time of enrollment (%)	33.7	33.2
In jail at time of enrollment (%)	100.0	100.0

(continued)

APPENDIX TABLE A.2 (continued)

Variable	Participants	Nonparticipants
Medical care		
Primary care and hospitalization		
Number of primary care visits in the two years before enrollment	0.6	0.5
Number of emergency services in the two years before enrollment	0.7	0.7
Number of hospital admissions in the two years before enrollment	0.1	0.1
Mental health (%)		
Ever had inpatient mental health admission within the previous three years	12.5	10.1
Ever had outpatient mental health service within the previous three years	43.8	41.8
Ever identified as having a substance use disorder within the previous three years	34.6	32.7
Sample size	208	208

SOURCES: Calculations based on data from the CHAMP management information system and InfoHub.

NOTES: "Jail enrollment" indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

[a]Racial demographic percentages represent a combination of race and ethnicity data from the CHAMP management information system. Self-reported Hispanic ethnicity and Latinx race were combined into the "Hispanic/Latinx" variable shown in the table. As such, percentages in this section will not add up to 100.

[b]Values not shown due to small cell size.

[c]Conviction data were available for the seven-year period prior to client enrollment.

APPENDIX TABLE A.3 Characteristics of RICMS Participants and Nonparticipants: Community Enrollment

Variable	Participants	Nonparticipants
Demographics		
Age (mean number of years)	40.8	40.9
Gender (%)		
Male	73.4	74.2
Female	25.2	24.5
Trans male	0.2	0.2
Trans female	1.1	1.0
Genderqueer	0.1	0.1
Race/ethnicity (%)		
Black	40.0	39.5
Multiracial	3.9	4.1
White	28.1	29.4
Hispanic/Latinx[a]	43.4	43.4
Asian	1.3	1.0
Native American	1.2	1.1
Pacific Islander	0.6	0.6
Enrolled during COVID-19 pandemic (%)	39.5	40.9
Contact with the criminal legal system		
Ever convicted of a misdemeanor (%)		
In the two years before enrollment	33.6	32.8
Between two years and seven years before enrollment	36.8	36.9
Ever convicted of a felony (%)		
In the two years before enrollment	36.5	36.6
Between two years and seven years before enrollment	31.3	31.2
Average number of days between most recent conviction and enrollment[b]	320.7	310.6
Average number of days incarcerated		
In the two years before enrollment	72.3	79.8
Between two years and eight years before enrollment	113.2	117.5
Ever arrested (%)		
In the two years before enrollment	62.8	63.1
Between two years and eight years before enrollment	60.9	59.5
On probation at time of enrollment (%)	28.9	28.3
In jail at time of enrollment (%)	0.0	0.0

(continued)

APPENDIX TABLE A.3 (continued)

Variable	Participants	Nonparticipants
Medical care		
Primary care and hospitalization		
Number of primary care visits in the two years before enrollment	0.6	0.6
Number of emergency services in the two years before enrollment	0.5	0.7
Number of hospital admissions in the two years before enrollment	0.1	0.1
Mental health (%)		
Ever had inpatient mental health admission within the previous three years	8.5	8.9
Ever had outpatient mental health service within the previous three years	35.8	36.0
Ever identified as having a substance use disorder within the previous three years	21.2	21.9
Sample size	3,469	3,469

SOURCES: Calculations based on data from the CHAMP management information system and InfoHub.

NOTES: "Community enrollment" indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

[a]Racial demographic percentages represent a combination of race and ethnicity data from the CHAMP management information system. Self-reported Hispanic ethnicity and Latinx race were combined into the "Hispanic/Latinx" variable shown in the table. As such, percentages in this section will not add up to 100.

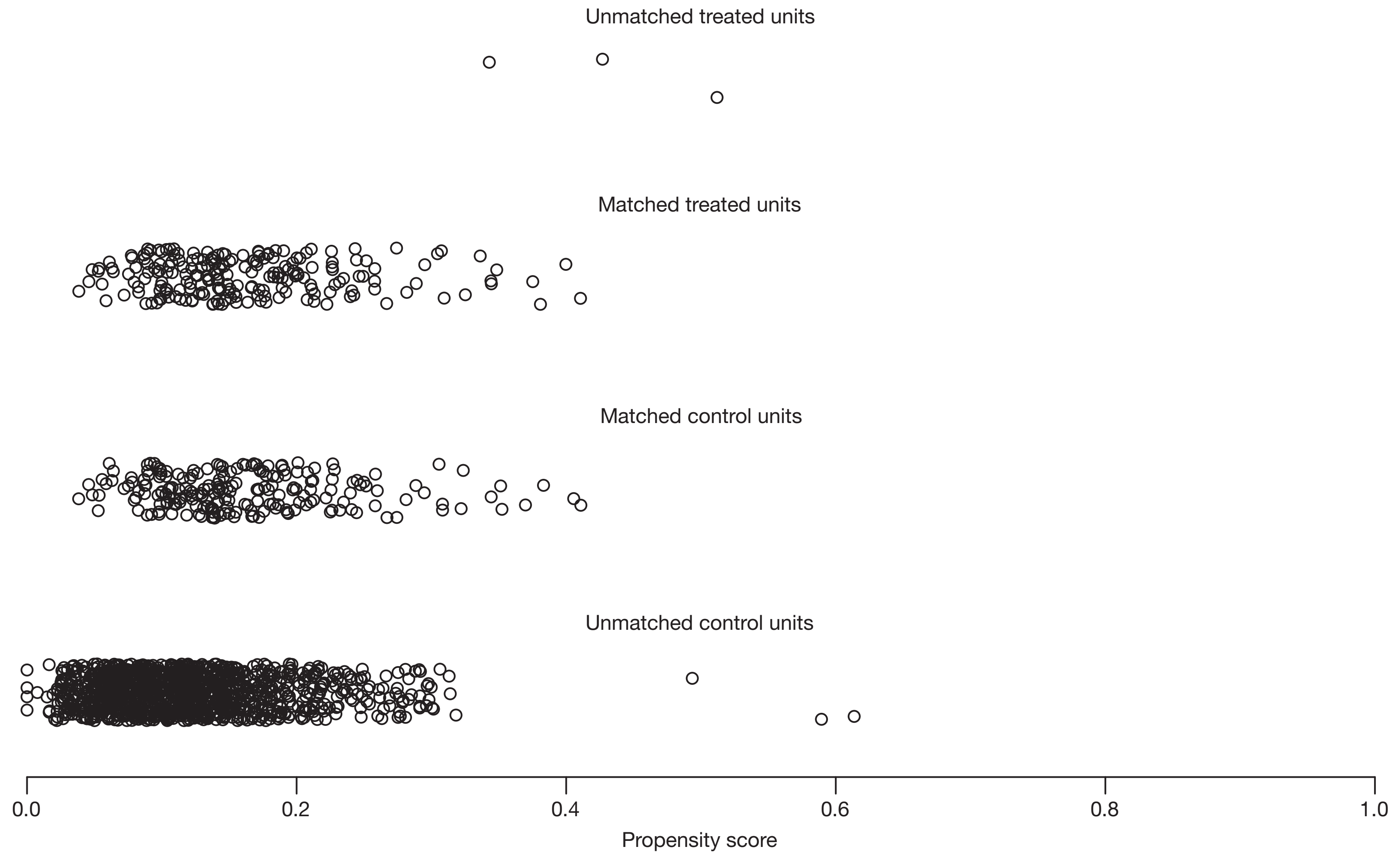
[b]Conviction data were available for the seven-year period prior to client enrollment.

were no statistically significant differences in any of the individual covariates. In the community enrollment group, only two covariates were significantly different. The groups as a whole, however, were not statistically different.

Finally, the team constructed an average standardized difference love plot for both streams after matching was done. The team used the cobalt bal.tab() function in R to produce balance statistics based on the treatment variable (participation in RICMS). The team then extracted the standardized difference statistics for each covariate and plotted them in relation to $x = 0$. In the jail enrollment group, all of the covariates fell between −0.05 and 0.05, except for two outliers. In the community enrollment group, all but one of the covariates fell between −0.05 and 0.05.

The team used several visual checks to assess the score assignment process. These checks included an examination of the region of common support using a histogram, a density plot of the slope of the probability distribution, line graphs of the quantile of probability, and a distribution plot of the propensity scores. See Figures A.1 and A.2 for the propensity score distribution plot for each enrollment group.

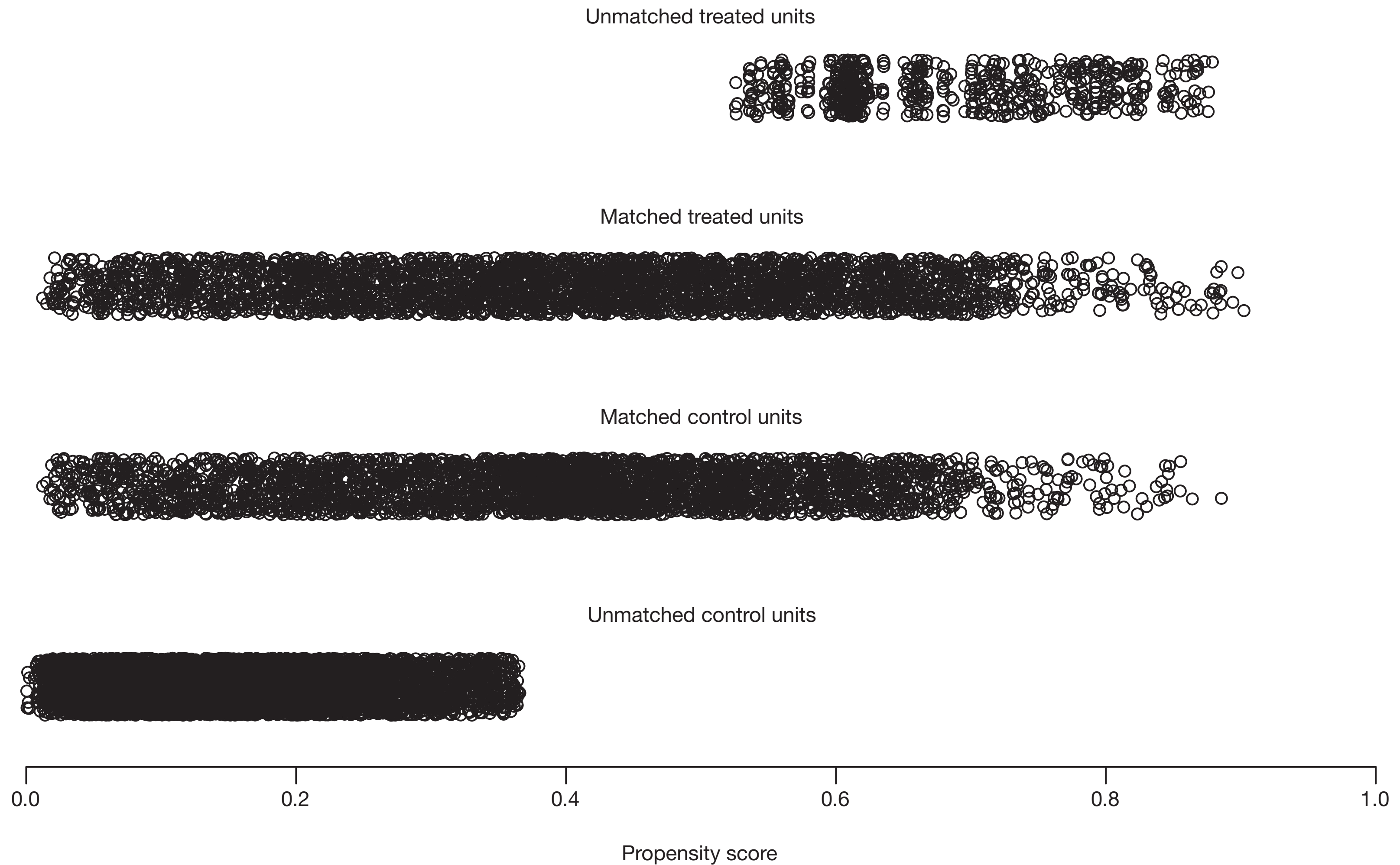
APPENDIX FIGURE A.1 Distribution of Propensity Scores: Jail Enrollment Group



SOURCE: MDRC analysis of the propensity score matching results.

NOTE: "Jail enrollment" indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

APPENDIX FIGURE A.2 Distribution of Propensity Scores: Community Enrollment Group



SOURCE: MDRC analysis of the propensity score matching results.

NOTE: "Community enrollment" indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

Participants and nonparticipants in the jail enrollment group had a similar distribution of propensity scores, even before matching. After matching, the plot shows nearly identical propensity score distributions for the matched treated units and the matched control units. There are only three unmatched treated units, which are those without similarly distributed units in the unmatched control pool. The plot for the community enrollment group shows similar score distributions for matched program participants (matched treated units) and matched nonparticipants (matched control units). As expected from a matching approach, the unmatched units are largely nonparticipants who were predicted to be highly unlikely to participate in the RICMS program and participants who were predicted to be highly likely to participate in the RICMS program. The distribution plot shows a strong match between the research groups.

MODEL SENSITIVITY CHECKS

The analysis team employed an iterative model-building approach to test the strength of their model specifications and preempt overfitting. The team delineated three different models with a decreasing number of covariates, prioritizing covariates with the highest expected predictive power of both treatment and outcome. The research team first ran a linear regression on the full proposed model with all the covariates above. The team then ran linear regressions on the two reduced models and compared them with the original model. Each model showed only slight differences in the regression outputs; the direction and significance of each outcome were consistent across the three models.

In order to minimize the false discovery rate, the research team implemented the Benjamini-Hochberg (BH) procedure on the outcomes, segmented by group and follow-up year. Under the adjusted p-values produced by the BH procedure, 10 of the jail enrollment outcomes were significant at the 0.1 level, including 6 one-year outcomes. Twenty-four outcomes for the community enrollment group were significant at the 0.1 level even after undergoing the BH procedure, including nearly all the criminal legal system outcomes where statistically significant differences have been observed in the main analysis. This provides support for the estimated differences for this group in the regression analysis.

The research team also conducted Rosenbaum's bounds tests to assess confidence in the results. These tests are designed to test the assumption of conditional independence implicit in propensity score analysis. They do this by determining how strong an effect an unmeasured confounding variable would need to have on treatment assignment to significantly influence the estimated causal effect. Two tests were used for continuous outcome variables: the Wilcoxon signed-rank test and the Hodges-Lehmann point estimate. Two tests were used for binary outcome variables: the Wilcoxon signed-rank test and McNemar's test.

The following results are for the community enrollment group. In Year 1, the criminal legal system outcomes were very robust, which the exception of "no felony conviction within one year of follow-up," which was sensitive to unmeasured bias. "Probation status" was similarly sensitive

to bias. The outcomes relating to arrests, incarceration, and probation term amendments were particularly robust. These patterns held for the two-year criminal legal system outcomes, except for the outcome "probation status," which became more robust in Year 2. Across both years, the primary care physical health outcomes were sensitive to bias, but the emergency services and inpatient hospital admission outcomes were robust against bias. All outpatient mental health outcomes were fairly sensitive to bias, but inpatient mental health outcomes were not. Substance use disorder treatment outcomes were overall very sensitive to bias in the Wilcoxon signed-rank test, but the Year 2 outcomes were robust according to McNemar's test.

LIMITATIONS

Data Sources

Data extracted from the CHAMP management information system may not reflect the full picture of client referrals and outcomes. CHAMP relies on information reported by program staff, which means that differences in the ways individual case managers enter data may influence the accuracy or completeness of the data. Additionally, staff may not always use the service referral functionality and may document some services in case notes. This limits how detailed the research team's analyses could be on services received by clients.

Another potential limitation is that outcomes analyzed in this study represent only data for LA County. For instance, outcomes data related to the criminal legal system included records from the LA Superior Court, LA Sheriff's Department, and the LA Probation Department. These records were limited to LA County, and arrests and convictions from other counties were not available for analysis. State prison admission and release data were also not available. Similarly, for primary care and hospitalization, mental health, and substance use disorder services and outcomes, the study captured only county-administered services and did not include information from private health care providers or noncounty agencies and organizations.

Propensity Score Matching

Propensity score matching is a powerful analytic tool to generate a comparison group when a randomized controlled trial is not possible. While it can provide initial information about differences in outcomes, propensity score matching, it cannot determine whether a causal relationship exists between the program and observed outcomes. A potential limitation of analyses that rely on propensity score matching is that there may be unobserved characteristics or unmeasured factors (for example, factors for which the team do not have data) that could predict membership in the research groups (that is, participant or nonparticipant) or could predict the outcomes. The research team has a rich dataset that contains multiple LA County agencies' records of RICMS clients, including demographic information and their histories with various government services and systems (the same systems and agencies from which the team's outcome measures

are derived) dating back several years.[9] However, these data are not exhaustive, and it is possible that unobserved characteristics are present that would threaten the validity of the results.

9. County substance use disorder services were an exception; they were not available for time periods prior to program enrollment due to agency limitations on what data could be provided to researchers.

APPENDIX

B

Staff Survey Responses

APPENDIX TABLE B.1 RICMS Staff Backgrounds and Lived Experiences

	Staff Type		
Variable	**Case-Carrying**	**Non-Case-Carrying**	**All**
Demographics			
Race/ethnicity[a] (%)			
Black	47.7	28.6	41.5
Multiracial	4.5	9.5	6.2
White	31.8	28.6	30.8
Hispanic/Latinx	54.7	68.2	58.1
Asian	4.5	0.0	3.1
Native American	0.0	0.0	0.0
Pacific Islander	0.0	0.0	0.0
Other	11.4	33.3	18.5
Gender (%)			
Male	36.2	18.2	31.9
Female	63.8	81.8	68.1
Age (mean number of years)	39.6	44.7	41.0
Lived experiences (%)			
Family or someone close has experienced[b]			
Homelessness or housing instability	61.1	73.9	64.2
Incarceration	70.8	87.0	74.7
Other justice system involvement	62.5	78.3	66.3
Extended unemployment	59.7	73.9	63.2
An ongoing physical or mental health issue	61.1	65.2	62.1
Staff members who have personally experienced[b]			
Homelessness or housing instability	45.6	54.5	47.8
Incarceration	51.5	45.5	50.0
Other justice system involvement	44.1	36.4	42.2
Extended unemployment	41.2	40.9	41.1
An ongoing physical or mental health issue	30.9	22.7	28.9
Prior experience providing case management	65.7	73.9	67.8
Received training or a certificate related to position[b]			
Certification[c]	32.3	26.1	30.7
Associate's degree	18.5	13.0	17.0
Bachelor's degree	26.2	43.5	30.7
Graduate degree	7.7	21.7	11.4
Sample size[d]	77	23	100

(continued)

APPENDIX TABLE B.1 (continued)

SOURCE: MDRC calculations from staff survey.

NOTES: [a]Racial demographic percentages represent a combination of race and ethnicity data from the staff survey. As such, percentages in this section will not add up to 100.

[b]"None of the above" was not an option when staff members were asked about these topics. Therefore, in instances where no options were indicated for questions on these topics, it is not possible to determine whether survey respondents intended to indicate that no options applied to them, or whether they skipped those questions. Respondents who did not indicate any options are counted in the denominator. Therefore, percentages shown for these variables should be seen as a minimum or floor. Respondents who indicated "Decline to answer" were not included in the denominator.

[c]For example, Alcohol/Drug Counseling Certificate, Clinical Mental Health Counseling, Recovery Support Specialists Certificate.

[d]The sample size shows the total number of respondents to the survey, though not every respondent answered each survey question associated with the variables shown on this table. The percentages reported are among the total number of respondents to the individual questions associated with these variables.

APPENDIX TABLE B.2 RICMS Staff Roles

Characteristic	N	Percentage
Staff type		
Community health worker	70	70.0
Program manager	19	19.0
Other	11	11.0
Start date at organization		
Before March 2020	55	56.1
March 2020 or later	43	43.9
Caseload carrying?		
Yes	77	77.0
Sample size[a]	100	

SOURCE: MDRC calculations from staff survey.

NOTE: [a]The sample size shows the total number of respondents to the survey, though not every respondent answered each survey question associated with the variables shown on this table. The percentages reported are among the total number of respondents to the individual questions associated with these characteristics.

APPENDIX TABLE B.3 Responsibilities of Caseload-Carrying RICMS Staff

Responsibilities	Percentage	Median
Caseload types		
Staff member has clients who are:		
Not yet released	50.6	--
Already released	98.7	--
Never been incarcerated	16.9	--
In-person[a]	98.7	--
Virtual[a]	98.7	--
Text/email[a]	93.5	--
Responsibilities in a typical week		
Number of clients staff member has assigned to their caseload	--	30
In-person caseload	--	5
Virtual caseload	--	10
Text/email caseload	--	10
Hours worked in a typical week		
Total hours worked	--	40
Hours worked on the RICMS program	--	35
Recruiting potential clients from a local agency or in the community	--	3
Working with new RICMS clients to complete the intake and enrollment process	--	4
Providing case management support to RICMS clients[b]	--	10
Entering data into CHAMP	--	8
Managing or supervising other RICMS staff or overseeing performance of the program	--	0
Participation in RICMS-related training or professional development[c]	--	3
Working on other activities for RICMS that are not mentioned above	--	2
Sample size	77	

SOURCE: MDRC calculations from staff survey.

NOTES: [a]Some staff reported not being able to recall their caseload types. These responses of "do not recall" were included in the denominator of the percentage calculation. Therefore, percentages shown for the participants in each type of caseload should be seen as a minimum or floor.

[b]For example, helping clients individually, connecting clients to services, and making referrals.

[c]Participation in training could mean receiving or delivering training.

APPENDIX TABLE B.4 Client Support Activities, as Reported by Caseload-Carrying Staff

Response	N	Percentage
Frequency of updating comprehensive screen assessment or other assessments of enrolled clients		
Frequently	25	35.2
Occasionally	37	52.1
Infrequently	7	9.9
Never	1	1.4
Don't recall	1	1.4
Frequency of developing or updating the service plans of enrolled clients		
Frequently	55	76.4
Occasionally	16	22.2
Infrequently	0	0.0
Never	1	1.4
Frequency of assisting enrolled clients with obtaining and navigating housing		
Frequently	42	58.3
Occasionally	26	36.1
Infrequently	3	4.2
Never	1	1.4
Frequency of assisting enrolled clients with benefits enrollment		
Frequently	42	58.3
Occasionally	24	33.3
Infrequently	5	6.9
Never	1	1.4
Frequency of assisting enrolled clients with obtaining employment or educational opportunities		
Frequently	46	63.9
Occasionally	22	30.6
Infrequently	3	4.2
Never	1	1.4
Frequency of assisting enrolled clients with obtaining medical or behavioral health treatment		
Frequently	41	56.9
Occasionally	28	38.9
Infrequently	2	2.8
Never	1	1.4

(continued

APPENDIX TABLE B.4 (continued)

Response	N	Percentage
Frequency of assisting enrolled clients with navigating court or supervision requirements		
Frequently	28	39.4
Occasionally	27	38.0
Infrequently	12	16.9
Never	4	5.6
Frequency of providing crisis intervention support to enrolled clients		
Frequently	25	34.7
Occasionally	30	41.7
Infrequently	17	23.6
Never	0	0.0
Sample size[a]	77	

SOURCE: MDRC calculations from staff survey.

NOTE: [a]The sample size shows the total number of case-carrying staff, though not every respondent answered each survey question associated with the responses shown on this table. The percentages reported are among the total number of respondents to the individual questions associated with these responses.

APPENDIX TABLE B.5 Client Referrals to Services, as Reported by Caseload-Carrying Staff

Service Type	N	Percentage
Children's service agencies (including welfare agencies, schools, day care providers, and pediatric health care providers)	31	43.1
Provided by staff member's organization	3	10.3
Provided by outside organization	26	89.7
Physical health services	62	86.1
Provided by staff member's organization	13	22.0
Provided by outside organization	46	78.0
Substance use disorder treatment	68	94.4
Provided by staff member's organization	18	28.1
Provided by outside organization	46	71.9
Mental health treatment	68	94.4
Provided by staff member's organization	25	39.1
Provided by outside organization	39	60.9
Employment services	70	97.2
Provided by staff member's organization	27	40.3
Provided by outside organization	40	59.7
Education support services	57	79.2
Provided by staff member's organization	17	31.5
Provided by outside organization	37	68.5
Housing services	69	95.8
Provided by staff member's organization	20	30.3
Provided by outside organization	46	69.7
Sample size[a]	72	

SOURCE: MDRC calculations from staff survey.

NOTES: In the staff survey, clients were asked multiple choice questions about each topic in this table.
[a]The sample size shows the total number of caseload-carrying staff who answered the individual multiple choice questions associated with the services shown.

APPENDIX TABLE B.6 Agencies That Worked With Staff to Support RICMS Clients in the Past Month, as Reported by Caseload-Carrying Staff

Agency	N	Percentage
Department of Mental Health	56	78.9
Department of Public Social Services	61	85.9
Department of Public Health	32	45.1
Other offices in the Department of Health Services (Housing for Health, etc.)	42	59.2
Los Angeles Housing and Community Investment Department	24	33.8
Workforce Development Agency (WDACS or other)[a]	30	42.3
Nonprofit service provider or other community-based organization	53	74.6
Sheriff's Department and jail staff	27	38.0
Community supervision (Probation Department or Division of Adult Parole Operations)	52	73.2
Reentry Division	38	53.5
Other	3	4.2
Sample size[b]	71	

SOURCE: MDRC calculations from staff survey.

NOTES: In the staff survey, clients were asked multiple choice questions about each topic in this table.

[a]WDACS = Workforce Development, Aging, and Community Services. It's now named the Department of Economic Opportunity.

[b]The sample size shows the total number of caseload-carrying staff who answered the individual multiple choice questions associated with the agencies shown.

APPENDIX TABLE B.7 Benefits Enrollment Support for RICMS Clients, as Reported by Caseload-Carrying Staff

Benefit	N	Percentage
CalWORKS[a]	50	70.4
Foster care	1	1.4
Medi-Cal	68	95.8
Supplemental Security Income	56	78.9
Social Security Disability Insurance	53	74.6
CAPI[b]	14	19.7
CalFresh[c]	68	95.8
In-Home Supportive Services	16	22.5
General relief	67	94.4
Other	1	1.4
Sample size[d]	71	

SOURCE: MDRC calculations from staff survey.

NOTES: In the staff survey, clients were asked multiple choice questions about each topic in this table.

[a]CalWORKS = California Work Opportunity and Responsibility to Kids.
[b]CAPI = State Cash Assistance Program for Immigrants.
[c]CalFresh = California's Supplemental Nutrition Assistance Program.
[d]The sample size shows the total number of caseload-carrying staff who answered the individual multiple choice questions associated with the services shown.

APPENDIX

C

Supplementary Outcomes Analysis

APPENDIX TABLE C.1 One- and Two-Year Substance Use Disorder Treatment Service Use Outcomes: Community Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had an SUD admission (%)	7.2	7.2	0.2	0.798
Number of SUD admissions	0.1	0.1	0.0	0.184
Ever had SUD outpatient treatment (%)	10.1	9.1	1.1	0.114
Number of SUD outpatient treatments	0.1	0.1	0.0	0.194
Sample size	3,469	3,469		
Two-year outcomes				
Ever had an SUD admission (%)	9.3	10.0	-0.5	0.535
Number of SUD admissions	0.2	0.2	0.0	0.426
Ever had SUD outpatient treatment (%)	12.4	11.3	1.5	0.113
Number of SUD outpatient treatments	0.2	0.2	0.0	0.542
Sample size	2,168	2,115		

SOURCE: Calculations based on data from InfoHub.

NOTES: “Community enrollment” indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

SUD = Substance use disorder.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.9).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.2 One- and Two-Year Mental Healthcare Service Use Outcomes: Community Enrollment

Outcome (%)	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had inpatient or outpatient mental health treatment	33.0	28.3	5.0 ***	<0.001
Ever had outpatient mental health treatment	32.9	28.1	5.1 ***	<0.001
Ever had inpatient mental health treatment	4.1	5.0	-0.6	0.181
Sample size	3,469	3,469		
Two-year outcomes				
Ever had inpatient or outpatient mental health treatment	37.8	35.5	3.2 ***	0.008
Ever had outpatient mental health treatment	37.6	35.3	3.2 ***	0.007
Ever had inpatient mental health treatment	6.0	7.5	-1.2 *	0.094
Sample size	2,168	2,115		

SOURCE: Calculations based on data from InfoHub.

NOTES: "Community enrollment" indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.10).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.3 One- and Two-Year Primary Care and Hospital Service Use Outcomes: Community Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had a primary care visit (%)	12.7	11.2	1.6 **	0.030
Number of primary care visits	0.5	0.4	0.1 **	0.023
Ever had an ER visit (%)	11.7	15.1	-2.9 ***	<0.001
Number of ER visits	0.3	0.4	0.0	0.225
Ever had an inpatient hospital admission (%)	2.6	3.7	-1.0 **	0.016
Number of inpatient hospital admissions	0.0	0.1	0.0 *	0.081
Sample size	3,469	3,469		
Two-year outcomes				
Ever had a primary care visit (%)	17.0	15.3	1.9 *	0.083
Number of primary care visits	1.0	0.7	0.3 ***	0.001
Ever had an ER visit (%)	18.4	22.6	-4.0 ***	<0.001
Number of ER visits	0.5	0.6	-0.1	0.135
Ever had an inpatient hospital admission (%)	4.8	6.8	-1.8 **	0.011
Number of inpatient hospital admissions	0.1	0.1	0.0	0.129
Sample size	2,168	2,115		

SOURCE: Calculations based on data from InfoHub.

NOTES: "Community enrollment" indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.11).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.4 One- and Two-Year Criminal Legal System Contact Outcomes: Community Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Average number of days incarcerated in jail	12.4	20.8	-7.8 ***	<0.001
No jail incarceration (%)	72.4	66.7	5.6 ***	<0.001
No arrests (%)	71.8	65.8	5.7 ***	<0.001
Convictions (%)				
No new felony convictions	93.1	91.8	1.1 *	0.076
No new misdemeanor convictions	94.0	91.2	2.9 ***	<0.001
No new felony or misdemeanor convictions	88.2	85.3	2.8 ***	<0.001
On probation (%)	19.8	19.5	0.0	0.976
Among those on probation supervision: (%)				
Probation revoked	8.7	15.8	-7.1 ***	<0.001
Probation terminated	1.1	1.3	-0.1	0.667
Probation extended	0.5	0.6	-0.1	0.650
Sample size	3,469	3,469		
Two-year outcomes				
Average number of days incarcerated in jail	23.0	37.3	-12.5 ***	<0.001
No jail incarceration (%)	63.7	57.3	6.1 ***	<0.001
No arrests (%)	62.9	56.7	5.8 ***	<0.001
Convictions (%)				
No new felony convictions	90.1	88.1	1.5	0.103
No new misdemeanor convictions	90.6	86.3	3.9 ***	<0.001
No new felony or misdemeanor convictions	83.1	78.8	3.6 ***	0.001
On probation (%)	16.1	17.9	-1.5	0.116
Among those on probation supervision: (%)				
Probation revoked	11.2	19.3	-7.7 ***	<0.001
Probation terminated	1.4	2.3	-0.8 **	0.042
Probation extended	0.8	1.0	-0.2	0.573
Sample size	2,168	2,115		

SOURCE: Calculations based on data from InfoHub.

NOTES: “Community enrollment” indicates people whose RICMS enrollment date falls after their release date, as recorded in CHAMP.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.12).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.5 One- and Two-Year Substance Use Disorder Treatment Service Use Outcomes: Jail Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had an SUD admission (%)	12.0	10.6	1.1	0.728
Number of SUD admissions	0.2	0.1	0.1	0.174
Ever had SUD outpatient treatment (%)	8.7	6.3	1.9	0.465
Number of SUD outpatient treatments	0.1	0.1	0.0	0.344
Sample size	208	208		
Two-year outcomes				
Ever had an SUD admission (%)	15.9	15.4	2.1	0.682
Number of SUD admissions	0.3	0.2	0.1	0.203
Ever had SUD outpatient treatment (%)	9.7	5.8	5.9	0.127
Number of SUD outpatient treatments	0.1	0.1	0.1	0.318
Sample size	113	104		

SOURCE: Calculations based on data from InfoHub.

NOTES: “Jail enrollment” indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

SUD = Substance use disorder.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.9).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.6 One- and Two-Year Mental Healthcare Service Use Outcomes: Jail Enrollment

Outcome (%)	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had inpatient or outpatient mental health treatment	40.9	28.9	9.6 **	0.014
Ever had outpatient mental health treatment	40.9	28.9	9.6 **	0.014
Ever had inpatient mental health treatment	8.7	6.7	0.7	0.777
Sample size	208	208		
Two-year outcomes				
Ever had inpatient or outpatient mental health treatment	42.5	39.4	4.9	0.414
Ever had outpatient mental health treatment	42.5	39.4	4.9	0.414
Ever had inpatient mental health treatment	8.9	11.5	-2.0	0.607
Sample size	113	104		

SOURCE: Calculations based on data from InfoHub.

NOTES: “Jail enrollment” indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.10).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.7 One- and Two-Year Primary Care and Hospital Service Use Outcomes: Jail Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Ever had a primary care visit (%)	10.6	10.1	0.7	0.810
Number of primary care visits	0.4	0.2	0.2	0.192
Ever had an ER visit (%)	17.3	18.8	-2.1	0.576
Number of ER visits	0.4	0.3	0.1	0.602
Ever had an inpatient hospital admission (%)	4.3	5.3	-0.9	0.675
Number of inpatient hospital admissions	0.1	0.1	0.0	0.985
Sample size	208	208		
Two-year outcomes				
Ever had a primary care visit (%)	15.9	19.2	-1.5	0.773
Number of primary care visits	0.5	0.5	0.0	0.911
Ever had an ER visit (%)	19.5	29.8	-8.6	0.148
Number of ER visits	0.3	0.6	-0.3	0.100
Ever had an inpatient hospital admission (%)	6.2	6.7	0.2	0.962
Number of inpatient hospital admissions	0.1	0.1	0.0	0.856
Sample size	113	104		

SOURCE: Calculations based on data from InfoHub.

NOTES: “Jail enrollment” indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.11).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.8 One- and Two-Year Criminal Legal System Contact Outcomes: Jail Enrollment

Outcome	Participant Group	Comparison Group	Estimated Difference	P-Value
One-year outcomes				
Average number of days incarcerated in jail	22.3	32.1	-9.2 *	0.096
No jail incarceration (%)	55.3	42.3	14.4 ***	0.003
No arrests (%)	54.8	41.8	14.5 ***	0.003
Convictions (%)				
No felony convictions	89.9	85.1	4.7	0.150
No misdemeanor convictions	91.8	80.8	11.0 ***	<0.001
No felony or misdemeanor convictions	81.7	72.1	9.8 **	0.018
On probation (%)	28.4	26.4	2.5	0.496
Among those on probation supervision: (%)				
Probation revoked	19.2	25.5	-6.5 *	0.083
Probation terminated	1.4	1.9	-1.1	0.355
Probation extended	1.4	0.0	1.6 *	0.071
Sample size	208	208		
Two-year outcomes				
Average number of days incarcerated in jail	36.0	68.3	-31.6 **	0.028
No jail incarceration (%)	47.8	29.8	17.4 ***	0.009
No arrests (%)	46.9	29.8	16.4 **	0.014
Convictions (%)				
No felony convictions	84.1	80.8	5.0	0.355
No misdemeanor convictions	91.2	67.3	20.2 ***	<0.001
No felony or misdemeanor convictions	76.1	58.7	15.8 **	0.012
On probation (%)	20.4	23.1	2.9	0.566
Among those on probation supervision: (%)				
Probation revoked	16.8	32.7	-11.3 **	0.034
Probation terminated	3.5	0.0	1.9	0.246
Probation extended	2.7	1.0	2.2	0.271
Sample size	113	104		

SOURCE: Calculations based on data from InfoHub.

NOTES: “Jail enrollment” indicates people whose RICMS enrollment date falls between their booking date and their release date (including enrolling on their date of release), as recorded in CHAMP.

Means are unadjusted so they can be easily compared with outcomes for the full unrestricted sample (see Table C.12).

Estimated differences in outcomes are regression adjusted, controlling for characteristics at time of program enrollment. The difference in the unadjusted means displayed in the table may not equal the adjusted estimated difference for that outcome.

Statistical significance levels are indicated as: *** = 1 percent; ** = 5 percent; * = 10 percent.

The p-value indicates the likelihood that the estimated difference (or larger) would have been generated by a program with no true difference.

APPENDIX TABLE C.9 One- and Two-Year Substance Use Disorder Treatment Service Use Outcomes: All Enrollment

	Participants		Nonparticipants	
Outcome	**One Year**	**Two Years**	**One Year**	**Two Years**
At least one outpatient service or inpatient admission (%)	13.7	16.5	15.2	19.3
Outpatient service use				
At least one outpatient service (%)	9.4	11.6	9.6	12.4
Average number of outpatient services	0.1	0.2	0.1	0.2
Inpatient service use				
At least one inpatient admission (%)	6.9	9.0	8.7	11.7
Average number of inpatient admissions	0.1	0.2	0.1	0.2
Among those admitted, more than one admission (%)	34.2	43.8	27.1	35.6
Among first admissions, discharges (%)	87.6	92.5	89.8	94.4
Sample size	4,300	2,675	10,748	6,461

SOURCE: Calculations based on data from the CHAMP management information system.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

APPENDIX TABLE C.10 One- and Two-Year Mental Healthcare Service Use Outcomes: All Enrollment

	Participants		Nonparticipants	
Outcome (%)	**One Year**	**Two Years**	**One Year**	**Two Years**
Ever had inpatient or outpatient mental health treatment	31.9	36.6	31.3	38.6
Ever had outpatient mental health treatment	31.8	36.3	30.9	38.3
Ever had inpatient mental health treatment	4.0	5.8	7.0	10.3
Sample size	4,300	2,675	10,748	6,461

SOURCES: Calculations based on data from the CHAMP management information system and InfoHub.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

APPENDIX TABLE C.11 One- and Two-Year County Primary Care and Hospital Service Use Outcomes: All Enrollment

	Participants		Nonparticipants	
Outcome	One Year	Two Years	One Year	Two Years
Ever attended primary care visit (%)	12.7	17.0	11.3	15.9
Mean number of primary care visits	0.5	1.0	0.4	0.7
Ever admitted to ER (%)	11.7	18.1	17.7	26.0
Mean number of ER visits	0.3	0.5	0.4	0.8
Ever admitted to inpatient hospital (%)	2.5	4.7	4.5	8.2
Mean number of inpatient hospital admittances	0.0	0.1	0.1	0.1
Sample size	4,300	2,675	10,748	6,461

SOURCES: Calculations based on data from the CHAMP management information system and InfoHub.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

APPENDIX TABLE C.12 One- and Two-Year Criminal Legal System Contact Outcomes: All Enrollment

	Participants		Nonparticipants	
Outcome (%)	One Year	Two Years	One Year	Two Years
Convictions				
No felony convictions	93.7	90.7	87.5	81.9
No misdemeanor convictions	94.5	91.4	87.3	80.5
No felony or misdemeanor convitctions	89.0	84.1	78.1	69.3
No arrests	73.3	64.7	51.3	40.4
Among those on probation supervision:				
Probation revoked	8.1	10.1	21.9	25.5
Probation terminated	1.1	1.4	2.1	3.3
Probation extended	0.5	0.8	0.6	1.3
Sample size	4,300	2,675	10,748	6,461

SOURCE: Calculations based on data from the CHAMP management information system.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

APPENDIX

D

Grantee Highlight

THE VALUE OF A PEER-DELIVERED SERVICES MODEL

The RICMS program aims to remove barriers to successful reentry from jail, prison, or probation by connecting clients to a variety of services. Community health workers (CHWs), who conduct outreach to engage clients, identify their needs, and help them navigate services, are an important part of the RICMS model. The use of peer-delivered services in reentry programs has been shown to increase program engagement and retention rates and can improve the health and lives of individuals involved with the criminal legal system.[1] MDRC's qualitative research on the implementation of the RICMS program has shown that the positive and supportive nature of the relationships between CHWs and their clients was a primary driver of participant engagement with, and enthusiasm toward, the program. These relationships played a major role in facilitating participants' success in achieving their goals.

A key component of the relationships that the RICMS program fostered was that CHWs had lived experience with many of the challenges and trajectories that clients navigated. Many CHWs were personally impacted by the legal system (and had been arrested or incarcerated) or were impacted by others close to them (for example, by having family members or close friends who had been arrested or incarcerated). Many CHWs also had histories with substance use disorders and addiction, among other experiences.

CHWs recognized that as clients reintegrated into society after incarceration, their mental and physical capacity to cope with stressors varied, which was why, in interviews with the research team, they all mentioned a similar motto: "Meet clients where they are at." CHWs accommodated clients by meeting them in locations where clients may have been more comfortable, or that were an easier commute for the client. CHWs focused on attending to clients' immediate needs and did not push goals that the client was not interested in or ready to pursue.

One participant described her CHW:

> [The CHW] listens to you and doesn't judge where you're coming from either, because it's really hard to feel like you're valid in a state of being displaced or whatever.

She then described her relationship with her CHW, and, without hesitation, said her CHW made her feel validated. Other social service support agencies, in her experience, made her feel inadequate or "dumb", but her experience with her CHW was the complete opposite. This was a common theme heard from participants.

While participants had unique needs and challenges—as well as diverse resources they brought with them as they navigated difficult reentry contexts—a consistent theme from all the interviews was how the bond between participants and their CHWs helped them deal with, and meet, the myriad demands required of them by various institutions. CHWs also helped connect partici-

1. Umez, De la Cruz, Richey, and Albis (2017).

pants to a wide range of resources in the community, from health to employment services. For participants, however, what set CHWs from the RICMS program apart from past case managers or criminal legal system staff was the depth and richness of their bonds with their CHWs. On top of being case managers, CHWs appeared to offer crucial social support and a sense of understanding and acceptance that, for participants, resulted in a genuine enthusiasm for participating in and adhering to the program.

This video (https://youtu.be/8c4_i6XXTeQ) highlights the perspectives of CHWs on the important work they did in their communities and demonstrates some of the strategies they employed to identify, engage, and work with clients to meet their reentry goals.

APPENDIX

E

The Interim Housing Program

The Reentry Division identified housing as a priority, given the strong intersection of homelessness and legal system involvement in LA County.[1] Therefore, the Reentry Division developed the Interim Housing program for individuals who are in early recovery from substance use disorders, with the goal of providing a safe housing environment that equips clients with the support they need to stay sober. The Reentry Division used Proposition 47 funds to provide short-term housing to individuals with immediate housing needs. The first location—a house for male clients with the capacity to hold 20 beds—is operated by the community-based nonprofit organization Christ-Centered Ministries.[2] The Reentry Division made interim housing slots available to its other reentry programs, but the Reentry Intensive Case Management Services (RICMS) program accounts for almost all referrals.[3] This appendix describes Interim Housing program implementation and the one- and two-year outcomes of RICMS participants who enrolled in the Interim Housing program between April 1, 2019, and December 31, 2021. The study team interviewed two Christ-Centered Ministries staff members and analyzed interviews with RICMS staff members for additional information about RICMS participants' housing needs and the challenges they faced.

ABOUT THE INTERIM HOUSING PROGRAM

Among RICMS staff members who were interviewed between July 2019 and August 2022, finding affordable and accessible housing was noted as the biggest challenge they faced when supporting clients on their caseloads. Christ-Centered Ministries, based in southwestern LA County, targets people who are experiencing homelessness and have mental health or substance use disorders. The house designated for the Interim Housing program contained shared bedrooms for up to 20 clients, shared living space, and office space for staff members to meet with clients. A case manager worked in the house and coordinated with RICMS community health workers to provide comprehensive support, with a focus on substance use disorder treatment and recovery. This support included behavioral health services and connections to off-site inpatient and outpatient treatment. Clients could also attend support groups that were focused on recovery and maintaining sobriety. Clients were eligible to stay in interim housing for up to 12 months. They were expected to coordinate with RICMS community health workers to secure longer-term housing options and access employment support, expungement assistance, and family reunification services.

1. Shadravan, Stephens, Appel, and Ochoa (2020).
2. Two additional interim housing sites have opened since the program was implemented, using other funding sources, but this document focuses primarily on the Christ-Centered Ministries housing experience.
3. The RICMS program is described in more detail in the main report. Staff members (known as community health workers) provide care coordination to their assigned clients and help them to navigate a wide array of services and supports. All clients were adults who were charged with or convicted of a crime, and who were identified as having mild to moderate mental health or substance use disorders. The RICMS program goal is to improve its participants' health and well-being outcomes and reduce future criminal legal system contact.

The Christ-Centered Ministries staff members who were interviewed reported that the Interim Housing program was a valuable supplement to help them meet clients' urgent housing needs, especially given the high rates of homelessness and housing insecurity in LA County.[4] However, the program had some limitations when examined as a complement to the RICMS program. First, while the RICMS program serves the entire county, the housing was concentrated in one geographic region of the county, which limited client access to the program. Additionally, the interim housing option may not be suitable for all clients who need housing. Staff interviewees said that many clients preferred not to be in shared housing, whether due to safety issues, a desire for privacy, or a wish to maintain independence from the policies and programs attached to shared housing.

CLIENT CHARACTERISTICS, PROGRAM PARTICIPATION, AND OUTCOMES

The analysis of Interim Housing program participation and outcomes included individuals who enrolled in both the RICMS program and the Interim Housing program.

Appendix Table E.1 shows the characteristics of the 56 RICMS clients who enrolled in the Interim Housing program between April 1, 2019, and December 31, 2021. Almost 50 percent of the participants identified as Black and almost 40 percent identified as Hispanic. Most participants were between the ages of 25 and 44 years. The average length of time between when participants checked in to the program and when they checked out was 145 days—or just under 5 months—and 93 percent of Interim Housing

4. Los Angeles Homeless Services Authority (2022).

APPENDIX TABLE E.1
Characteristics of RICMS Participants Who Enrolled in the Interim Housing Program

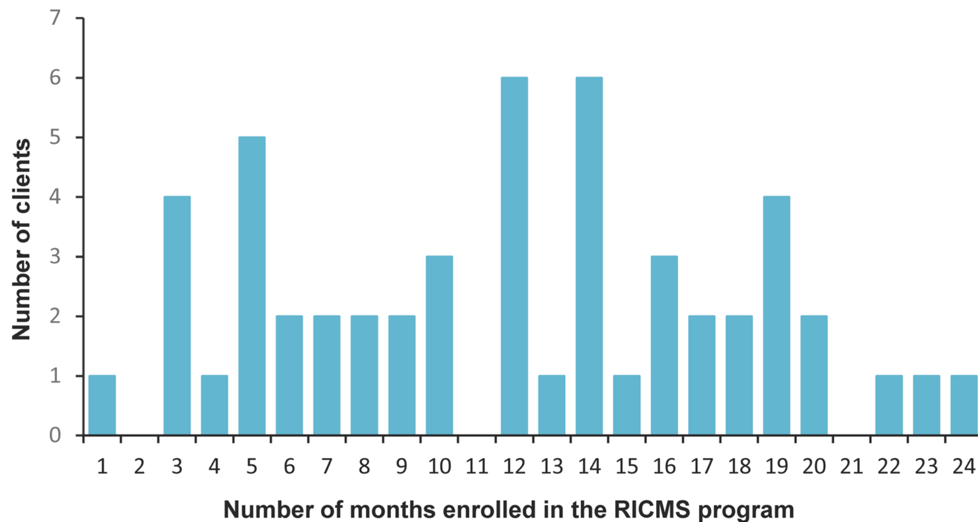
Outcome	N	Percentage
Gender		
Male	56	100
Race		
Black	27	48.2
Multiracial	4	7.1
White	9	16.1
Hispanic/Latinx[a]	22	39.3
Asian	1	1.8
Native American	1	1.8
Pacific Islander	0	0.0
Age		
18-24 years	5	8.9
25-34 years	21	37.5
35-44 years	12	21.4
45 or more years	18	32.1
Service planning area		
1. Antelope Valley	0	0.0
2. San Fernando Valley	1	1.8
3. San Gabriel Valley	2	3.6
4. Metro	8	14.3
5. West	2	3.6
6. South	30	53.6
7. East	3	5.4
8. South Bay	8	14.3
Sample size	56	

SOURCES: Calculations based on data from the CHAMP management information system and InfoHub.

NOTE: [a]Racial demographic percentages represent a combination of race and ethnicity data from the CHAMP management information system. Self-reported Hispanic ethnicity and Latinx race were combined into the "Hispanic/Latinx" variable shown in the table. As such, percentages in this section will not add up to 100.

participants exited within one year (not shown). Appendix Figure E.1 shows the variation in length of RICMS program participation among interim housing participants.

APPENDIX FIGURE E.1 Participant Enrollment in the RICMS Program Among Participants Who Also Enrolled in the Interim Housing Program



SOURCE: Calculations based on data from the CHAMP management information system.

NOTE: Participants are RICMS clients who were enrolled in the program for at least 30 days and had a care plan recorded in CHAMP.

Appendix Table E.2 shows the criminal legal system outcomes for interim housing participants one year and two years after the date they enrolled into the RICMS program. The percentage of participants who did not have new felony convictions was consistently high in Year 1 and Year 2. In Year 1, 71 percent of participants did not have a new felony arrest and 73 percent did not have a new misdemeanor arrest. By the end of Year 2, 61 percent of interim housing participants had not experienced a new felony arrest and 58 percent had not had a misdemeanor arrest.

APPENDIX TABLE E.2 One- and Two-Year Criminal Legal System Contact Outcomes for RICMS Participants Who Enrolled in the Interim Housing Program

Outcome (%)	One Year	Two Years
Convictions		
No new felony convictions	98.2	93.9
No new misdemeanor convictions	89.3	84.8
No new felony or misdemeanor convictions	87.5	78.8
Arrests		
No new felony arrests	71.4	60.6
No new misdemeanor arrests	73.2	57.6
No new felony or misdemeanor arrests	58.9	45.4
Among those on probation supervision:		
Probation revoked	5.4	6.1
Probation terminated	0.0	0.0
Probation extended	0.0	0.0
Sample size	56	33

SOURCE: Calculations based on data from the CHAMP management information system.

NOTE: One-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2021. Two-year outcomes measures include RICMS clients who enrolled between April 2018 and March 2020.

CONCLUSION

This descriptive analysis of a small number of Interim Housing participants limits the conclusions that can be drawn about the program. Namely, it is not possible to know whether a causal relationship exists between the Interim Housing program and the observed criminal legal system outcomes. This analysis is a good first look at how supplementing programs like RICMS with housing programs can reduce participants' future criminal legal system contact. Additional research, including a more rigorous quantitative analysis with a bigger pool of participants, would help to better understand the effects of such programming on participants.

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