San Mateo County
Collaborative Reentry Plan

Proposed Unified Reentry Plan

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Introduction and Overview

The San Mateo County Probation Department engaged Resource Development Associates (RDA) to assist the Department and other County stakeholders in developing a plan for a unified system of reentry services for the class of individuals that would have been eligible for service from Achieve 180, as well as those individuals currently served by Service Connect. If funding permits, these County agencies also seek to provide reentry assistance to other inmates leaving adult county jail custody. A collaborative, consisting of the Probation Department (SMCPD), the Sheriff's Office (SMSO), Correctional Health Services (CHS), Behavioral Health and Recovery Services (BHRS), Human Service Agency (HSA), and other community partners seek approval of this expansion of reentry services. The following approach includes establishing a unified case management protocol with clear lines of leadership and strong, formalized collaborative communication among all participating stakeholders.

The proposed plan is guided by an overall vision, as articulated by the Probation Department, to meet the strategic goals set forth in the 2012 San Mateo County Public Safety Realignment Local Implementation Plan (LIP), as well as best practices in reentry case management and services. The proposed plan addresses existing gaps in the County's reentry programs and services and new gaps that have arisen upon the sunset of the Achieve 180 program.

Background

Achieve 180

San Mateo County's Achieve 180 program has provided collaborative reentry case management services designed to support adult county jail inmates during the last two months of their sentences through their transition back into the community and for one year from the date of release. The Achieve 180 program provided 200 high-risk county jail inmates with assessments, individualized case management plans, job readiness and development and referrals, substance abuse treatment referrals, and transitional housing. Funding for Achieve 180 came from a federal Department of Justice, Bureau of Justice Assistance (BJA) Second Chance Act Community Reentry Initiative grant, with matching funds from San Mateo County. Because the BJA grant funding ended in March 2014, Achieve 180 ceased operation at that time.

Service Connect

Funded by a state Community Corrections Partnership (CCP) grant and matching funds from the County, Service Connect is a partnership among HSA, the Health System (including CHS and BHRS), and the Probation Department. Service Connect has provided reentry assistance to individuals under Post-Release Community Supervision (PRCS) or sentenced to adult county jail pursuant to PC 1170(h) with Mandatory Supervision by Probation upon release. Individuals serving a straight sentence without a probation tail have not been eligible for Service Connect assistance. For eligible individuals, Service Connect provides emergency resources in the form of a "safety net bundle" (consisting of food,

clothing, temporary shelter, and transportation), assesses needs, refers to numerous services and programs (including medical and dental services, alcohol and drug treatment, and mental health counseling and treatment), assists with benefits eligibility determinations and applications, and links individuals to employment opportunities and services.

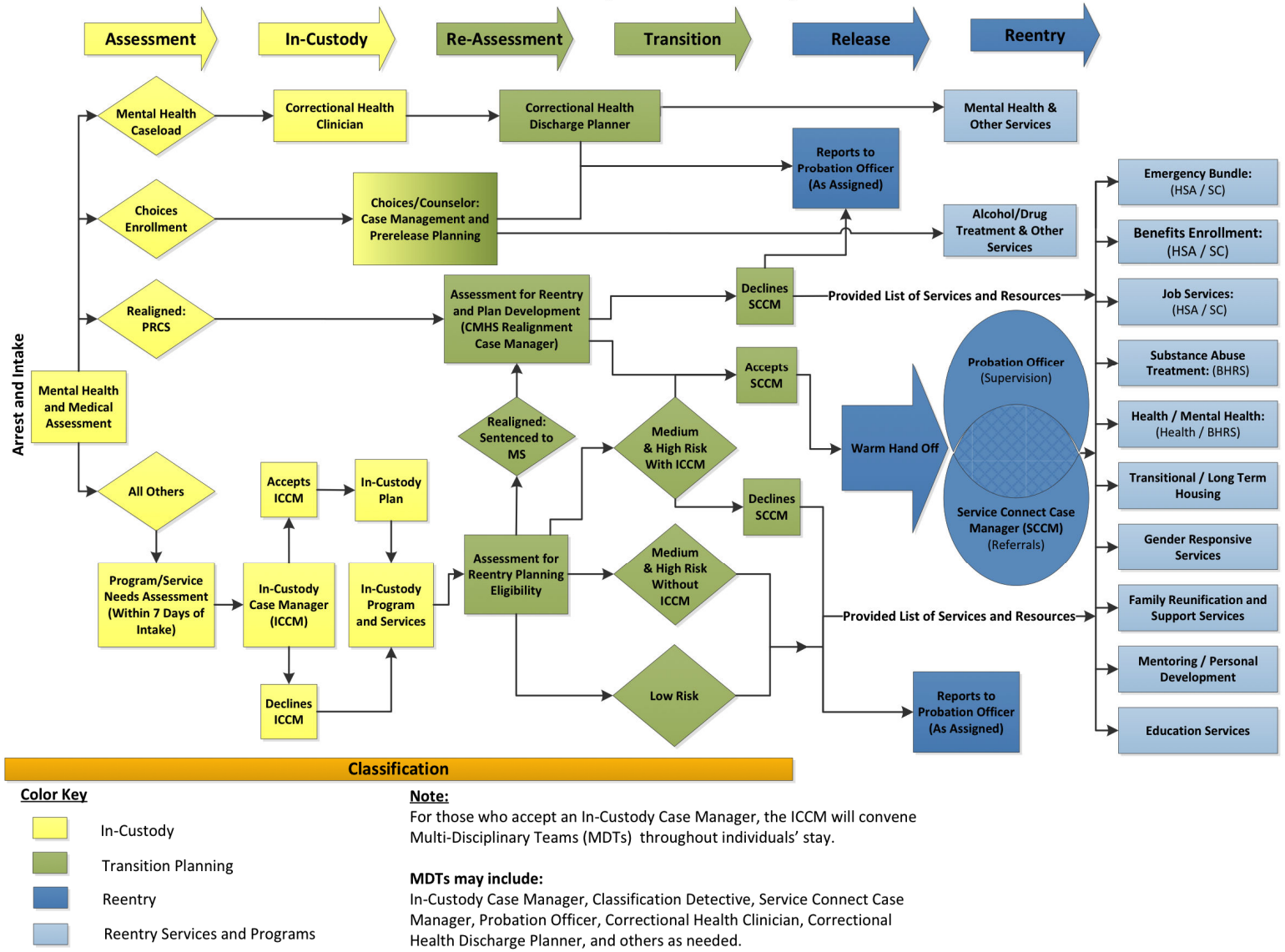
SMC Unified Reentry Plan: Continuum of Care Model

Successful transitions out of custody rely upon a continuum of care that spans the period from custody through release and transition back into the community. According to best practices in reentry case management, service plan development should begin while the inmate is still incarcerated and should address critical needs (food, shelter, clothing, etc.), necessary skill development, and engagement in treatment at the appropriate level of care for the individual.[1] San Mateo County stakeholders in SMSO, Probation, CHS, BHRS, and HSA will work together in an integrated fashion to provide necessary programs and supports, beginning in custody and continuing through discharge to the provision of post-release services. The post-release program services, supports, and resources are discussed in detail later in this document.

Below is a diagram of the proposed unified reentry plan that includes in-custody, transition and post release elements.

[1] Burke, Peggy B. 2008. *TPC Reentry Handbook: Implementing the NIC Transition from Prison to Community Model.* Washington, DC: U.S. Department of Justice, National Institute of Corrections.

San Mateo County Probation Reentry Plan



Classification

Color Key

- In-Custody
- Transition Planning
- Reentry
- Reentry Services and Programs

Note:
For those who accept an In-Custody Case Manager, the ICCM will convene Multi-Disciplinary Teams (MDTs) throughout individuals' stay.

MDTs may include:
In-Custody Case Manager, Classification Detective, Service Connect Case Manager, Probation Officer, Correctional Health Clinician, Correctional Health Discharge Planner, and others as needed.

In Custody - Reentry Needs Assessment and Service Provision

Program/Service Needs Assessment

In 2013, the Board of Supervisors approved the SMSO's Strategic Implementation Plan (SIP) for Jail Based Services and Reentry Programming. The SIP outlines strategies for a comprehensive system of programs and services to meet adult inmates' in-custody service and program needs and to prepare for inmates' release needs. The SIP calls for the creation of a continuum of care that begins with an in-custody program/service needs assessment and the offer to work with an individual case manager. The intention is to create an individualized case plan to provide relevant in-custody programming and services (activity/re-integrative, evidence-based/re-entry) as needed and desired throughout an individual's time in custody, including transition/reentry planning. The plan also includes system-wide program review and evaluation to enhance programming and include relevant evidence-based programs and coordination of re-entry planning. Throughout this process, an assigned case manager will communicate and work collaboratively with all relevant programs and agencies as needed at each juncture of an inmate's stay to determine their needs and recommend services and treatment.

Under the SIP, SMSO's Classification Officers will continue to conduct Classification's security/risk assessment to inform appropriate housing placement and other security considerations in custody. Reassessment will occur as needed throughout custody. Classification will coordinate with a Sheriff's Office In-Custody Case Manager (ICCM) supervised by the SMSO Program Services Manager.

Upon booking, and concurrent with the classification process, CHS will conduct a triage assessment to determine which inmates will move to a CHS caseload and which will proceed through standard program service needs assessment and case management with an ICCM. Following current practice, SMSO and CHS will continue to work together throughout an inmate's time in custody as the inmate's needs dictate. For example, the ICCM may refer an inmate for assessment or services by CHS. Similarly, inmates under a CHS Medical or Mental Health treatment plan may also receive supplemental services or access to other jail coordinated programs from the ICCM if those services are not available through CHS.

For each individual served by Correctional Mental Health (CMH), a CMH Clinician will determine a case treatment plan in custody (including participation in the broader array of programming offered in custody) and create and commence a discharge plan with the individual, engaging assistance from a Correctional Health Discharge Planner. For each participant in the Choices Program, a Choices Counselor facilitates a comprehensive treatment, program, and discharge plan, coordinating directly with residential substance treatment and other providers who will serve the individual upon release. For inmates subject to Public Safety Realignment, CMH staffs a Reentry Case Manager who assesses global needs and crafts an extensive reentry plan, including close coordination with Service Connect and other providers. Members of these treatment populations will receive case management from

their respective CHS professionals. In each case, the CHS professional will communicate treatment plans and coordinate with SMSO ICCMs as needed.

For those inmates not already assigned a CHS treatment and service plan under CHS case management, an ICCM will conduct an evidence-based risk/need assessment as part of the inmate intake process (within the first 7 days) unless contraindicated by classification or CHS treatment concerns. Inmates opting to work further with an ICCM will develop an Individual Case Plan (ICP) and receive ongoing support to complete it. The ICCM will defer program planning for inmates under consideration for the CHS Choices Program pending a Choices enrollment and/or Classification Officer decision.

The ICCM will coordinate and collaborate with an in-custody multidisciplinary team (MDT) that may include participation from the Sheriff's Classification Unit, CHS, and others as needed for reentry planning. MDTs are groups in which individuals from diverse disciplines with specialized knowledge and/or expertise come together to review a case, make recommendations, and assist in development of an individualized case plan. MDTs promote coordination between agencies and identify service gaps or breakdowns in coordination or communication between agencies or individuals. The in-custody MDT will consist of those individuals whose role is relevant to case planning considerations at any given time, including a Classification Officer and other reentry partners as deemed appropriate.[2] Details regarding composition of the in-custody MDTs and how they operate will be developed by the Sheriff's Office in consultation with other stakeholders.

Case Management

Case management is a collaborative process of assessment, planning, facilitation, coordination, evaluation, and advocacy for resources and services to meet an individual's comprehensive needs. It refers to the use of a professional, typically with a social work, human services, or health care background, to secure and coordinate services to support an individual's identified needs and goals. Case managers use a variety of techniques to engage clients to participate in services and programs, and motivate inmates to actively use needed services and programs rather than relying on his or her own internal motivation and will alone.[3] The case management relationship and follow-up meetings provide a consistent relationship for the inmate and enable the case manager to monitor an inmate's progress toward goals.

For the purpose of this collaborative reentry plan, the term ***case manager*** will only apply to the person whose role it is to work with an inmate or client to develop an overarching individual case plan based upon needs identified through the program/service needs assessment and/or other factors. There will

[2] MDTs led by ICCMs can include the Correctional Health Clinician or Correctional Health Discharge Planner for those individuals with physical health, mental health, or substance abuse issues.

[3] Kerry Murphy Healy, "Case Management in the Criminal Justice System," National Institute of Justice: Research in Action, February 1999, https://www.ncjrs.gov/pdffiles1/173409.pdf.

be one case manager for the inmate while s/he is in custody (a CHS Clinician, Choices Counselor, or ICCM, however coordination will need to occur for overlap and MDT/release planning) and one case manager after the inmate has been released, the Service Connect Case Manager (SCCM). Case managers will consult as needed with each other and with other key stakeholders to ensure that reentry planning for an individual is meaningful, effective, and not duplicative. After the individual has been released from custody, the SCCM will work closely with Probation in determining the case plan; Probation will have the ultimate authority to approve program and service referrals for individuals under its jurisdiction.

In-Custody Case Management

All inmates that receive the program/service needs assessment (i.e., not on the mental health caseload or enrolled/pending enrollment in Choices) will be eligible to opt in to case management with an ICCM to develop an Individual Case Plan (ICP) and facilitate placement and participation in programs, services, and reentry planning in custody. Inmates who do not choose to participate in case management will not be assigned an ICCM but will be informed of available programs and services and can re-engage the ICCM during their custody time. Those eligible for, but not opting into, case management by an ICCM will still have the ability to seek programs and services while in custody. However, housing location or other risk-based issues may limit in-custody program accessibility. In addition, those who are in the Realignment population (initially, those determined to be PRCS or, after sentencing, those who have been sentenced to Mandatory Supervision) may receive in-custody programs and services prior to release. However, for these individuals, the CMHS Realignment Case Manager will coordinate with the ICCM to ensure access to programming and will also assist individuals with reentry assessment and reentry plan development prior to release.

In preparing a case plan, the ICCM will invite input and collaboration from qualified staff at appropriate county agencies, community programs, and service providers to inform decisions about in-custody program and service participation. The ICCM and collaborative partners will secure appropriate authorization to exchange information about the inmate and limit information exchange within each partner's need and right to know the inmate's information. For those opting into case management in custody, SMSO's ICCM will lead initial development of a case plan, with relevant MDT input.

ICP development will generally occur after the program/service needs assessment and is based on identified needs and realistic access to appropriate programs. Needs that cannot be addressed from available programming will be documented and alternative strategies and timelines to meet those needs can be developed. Communication within the MDT is intended to diminish any risk of service duplication and ensure that the services provided to an inmate do not conflict with each other.[4] The MDT will meet periodically throughout the inmate's time in custody to advise any adjustments needed to the inmate's case plan. The ICCM will meet with the inmate at regular intervals to track program progress, reassess service needs, plan for transition and reentry, and revise the ICP as needed.

[4] Any privacy issues implicated will be addressed by written agreement/waiver from the inmate allowing for information to be shared in the context of case planning.

Planning for Post-Release Case Management

At 60 or fewer days before release, the ICCM will consult with a reentry-focused MDT to further develop the inmate's reentry plan with key stakeholders, including CHS personnel, the Service Connect Case Manager (SCCM), and a Probation representative. For individuals who opt in to post-release case management, the SCCM will assume responsibility for coordinating treatment and services. For those individuals who are in the Realignment population, at 60 days or fewer before release, the Correctional Mental Health Realignment Case Manager will assess and coordinate reentry-planning efforts. After release, Probation will supervise those individuals under its jurisdiction. Strong communication will be essential among all parties involved in providing case management and referrals to ensure a unified continuum of care for the individual.

In the context of post-release case management, the term ***case manager***, will refer to the SCCM. In addition to the SCCM, a Probation Officer (PO) supervises an individual under Probation supervision and is the ultimate authority on any program and service placements or referrals. All others working to serve the needs of the individual may coordinate programs and services and/or participate in MDTs created by the SCCM once the individual is released. Participants in the MDTs may include community-based service providers of employment or job readiness/job training, housing, or other services upon release from custody. Complete and timely communication from MDT participants will be critical to the success of this model and will require development and fidelity to specific protocols detailing the communication processes and expectations.

For continuity of service, the PO and SCCM who are responsible for supervising and assisting the inmate after release attend the MDT relating to an individual's reentry and release planning. Ideally, while the inmate is still in custody, the PO and/or SCCM will meet with the inmate to begin developing a relationship prior to release. Also, the SCCM, a Service Connect Peer Support Worker, and/or PO will participate in a "warm-handoff" from the SMSO's ICCM or CHS professional at release. From this point, the SCCM will provide case management to assist the ex-inmate in obtaining needed services, resources, and skills. The individual's service and treatment needs will determine the duration of case management services in the community.

Reentry and Transition Planning

Reentry and transition planning will begin while an inmate is still in custody[5]. As stated earlier, the ICCM or CHS professional will lead in planning for individuals participating in this unified reentry structure, including coordinating with Service Connect staff (both HSA and BHRS) to continue or line up services for an inmate who will be released soon. Identified needs may include obtaining housing, identification, medical and behavioral health treatment, educational or vocational training, and coordinating family pick-up or reunification upon release.

If the inmate nears release presenting significant mental health, substance recovery, or medical needs, then the SCCM role will be filled by BHRS staff with specialized knowledge and training in mental health

[5] As outlined in the SIP currently being implemented by the Sheriff's Office

services and/or substance abuse treatment. BHRS will refer to Public Health as needed to address medical needs and will coordinate with the CHS Discharge Planner. If the inmate's needs largely exclude mental health, medical, or substance recovery concerns and fall more squarely in the human services needs category, then an HSA worker will serve as the SCCM for that individual. HSA's capacity to provide housing, employment, and benefits services fulfill the primary needs of the individual.

Once identified, the SCCM and PO will consult whenever appropriate on any ICCM or CHS decisions in release planning. Ideally, before an individual is released, the SCCM will meet with the inmate to begin establishing a relationship with the client and to discuss implementation of the post-release reentry case plan. RDA recommends that, when possible, a PO join the SCCM and the client; ideally, the SCCM and the assigned PO will meet with the inmate together at least once prior to the release date. Starting the post-release case management relationship while an individual is in custody is a best practice and promotes a robust continuum of care.

Assessing Eligibility

The sunset of Achieve 180 in spring 2014 marks a loss of federal funding for reentry case management of the population that would have been served by the program: those individuals with a classification of high or medium risk for recidivating who are not in the realignment population. These individuals may or may not be subject to Mandatory Supervision, may or may not be modifiable, and may or may not have a probation tail. Without additional funding, this group will not have access to post-release reentry case management services as they would have under Achieve 180.

In the past, in order to identify the population eligible for services under the Achieve 180 program, SMSO, in conjunction with a Service League case manager, administered a screening tool, post-sentencing, to determine an inmate's risk level. Individuals scoring 15 or higher on the Quick CAIS were deemed provisionally eligible for Achieve 180 case management and services pending further interview for needs assessment, legal status, county residence, and interest in program participation. The Strategic Implementation Plan Steering Committee recently approved the use of the National Council on Crime and Delinquency's validated Correctional Assessment and Intervention System (CAIS) risk assessment tool for the initial assessment of inmate in-custody program/service needs and to anticipate transition/reentry needs. The CAIS tool can also be used by the ICCM to determine program eligibility for post-release reentry services, and is already used by the Probation Department to assist in case planning. In addition to a number of factors, including that the tool is gender-responsive and validated, and that use of the tool leverages the substantial investment that San Mateo County has already made in CAIS, the CAIS tool can be amended to ensure pre-trial offenders may be assessed using the tool. The Intake and Assessment Committee also expressed support for a strengths-based approach to be incorporated into the program/needs assessment process in custody. Additional review of specific approaches will be conducted by the SMCSO and CHS while CAIS is finalized and rolled out.

It is the consensus of this collaborative that the population recently served by Achieve 180 (individuals at medium to high-risk for recidivating who may not be in the realignment population) continues to access the same level of reentry services, including post-release case management even if they are not in the realignment population. Funding will be needed for the provision of such services to all of this population.

Post-Release Reentry Services[6]

> *"I remember when I got my (Achieve 180 certificate). It was amazing; I was thinking I am actually in the Board Chambers getting a certificate. It was definitely a boost for my self-esteem."*
>
> *Achieve 180 Focus Group Participant*

As previously described, while the inmate is still in custody, unless s/he is participating in CHS treatment with a CHS professional leading the case management, the ICCM will lead reentry/transition planning, coordinating as needed with CHS, and will consult with the reentry MDT, ideally including a PO and SCCM, on the provision of the services outlined below. The division of tasks associated with the coordination and provision of services will be determined by the ICCM and the reentry MDT. It should be noted that CHS staff currently assists inmates on realignment access benefits by providing information and applications for benefits and services and referrals to employment, treatment, and other resources to the inmate while s/he is in custody. An ICCM may do this as well, and can coordinate with Service Connect to continue benefit eligibility screening and application after release. While the inmate is in custody, the ICCM will work with CHS staff, as well as Probation and the SCCM, to ensure a unified reentry plan is in place prior to release.

For inmates who opt in to case management, the ICCM, CHS, Probation, and Service Connect will work together on the reentry MDT to develop one ICP for an individual. After release, the SCCM and PO will assist the individual in accessing necessary services and updating and maintaining the ICP. This includes providing warm hand-offs to other service providers as they are engaged and assisting the individual with transportation or anything else necessary to get to the appointments.

In order to cover both the Achieve 180 population and the existing Service Connect population, post-release case management services should target individuals reentering the community at high and moderate risk of recidivating who may or may not be in the realignment population.

[6] The following descriptions of reentry services that could be utilized do not contain an exhaustive list of all San Mateo County programs that may be available in a particular category or all the details relating to any particular program highlighted. While some illustrative examples are provided, this Plan allows for flexibility in design for those stakeholders involved in planning reentry service provision. Unless specifically noted, the discussions do not address whether a program should be made available in custody; they refer only to post release program and services. In-custody programs and services are currently under review within the scope of the Sheriff's Implementation Plan.

"Emergency Bundle"

Individuals reentering the community should have access to critical life supports. Service Connect (via HSA) provides an "emergency bundle," consisting of assistance with food, clothing, temporary housing, transportation, and a phone card for those individuals with identified needs. Currently, only individuals on Mandatory Supervision or PRCS are eligible for Service Connect assistance. In order to make the "emergency bundle" available to an expanded population (all those that would have been eligible for Achieve 180), individuals who are determined to be high or medium risk reentering the community will be able to access an emergency bundle, if needed. Service Connect seeks additional funding in order to expand this service. (See funding request document for further details.)

Benefits Enrollment

> *"When my insurance stopped, so did my counseling; not only individual counseling, but family counseling. I wanted to go with my older son, but I couldn't. Where do you go when you don't have insurance or an income?"*
>
> *Achieve 180 Focus Group Participant*

The HSA staff at Service Connect currently assists individuals in the realignment population, on Mandatory Supervision or PRCS, in applying for benefits. HSA staff screen and process reentry individuals' applications for health insurance, General Assistance, CalFresh (formerly known as Food Stamps), and in some instances, CalWORKS. HSA staff at Service Connect also assists reentering individuals in obtaining identification cards or drivers' licenses. Under this Plan, availability of these post-release services will extend to the population that is not under Mandatory Supervision or PRCS (medium to high-risk offenders either with straight sentences pursuant to PC 1170(h) or who are not in the realignment population).

Job Services

> *"Everything has been a blessing and it's still coming. When I first got out I was in transition and I got work at Caltrans. Now, I can get a real job or get schooling."*
>
> *Achieve 180 Focus Group Participant*

Job services may be initiated by the ICCM with Job Train or other community-based organizations while inmates are in custody as part of programming and services and will coordinate continuation upon release with the SCCM. Job services will also be provided by a combination of community-based organizations and Vocational Rehabilitation Services (VRS), a department under SMC WORKS, which is a division of HSA. HSA will partner with community-based organizations such as JobTrain and/or InnVision Shelter Network to provide either a referral to vocational training and/or supported employment services offered together with the employment services provided by VRS.

One key component of the employment services offered by VRS is 550Jobs! 550Jobs! is a subsidized employment program, currently available only via a referral from Service Connect. The program provides temporary transitional employment to individuals upon release at $8/hour, 30 hours a week,

for up to 3 months. The program is structured so that the AB109 population can begin working the Monday following release. The job site is at the VRS location in San Carlos, which enables the Vocational Rehabilitation Counselor, the WorkCenter supervisors who work in the warehouse, and the Job Developer to easily meet to assess the client's job readiness, looking at the individual's employment history, education/certifications, attitude towards work, motivation, coping/resilience skills, soft and hard skills, and personal or family challenges such as housing or mental health diagnoses.

While clients are working at the VRS WorkCenter, these staff members determine whether further transitional employment may be needed. If so, an individual may be referred to several off-site opportunities for transitional employment at South Bay Recycling or Catering Connection. Funded by a CCP grant, the AB109 population can also find employment with the existing San Mateo County Parks program that will not be affected by the sunset of Achieve 180.

Although services have been limited to serving the realignment population in the past, under this Plan, these services will be made available to individuals at medium to high-risk for recidivating who are not in the realignment population, to ensure continuity of services to formerly incarcerated, at-risk individuals in need. As appropriate, the ICCM or CHS professional will share in-custody case plans, including inmate vocational and educational program progress to ensure that continued vocational/job placement is engaged upon release.

JobTrain has provided Achieve 180 clients a number of services, including work readiness assessment and training/workshops, as well as referrals to transitional employment. JobTrain has also provided Achieve 180 and realigned clients transitional work opportunities on highway work crews through a Caltrans program. After the funding for Achieve 180 ended this spring, JobTrain now serves reentry clients who are AB109 eligible by assisting with developing resumes, cover letters, interviewing skills, and providing education about professional behavior and practices in the workplace. These services are provided in partnership with VRS at their San Carlos location.

Substance Use Treatment

The ICCM, CHS professional, SCCM, and PO, in coordination with the other reentry MDT members, will work together to refer individuals to relevant substance abuse treatment programs for continued treatment. Residential and non-residential treatment programs are available in San Mateo County. Under this Plan, Probation and Service Connect will continue their partnership with Alcohol and Other Drug (AOD) Services and Mental Health Services (both part of the San Mateo Health System), which serve the reentry population (among others in the community of San Mateo County).

Programs available should include services for individuals not eligible for placement in a residential treatment program (e.g. sex offenders or individuals with a history of violence or arson). For these individuals, an outpatient treatment program linked to case management and services may be an alternative. The County is currently building its capacity of service providers to serve high needs individuals so that in the future there should be more placements available.

Health/Mental Health

> *"I think that everything about benefits, housing and jobs (is important). The thing that makes mental health and substance abuse so important is that if you're not stable in those two places, you can't keep any of that (jobs, housing)."*
>
> *Achieve 180 Focus Group Participant*

Before release, a case manager, in consultation with the reentry MDT will have determined the medical and mental health needs of the individual. Ideally, the warm hand-off will include the Probation Officer, ICCM, SCCM, CHS professional, and/or Service Connect Peer Support Worker, who would accompany the individual to Probation (as needed) and to the Service Connect office to initiate addressing his or her medical and mental health service needs, including assistance in making necessary appointments for medical, dental, and mental health services. If the PO, SCCM, and/or Service Connect Peer Support Worker are unable to participate in the warm hand-off, newly developed communication protocols will ensure that Probation and Service Connect are fully informed about the status of the individual re-entering the community.

Currently, the CHS professional ensures prescription and medication continuity for realigned inmates prior to release, links individuals to a mobile health clinic, and/or refers individuals to mental health or health clinics. Going forward, the CHS professional should continue to do this, in coordination with the ICCM, PO, and SCCM. The post-release case manager (the SCCM) should also assist, as needed, with handing the individual off to the medical provider. Services available through Health and BHRS include primary care, dental care, medication support, and the provision of counseling and other therapeutic services.

Housing

> *"(If I could), I'd house non-violent people to live in a safe environment. That would lessen the residual (recidivism) rate of people coming back to jail."*
>
> *Achieve 180 Focus Group Participant*

Housing is a critical need that, if not met, may impede the progress of an individual reentering the community after incarceration.[7] HSA provides emergency temporary housing vouchers to individuals reentering the community. Transitional housing should be provided, both in the form of facilities affiliated with treatment or sober living, and also for those individuals who do not have a substance abuse problem. More transitional housing placements need to be developed to serve the many individuals reentering the community in need of such assistance. Incentives or vouchers for families who provide housing for individuals can also be created as a way to increase housing options and support family stability.

[7] "Recent Findings from the Urban Institute on Housing and Reentry." The Urban Institute. The Urban Institute, n.d. Web. 13 Dec 2013. <http://www.urban.org/projects/reentry-portfolio/housing.cfm>.

San Mateo County's dearth of affordable, permanent, long-term housing has a deep impact on the well-being of its low-income population, especially those individuals with a criminal record or a history of drug or alcohol abuse. Efforts should be made to develop permanent housing.

Family Reunification and Support Services

Best practices[8] suggest that family reunification elements should be incorporated into programs assisting individuals reentering the community. Service Connect should provide therapy or group discussions for families and children of incarcerated parents, parenting classes, and resources, also ensuring that family involvement is built into other reentry programs, such as substance abuse treatment. The ICCM will share with Service Connect in-custody case plans that include parenting and family program progress of in-custody inmates to ensure continued support services are offered/connected upon re-entry.

Addressing Criminogenic Thoughts, Behaviors, Peer and Social Influences

Mentoring

> *"To talk to someone who doesn't know you and is willing to sit, listen and give you suggestions is very powerful."*
>
> *Achieve 180 Focus Group Participant*

Mentoring is defined as a relationship over a prolonged period of time between two or more people where caring volunteer mentors assist formerly incarcerated individuals in successfully and permanently reentering their communities.[9] The Achieve 180 program provided peer mentors to inmates who would meet with program participants while they were in custody (initially) and then after they were released into the community. Evidence shows that peer mentors reduce recidivism risk for the reentry population by providing consistent support, guidance, and encouragement to individuals, which helps them develop positive social relationships and achieve program outcomes.

With the sunset of Achieve 180, funding for the current formal mentoring program, run by Service League, has ceased. A formal mentoring program should be integrated into the unified reentry program for the 1170(h) realignment population and those individuals in the medium to high-risk level that may not be in the 1170(h) population. Ideally, the program would include peer mentors with lived experience in the criminal justice system. The program may also utilize mentors recruited from

[8] Joceyln Fontaine, Douglas Gilchrist-Scott and Megan Denver, "Impact of Family-Inclusive Case Management on Reentry Outcomes: Interim Report on the Safer Return Demonstration Evaluation," Urban Institute – Justice Policy Center (September 2011). See also Fontaine, Gilchrist-Scott and Denver, "Impact of Family-Inclusive Case Management on Reentry Outcomes: Interim Report on the Safer Return Demonstration Evaluation".

[9] "Reentry Matters", *supra.* See also Parker, *supra.* See also Wilkinson, *supra.*

community based organizations as well as other resources.[10] SMSO currently offers family reunification support in its transitional facilities, and through the SIP, SMSO also plans to enhance/add mentoring and family reunification and veteran services into its existing facilities and its new facility.

Service Connect has relied upon the peer-focused substance recovery organization Voices of Recovery to staff a Peer Support Worker. This individual has supported and guided clients from the perspective of having reentered to the same community from custody and gained enough stability to begin helping others. The Peer Support Worker has played a central role in receiving warm hand-offs from custody and engaging clients with Service Connect. Both BHRS and HSA are currently hiring peer support staff with lived criminal justice and substance recovery experience to increase these vital capacities. SMSO may add enhanced peer mentoring support in custody through the SIP.

Moral Reconation Therapy

Widely regarded as an evidence-based practice in reentry, moral reconation therapy (MRT) is a form of cognitive behavioral therapy. MRT takes the form of group and individual counseling and uses structured group exercises and prescribed homework assignments. MRT focuses on the confrontation of beliefs, attitudes, and behaviors, assessment of current relationships, reinforcement of positive behavior and habits, positive identity formation, enhancement of self-concept, decrease in hedonism and development of frustration tolerance, and development of higher stages of moral reasoning. Participants meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of 3 to 6 months. HSA and BHRS both offer MRT. MRT is currently available to the AB109 population and should be made available through Service Connect to all those formerly served by Achieve 180.

Educational Services

Reentry services should include educational opportunities, such as GED preparation, classes to develop literacy and computer skills, and linkages to community college and university programs. Achieve 180 case managers took an active role in linking clients to community college and training programs. Under this proposed plan, the SCCM should take a similarly active role in assessing the client's interest in educational advancement and actively helping him/her to pursue these goals. Education linkages should be made available to all medium to high risk individuals identified as medium to high risk for recidivating. Several educational programs are offered in-custody and are being evaluated as part of the Sheriff's SIP. The ICCM will share in-custody case plans that include educational programs and progress of inmates with the SCCM to ensure continued education is offered and engaged upon re-entry into the community.

[10] HSA has expressed interest in developing a formalized mentorship program (which would include recruitment, screening, training, and monitoring of mentors). A number of target resources exist for the recruitment of potential mentors, including the alumni of the Choices treatment program and individuals involved in faith-based communities.

Evaluation Measures[11]

Ongoing outcome measurement is a hallmark of evidence-based practice. Tracking and evaluating outcomes is necessary to understand whether or not a reentry plan produces the intended results and if not, what in the plan is working and what needs to change. Regular outcome reporting will keep all stakeholders aware of interim outcomes, while a comprehensive impact evaluation will provide a broad assessment of what is working and what is not, so that the County can make changes to the plan as necessary. Stakeholders have met to discuss, and are continuing to develop, specific performance/outcome measures as a method for monitoring progress. The Sheriff's Office SIP will also share in-custody programming and services evaluation results to ensure the continuum of care models are jointly informed in a system-wide approach.

Social Solutions is the new client data and referral tracking system, which will be used by numerous stakeholders (CHS, SMSO, Probation, HSA, and BHRS) and will enable the users to see real-time information concerning the individual. In its initial pilot phase, only individuals in the realignment population will be tracked in this system (pursuant to CCP funding limitations). The expectation is that Social Solutions may allow for more efficient tracking and reporting of performance/outcome measures as it coordinates with relevant data by participating agencies' case management systems.

[11] Wiebush, Richard G., et al. "Implementation and Outcome Evaluation of the Intensive Aftercare Program: Final Report ." National Council on Crime and Delinquency. N.p., n.d. Web. 10 Dec 2013.