Opening Avenues to Reentry Success (OARS) Annual Report

This is an excerpt of a larger report.

Fiscal Year 2015 (FY15)
July 1, 2014 – June 30, 2015

Wisconsin
Department of Health Services

Division of Mental Health and Substance Abuse Services
P-00572A (12/2015)

From the Director

The Office of Community Forensic Services publishes a report following each fiscal year as part of our commitment to accountability and quality improvement.

The Office of Community Forensic Services manages and supports programs for individuals with criminal justice histories and mental health concerns. The result of the work we perform in partnership with Wisconsin's court, correctional, and mental health systems is stronger and healthier individuals and communities.

This edition of the *Office of Community Forensic Services Annual Report* shows our commitment to the application of evidence-based, client-centered services in all of our programs. Our service-delivery model meets the unique needs of each individual. With the diverse and ever changing population we serve, it is more important than ever to have a trauma-informed approach that does no harm and encourages healing.

I thank all the dedicated individuals who contribute their expertise, hard work, and passion to make the important community programs we manage and support successful. We appreciate your support and hope this report increases your understanding of our programs, outcomes, and those we serve.

Glenn Larson
Behavioral Health Director
Office of Community Forensic Services

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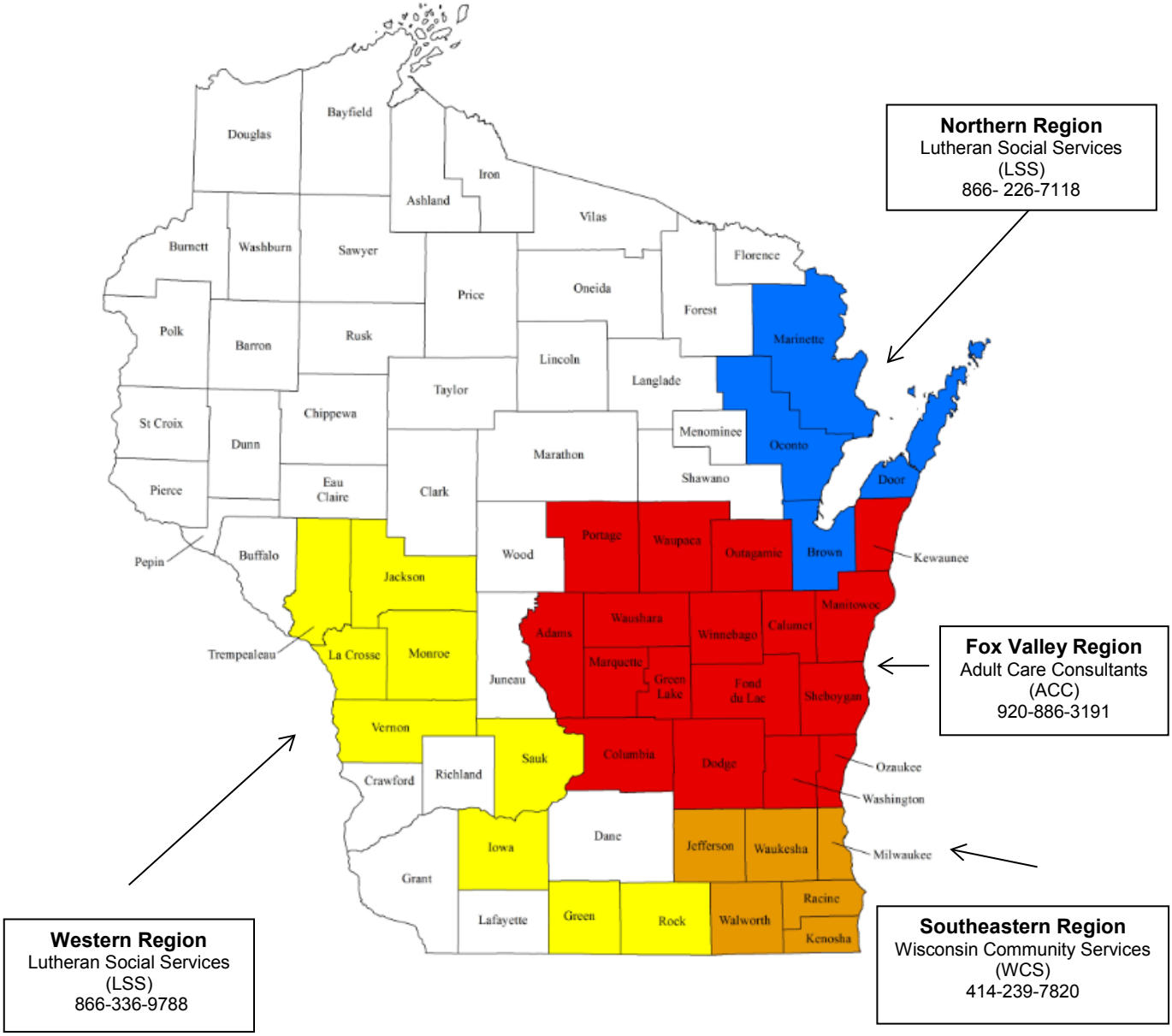
Opening Avenues to Reentry Success Program

The Opening Avenues to Reentry Success (OARS) is a voluntary program that enhances public safety by supporting the transition and self-sufficiency of individuals with mental health needs as they release from prison and reintegrate into the community. Participants include the most seriously and persistently mentally ill assessed at a moderate or high risk for reoffending. OARS uses a team approach and evidence-based practices to reduce recidivism and revocation rates for this population by providing specialized supervision built around the individual's unique recovery needs.

Regional Provider Map

DHS Forensic Services Specialists:

- **Boon Coleman** - Southeastern Region, 608-266-3878
- **Lila Schmidt** - Fox Valley, Northern, and Western Regions, 608-261-5314



Summary of FY15 Goals, Activities, and Outcomes

In FY15, OARS served 148 individuals.

2015 Goal	Performance Expectation	Performance Standard	Result
1	To the extent possible, OARS participants will be financially self-sustained.	At six months post release, 75 percent of OARS participants will have a reduction in the cost of their care, which may assist in clients becoming more financially self-sustained.	This goal was not met. Sixty-five percent of OARS participants (on average) had a reduction in their cost of care.
2	OARS participants engage in meaningful daily activities.	Ninety percent of OARS participants will be involved in meaningful daily activities. Meaningful activities will be discussed and implemented as a goal on client individual case plans.	This goal was met. All OARS participants engaged in meaningful activities.
3	Justifications for all OARS participants placed in CBRFs are completed at three months, and every month thereafter, unless otherwise exempt, until a lesser restrictive environment is appropriate for the participant and community.	Prior to discharge from OARS, 90 percent of participants who were residing in a CBRF or adult family home when they were placed in the community are moved to a less structured living situation.	This goal was not met. Approximately 77 percent of OARS participants (on average) are moved to a less structured living situation.
4	Case managers will use motivational interviewing with participants to address their treatment and behavioral issues.	Measures include: • Staff attendance • Staff presentation of recorded audio • Peer review results • Individual learning plan on file • Staff participation in learning activity • Staff submit one consumer evaluation monthly	This goal was met. All case managers used MI with OARS participants.

Program Expansion

In FY15, modifications to Wisconsin's BadgerCare Plus program allowed more OARS participants to become eligible for Medicaid. This resulted in cost savings, allowing the program to add 11 counties (Green, Iowa, Jackson, La Crosse, Marinette, Monroe, Rock, Oconto, Trempealeau, Sauk, and Vernon) and accept more participants.

Trauma-Informed Care

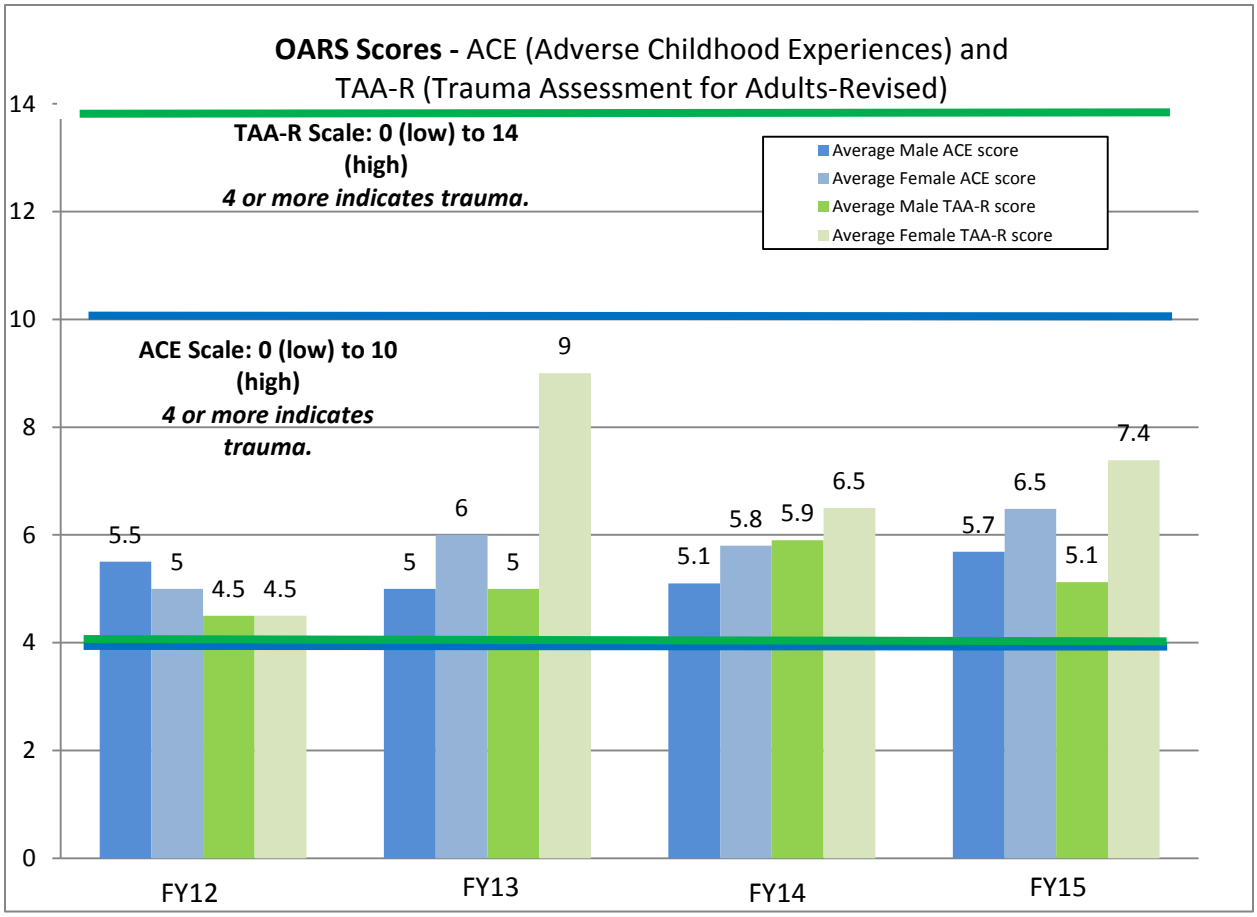
OARS utilizes two trauma screening tools: the Adverse Childhood Experiences (ACE) and Trauma Assessment for Adults-Revised (TAA-R). These screening tools are administered by the OARS case manager in the pre-release and post-release phases. Screening provides an opportunity to:

- Enhance the professional working relationship with the participant
- Reduce the stigma

- Silence surrounding traumatic experiences
- Recognize many problem behaviors as coping strategies

Results from these tools indicate a significant degree of trauma history in both the male and female populations served. All participants were offered these screens.

A 2013 study by the Centers for Disease Control and Prevention found there is a strong relationship between the breadth of exposure to abuse or household dysfunction during childhood and risk factors for several of the leading causes of death in adults.



Recidivism Review

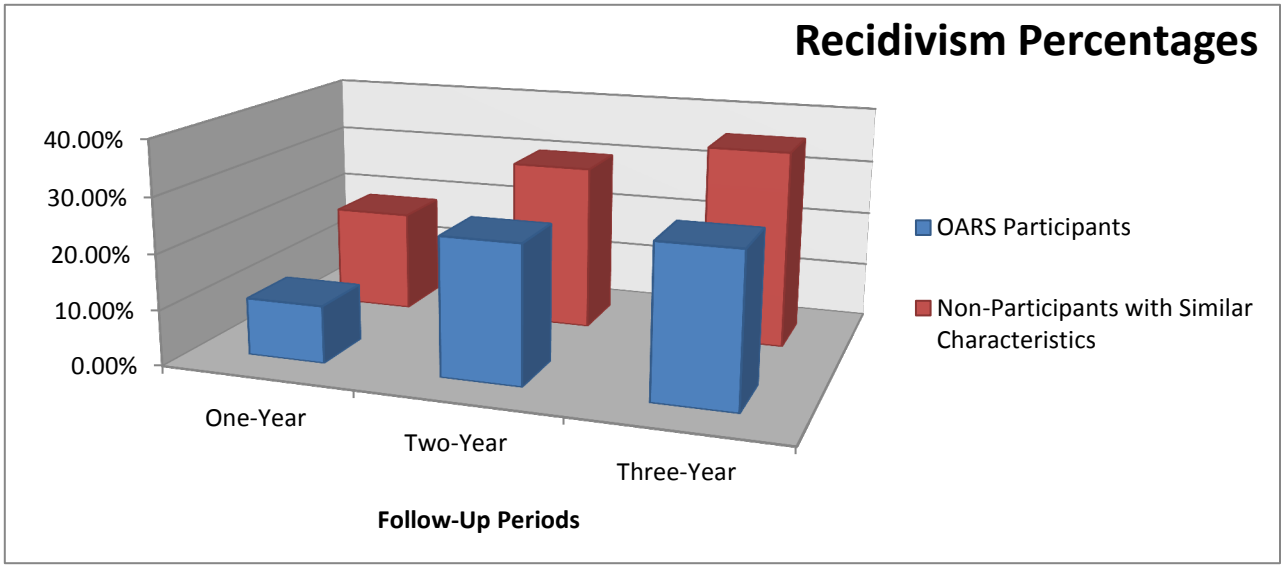
The following information is from the Wisconsin Department of Corrections Becky Young Community Corrections Recidivism Reduction Fiscal Year 2015 Report.

OARS PARTICIPANT RECIDIVISM FY2011-2013								
Sample Size	Recidivists	One-Year	Sample Size	Recidivists	Two-Year	Sample Size	Recidivists	Three-Year
54	7	12.96%	50	10	20.00%	48	13	27.08%
60	6	10.00%	59	17	28.81%	…	…	…
60	5	8.33%	…	…	…	…	…	…
174	18	10.34%	109	27	24.77%	48	13	27.08%

MENTALLY ILL, MEDIUM AND HIGH RISK OFFENDER RECIDIVISM FY2011-2013								
Sample Size	Recidivists	One-Year	Sample Size	Recidivists	Two-Year	Sample Size	Recidivists	Three-Year
257	43	16.73%	265	79	29.81%	242	86	35.54%
386	84	21.76%	367	111	30.25%	…	…	…
304	48	15.79%	…	…	…	…	…	…
947	175	18.48%	632	190	30.06%	242	86	35.54%

Recidivism measures for participants in the first three fiscal years of the program indicate 44 percent lower rates when compared to non-participants with similar characteristics. The two-year follow-up rate for OARS participants shows a 17.61 percent lower rate than the group with similar characteristics.

This fiscal year is the first in which program staff have been able to evaluate the three-year recidivism follow-up period for OARS participants. The three-year follow-up recidivism rate for OARS participants is 27.08 percent, which is 23.79 percent lower than the group with similar characteristics. While the sample size for the three-year rate is relatively small at 48 participants, it offers an encouraging sign that the program has a positive effect on participants well after completion of the program.



Summary of FY15 Program Data

*** In FY15, data was collected in a different format from previous years*

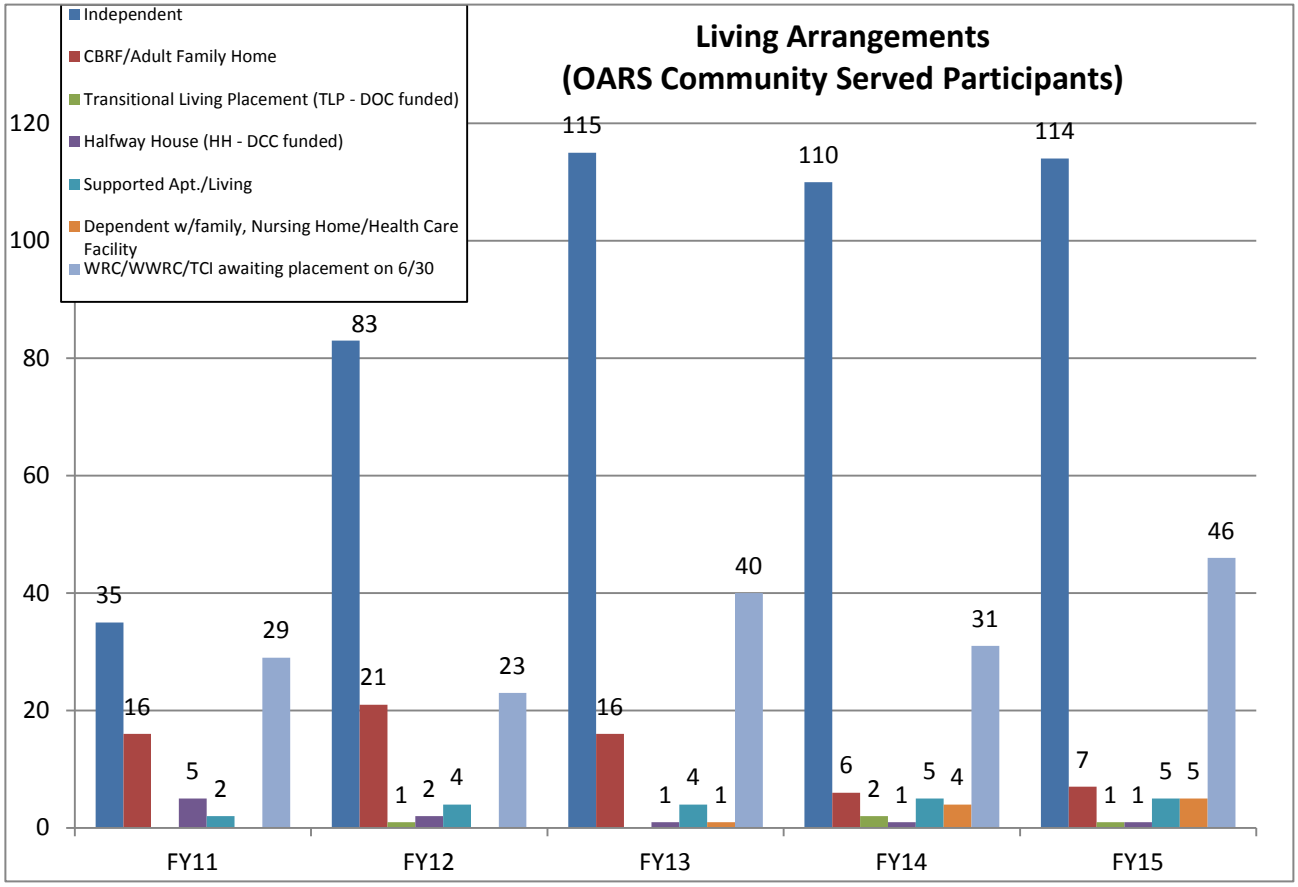
	FY11	FY12	FY13	FY14	FY15
Total Served, pre-release and post-release	88	142	177	162	148
Average Daily Population (ADP)	48	79	101	97	98
Admissions to OARS Program					
Pre-release as of June 30	29	23	40	30	45
Post-release as of June 30	72	76	69	92	63
New Admissions Release Origin					
Wisconsin Resource Center (WRC)	52	34	42	44	34
	59%	45%	61%	44%	39%
Taycheedah Correctional Institution (TCI)	36	23	24	23	13
	41%	30%	35%	33%	18%
Women's Wisconsin Resource Center ONLY	n/a	3	2	4	n/a
	n/a	4%	3%	3%	n/a
Women's Wisconsin Resource Center, Oshkosh Correctional Institution, Robert E. Ellsworth Correctional Center, Redgranite Correctional Institution, Racine Correctional Institution, John C. Burke Correctional Center	n/a	n/a	n/a	n/a	11 **
	n/a	n/a	n/a	n/a	17% **
Living Situation					
Independent	35	83	115	110	114
CBRF/adult family home	16	21	16	6	6
Transitional living placement (Department of Corrections funded)	0	1	0	2	1
Halfway house (Division of Community Corrections funded)	5	2	1	1	1
Supported apartment/living	2	4	4	5	5
Dependent w/family, nursing home/health care facility	0	0	1	4	5
Pre-release awaiting placement on June 30	29	23	40	31	46
Employment					
Competitive	5	12	17	19	50
Sheltered/supportive	2	2	1	2	1
Unemployed	50	85	99	100	65 **
Pre-employment training/vocational rehabilitation, school/other educational, retired, unknown	31	60	20	41	32 **
Diagnostic Categories					
Schizophrenia	17%	18%	35%	17%	17%
Other psychotic disorders	29%	28%	16%	15%	16%
Mood disorders	42%	39%	43%	52%	45%
Anxiety disorders	8%	13%	13%	9%	7%
Percent of total population with co-occurring mental health/substance abuse diagnosis	85%	74%	67%	72%	96%
Percent of total population with co-occurring personality disorder diagnosis	75%	72%	58%	54%	34%
Department of Corrections (DOC) Mental Health Code 2A	85%	90%	89%	98%	100%
Department of Corrections (DOC) Mental Health Code 2B	15%	10%	11%	2%	0%
Crime at Sentencing					
Total served—violent felony committing offense	42%	46%	49%	48%	65%
Total served—nonviolent felony committing offense	56%	38%	36%	58%	36%
DOC Risk Assessment Rating—medium	45%	50%	52%	48%	29%
DOC Risk Assessment Rating—high	55%	78%	48%	48%	25%
Total served revoked	**3%**	**4%**	**1%**	**2%**	**1%**
Total participants placed in short-term hospitalization	**9**	**20**	**24**	**20**	**14**
Percentage of total	29%	18%	17%	15%	11%
Population approved for Social Security benefits as of June 30	**63%**	**66%**	**66%**	**52%**	**32%**

The following is data from the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) risk and needs assessment tool administered in 2015 to 298 former and current OARS participants.

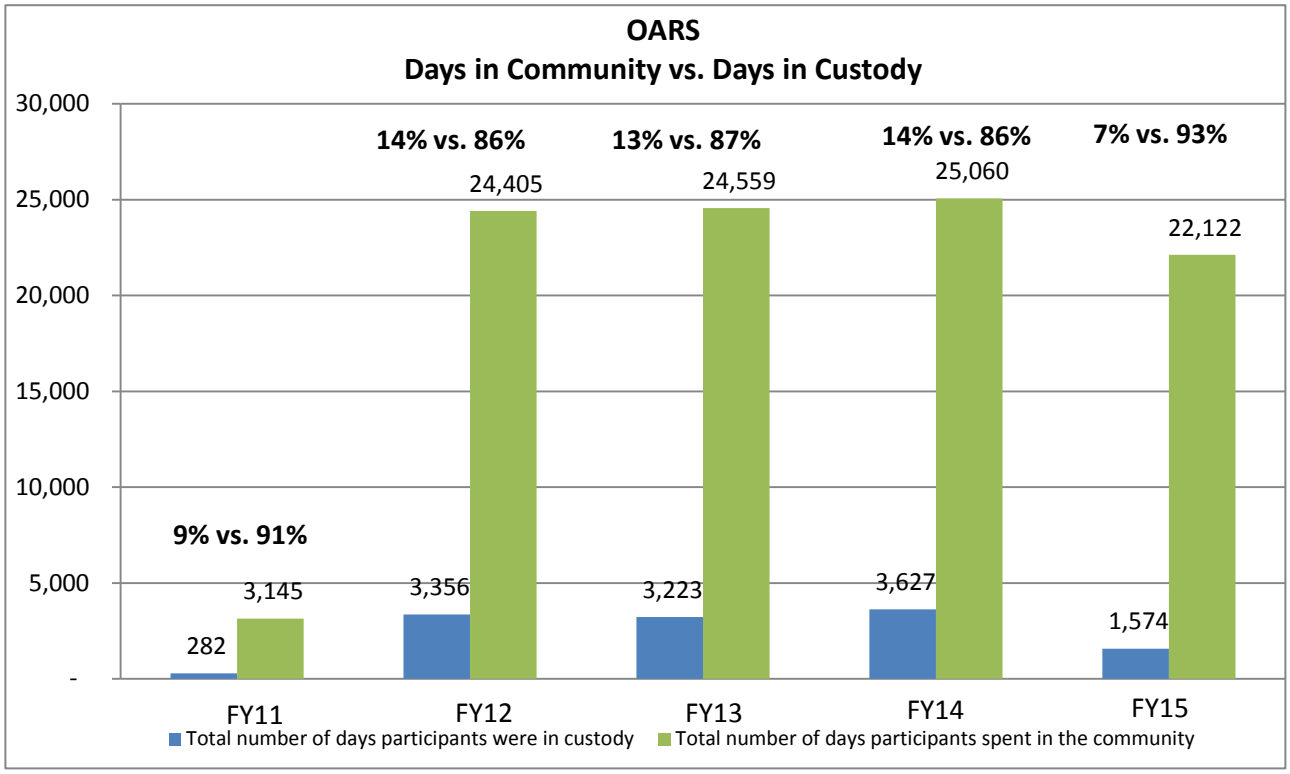
17.5	• Average age of first arrest
13	• Average number of arrests
5+	• Number of jail stays of 30 days or longer for 94 of the 298 participants
24.5%	• Percent of crimes committed in the "Other" category, the leading criminal charge category for participants • This category includes resisting/obstructing, driving after revocation, disorderly conduct, loitering, public intoxication, and urinating in public
50%	• Percent who have had serious or administrative prison disciplinary infractions
58%	• Percent determined highly probale to have problems with social adjustment of the 165 who took the assessment containing this scale

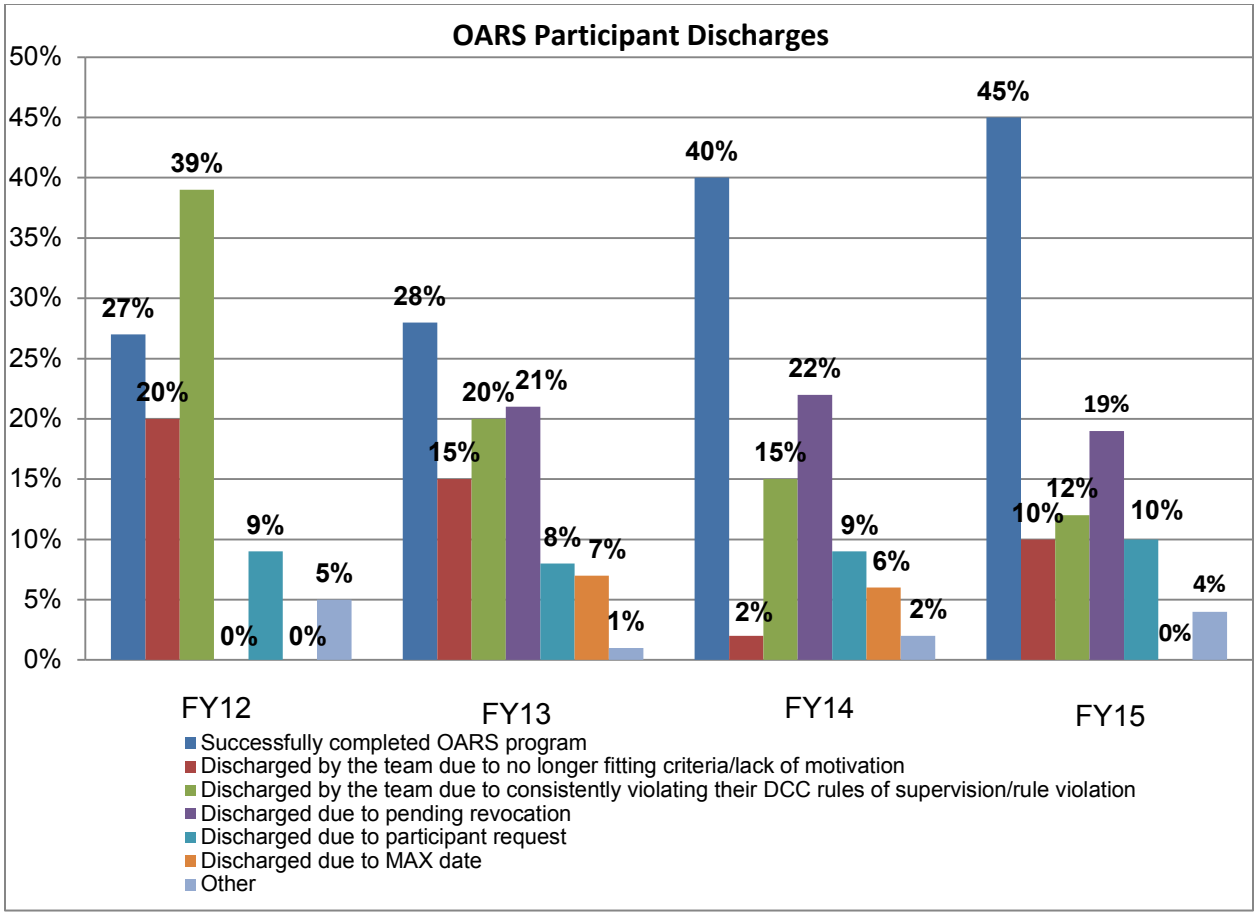
In FY15, of the OARS participants receiving treatment for mental health and substance use concerns:

- 96 percent were diagnosed with a co-occurring mental health/substance use diagnosis.
- 52 percent were diagnosed with both a major mental illness and a personality disorder.



In FY15, 77 percent of OARS participants resided in independent living during the majority of the post-release phase, only 4 percent of participants resided in a CBRF or adult family home throughout the majority of the post-release phase.





FY16 Goals

1. Ensure participants participate in meaningful daily activities.
2. Educate case managers on motivational interviewing to help them demonstrate fidelity.
3. Ensure case managers use of motivational interviewing in behavior change conversations.
4. Provide participants the opportunity for ongoing input into their treatment.
5. Encourage participants to provide insight into their experience in OARS.

Appendix A: Motivational Interviewing and Implementation Project Report

By Scott Caldwell, Motivational Interviewing Trainer, Wisconsin Department of Health Services

This report summarizes the Motivational Interviewing Training and Implementation Project (MI-TIP) in the Division of Mental Health and Substance Abuse Services, Office of Community Forensic Services for Conditional Release (CR) and Opening Avenues to Reentry Success (OARS) programs during contract year 2014-2015. CR/OARS provider agencies have been involved with MI-TIP since 2012. The stated goal of MI-TIP is for case managers to systematically integrate MI into all behavior change conversations with fidelity. Results of the most recent contract year will be described for three components of MI-TIP: workshop training, peer learning, and fidelity reviews. Conclusions and recommendations will also be discussed.

Workshop Training

One component of MI-TIP is an annual workshop for all CR/OARS case managers and agency supervisors, as well as invited participation for Department of Corrections, Division of Community Corrections' agents and supervisors. During spring 2015, three two-day MI trainings were provided statewide and 67 staff participated. Workshop training was highly experiential and focused on skill building. Approximately 95 percent of CR/OARS case managers completed a required pre-workshop reading and written exercise. At the conclusion of the workshop, a standardized evaluation was administered. The evaluation was completed by 90 percent of staff. Staff were asked to rate their experiences with several aspects of training (e.g., usefulness, content, exercises, workshop materials) as either 1 (poor), 2 (fair), 3 (good), or 4 (excellent). The evaluation items showed strong reliability (alpha = 0.91), therefore, all items were averaged together. The overall evaluation average was 3.6 suggesting staff perceived the workshop to be between good and excellent. Average evaluation results by site are shown in **Table 1**. There was no difference (p = .15) in evaluation results between workshop sites.

Table 1. Summary of workshop evaluation results.

Workshop site (dates)	N	M	SD
Stevens Point (May 5-6)	22	3.57	0.43
Milwaukee (June 2-3)	19	3.50	0.46
Madison (June 9-10)	16	3.78	0.36

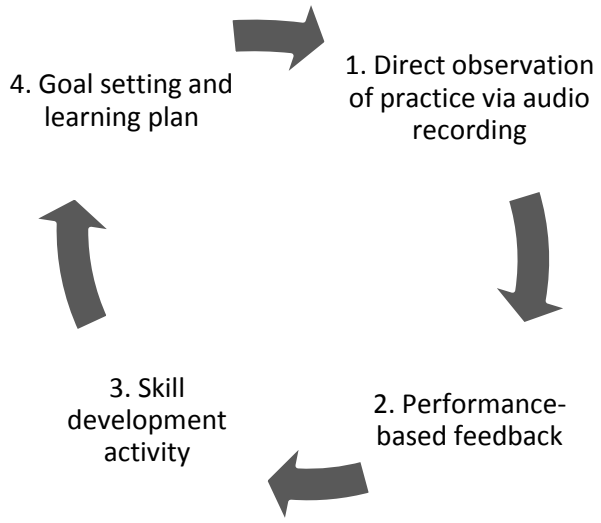
Key: Number (N) of participants, Mean (M), and Standard Deviation (SD)

The final evaluation item asked, "Would you recommend this training to others?" and staff made a 0 (not at all recommend) to 10 (highly recommend) rating. Originally developed as a metric of customer satisfaction in the private sector, this question represents a Net Promoter Score (NPS) ranging from -0 percent to 100 percent.[1] An NPS of 50 percent or higher is considered a strong benchmark for business. Overall evaluation in this MI workshop showed an NPS of 56.1 percent suggesting a solid level of staff satisfaction—with room for improvement. On the evaluation, staff noted several suggestions for training improvement and these will be incorporated into the 2016 workshop.

Peer Learning

Another component of MI-TIP involves peer learning. MI training outcome studies consistently show that "one shot" workshops are insufficient to promote fidelity.[2, 3] Moreover, like learning any complex skill, learning MI to fidelity requires ongoing learning.[4, 5] As a contract deliverable, CR/OARS case managers attended a monthly one-hour peer group with a learning process depicted in **Figure 1**.

Figure 1. Peer learning group process.



First, case managers presented (on a rotating basis) an audio-recorded practice sample of MI obtained with written permission from a client. Direct observation of practice is critical as there is "no reliable and valid way to measure MI fidelity other than through the direct coding of practice samples."[6] Then, performance-based feedback was offered by peers using a structured coding system. With time remaining, staff participated in a pre-determined skill building activity.[7] Finally, once peer review coding sheets were collected, averaged, and examined by the presenter, an individualized learning plan was formulated for practice improvement with supervisor input.

During the contract year, each case manager was required to present two audio-recorded practice samples of MI. Practice sample #1 was presented during 2014 (the first six months of the contract year) and practice sample #2 was presented during 2015 (the last six months of the contract year). With feedback on two practice samples, each case manager was able to compare their results and revise their learning plan accordingly. As shown in **Table 2**, case managers were highly engaged in the peer learning process. Each group, on average, comprised 7-10 case managers and this reflected approximately 90 percent of CR/OARS program staff. Furthermore, all case managers (100 percent) developed and revised an individualized learning plan.

Table 2. Peer learning group descriptives.

Measure	First six months (2014)	Second six months (2015)
Number of staff presenting an audio-recorded practice sample	32	31
Average number of staff attending peer groups	7.7	10.2
Average percentage of CR/OARS staff in attendance (of total)	89.5%	89.4%
Average percentage of staff who completed a learning plan	100%	100%

Fidelity Reviews

A critical question in the delivery of any evidence-based practice is this: are staff delivering the practice as intended, that is, to specified fidelity benchmarks? This question is critical because fidelity of MI practice directly links to service outcomes,[6] that is, MI must be delivered with fidelity if clients are to benefit. Peer fidelity reviews of the audio-recorded practice samples were based on the behavior count coding system of the Motivational Interviewing Treatment Integrity (MITI) instrument.[8] During audio playback, peers coded presenter utterances into the following (mutually exclusive) categories: Open Question, Closed Question, Simple Reflection, Complex Reflection, MI Adherent behavior, or MI Non-Adherent behavior. Staff received guidance for coding during workshop training. As shown in **Table 3**, this coding system allows five measures of MI to be calculated with comparison to established fidelity benchmarks.[9] Each provider

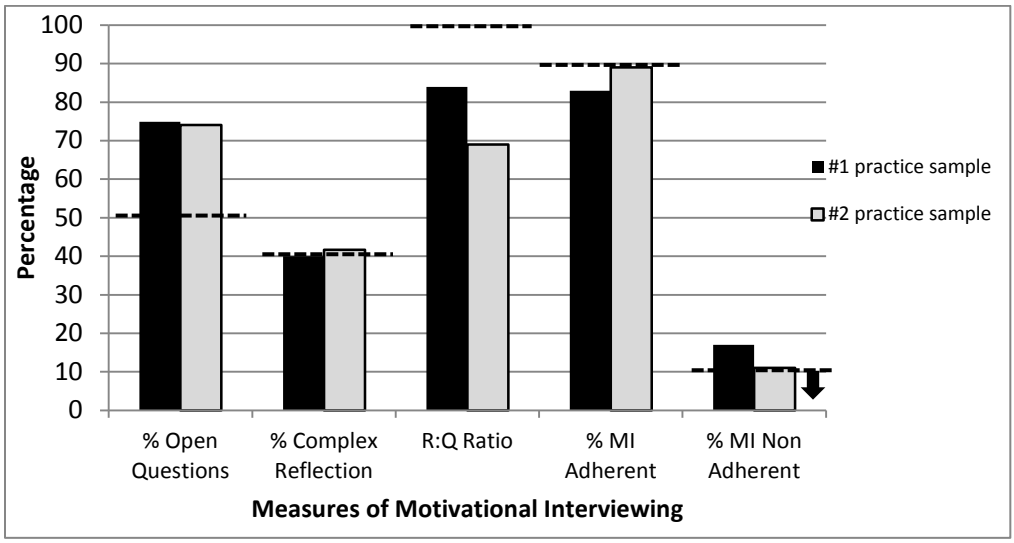
agency entered fidelity review results for each case manager into a spreadsheet and submitted this data quarterly to the DHS contract manager. DHS maintained a database of all CR/OARS program data, then imported the data into a statistical software program (SPSS) for analysis of aggregate results.

Table 3. Calculation of MI measures and corresponding fidelity benchmarks.

MI Measure	Calculation	Fidelity Benchmark[9]	
		Basic	Advanced
Percent open questions	# of open questions/total questions x 100	≥ 50%	≥ 70%
Percent complex reflection	# of complex reflections/total reflections x 100	≥ 40%	≥ 50%
Reflection to question ratio	Total # of reflections/total # of questions	≥ 1.0	≥ 2.0
Percent MI adherent behaviors	# of MI adherent behaviors/# of total other behaviors x 100	≥ 90%	≥ 98%
Percent MI non-adherent behaviors	100% - % MI Adherent	≤ 10%	≤ 2%

Two data analysis strategies were taken. First, case manager practice sample #1 was directly compared to practice sample #2 for the 2014-2015 contract year. All results were compared to the benchmarks for *basic fidelity*. As depicted in **Figure 2**, results showed one MI measure (percentage of open questions) exceeded and another measure (percentage of complex reflection) met basic fidelity. Other measures (ratio of reflection to question, percentage of MI adherent, percentage of non-adherent behaviors) did not reach fidelity with the exception of practice sample #2 decrease in non-adherent behaviors.

Figure 2. Average case manager practice sample results compared to basic fidelity benchmarks.



Key: Dashed line denotes threshold for basic fidelity.

Pair-wise comparisons (practice sample #1 versus practice sample #2) were made for all MI measures. Results showed no statistically significant improvement in the use of MI (*ps* ranged from .15 to .88). (Note: a statistically significant difference is when the probability [*p*] of results due to chance is less than 5 in 100, that is, $p < .05$.)

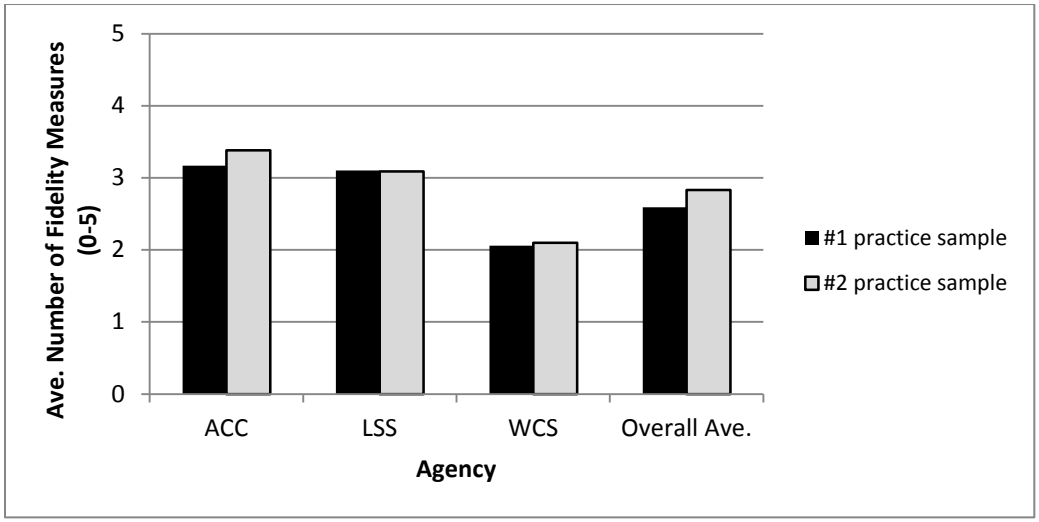
To what extent did individual case managers demonstrate basic fidelity during contract year 2014-2015 and was there improvement over time? To address this question, each MI measure for all case managers was converted into a dichotomous score of either 0 (did not demonstrate fidelity) or 1 (demonstrated fidelity), thus creating a 0 (no fidelity measures) to 5 (all fidelity measures) scale. Overall, there was no statistically significant improvement in MI practice. Case managers, on average, demonstrated about the same number of MI fidelity measures on practice sample #1 (M = 2.6) as they did on practice sample #2 (M = 2.8). For practice sample #2, **Table 4** shows the breakdown of percentage of case managers (N = 30) who demonstrated the average number of basic fidelity measures: 30 percent demonstrated fidelity on 1-2 measures; 44 percent demonstrated fidelity on 3-4 measures; and only 3 percent (n = 1) demonstrated fidelity on all 5 measures.

Table 4. Percentage of staff who demonstrated fidelity by number of MI measures on practice sample #2.

No. Fidelity Measures	Percentage of Case Managers
0	0%
1	15%
2	15%
3	21%
4	23%
5	3%

Additionally, an agency-level analysis showed no statistically significant within-agency improvement of MI practice during the contract year. However, there was one significant between-agency practice difference ($p < .05$) regarding practice sample #2 such that ACC case managers (M = 3.4) demonstrated a higher number of fidelity measures than WCS case managers (M = 2.1).

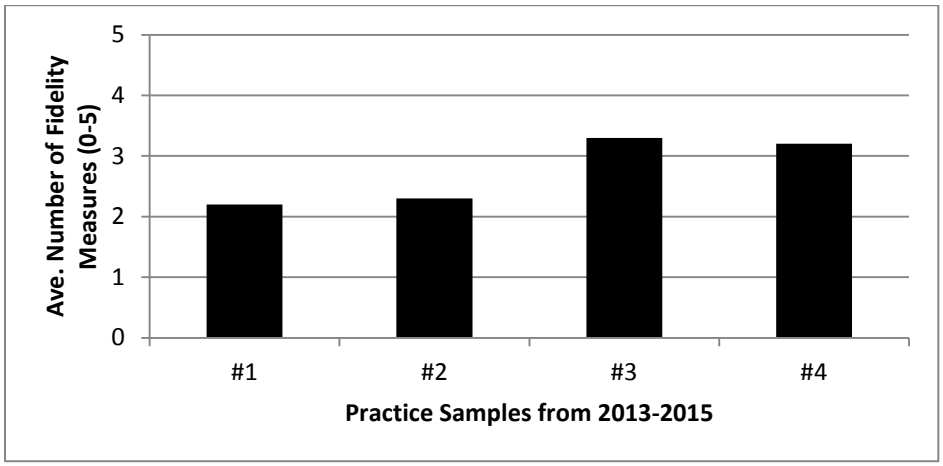
Figure 3. Average number of fidelity measures demonstrated by agency.



The second data analysis strategy examined practice sample results over a longer time period. Four sets of practice samples from contract years 2013-2014 and 2014-2015 were examined. This analysis involved 38 case managers and a total of 95 practice samples. This data analysis approach addresses an important confound. Because of staff turnover, “practice sample #1”

within a single contract year may not necessarily be the *first* practice sample submitted by an individual case manager. Therefore, by examining practice samples in the order submitted by each case manager, a more clear analysis of practice improvement can be ascertained. A between-subjects analysis of variance was conducted to examine four (4) practice samples across a two-year period regarding the number of fidelity measures (0-5) demonstrated. As depicted in **Figure 4**, results showed there was no practice improvement in case managers' (n = 38) practice sample #1 (M = 2.24, SD = 1.34) compared to case managers' (n = 30) practice sample #2 (M = 2.33, SD = 1.29). Additionally, there was no practice improvement from case managers' (n = 16) practice sample #3 (M = 3.31, SD = 1.19) compared to case managers' (n = 11) practice sample #4 (M = 3.18, SD = 1.33). However, case managers did show a statistically significant practice improvement ($p < .02$) from practice sample #2 to practice sample #3.

Figure 4. Average number of fidelity measures achieved by case managers over time.



What may explain the lack of steady practice improvement during this time period? To examine this, an individual-level analysis was conducted for case managers who submitted at least two practice samples. The goal was to identify possible patterns of results. Three unique patterns from the fidelity review results were identified, which seemed to underscore three types of learners. *Strugglers* (n = 36) were case managers who were only able to demonstrate 1-2 fidelity measures on practice sample #1, then never improved beyond this starting point. *Slight improvers* (n = 24) may have started low (1-2 measures), but improved over time, or started higher (3 measures) and then maintained. *Strong improvers* (n = 28) were case managers who, regardless of starting point, ended much higher than they started. For number of fidelity measures demonstrated, a between-subjects analysis of variance showed a strong and significant effect for learner type ($p < .001$) such that, on average, strugglers (M = 1.72, SD = 1.09) showed the least number of fidelity measures, compared to the slight improvers (M = 2.50, SD = 1.10), and the strong improvers (M = 3.79, SD = 1.03). Of note was an average difference of 2 fidelity measures (on a 0-5 scale) between the strugglers and the strong improvers. Interestingly, there was no difference ($p = .44$) in length of time case managers were employed with the agency (in months) and learner type. Moreover, there was no correlation ($r = .04$, $p = .72$) between length of time employed and the number of fidelity measures demonstrated.

Conclusions and Recommendations

How to make sense of these findings? Several conclusions can be made. First, the CR/OARS case managers and supervisors are to be commended for their ongoing participation in MI-TIP. Rarely is direct observation of practice and performance-based feedback utilized in the behavioral health field.[10] These innovative agencies have invested in staff professional development for MI learning. Second, learning MI to fidelity is not easy.[11] MI is a relatively

simple practice, but like any complex skill, dedicated effort is required to achieve proficiency. It is of note that the results reported here were based on comparisons to *basic* fidelity—not advanced fidelity. Third, the peer learning group appears to be a useful format for case managers to continue developing MI skills. The data showed a trend in practice improvement over time, especially between practice samples #2 and #3. The significant decrease in case manager MI Non-Adherent behaviors (with the subsequent increase in Adherent behaviors) probably accounted for the practice improvement. "Non-Adherent" behaviors included case managers warning, advising, or confronting clients to change. These practices are ineffective in promoting behavior change[12] and for some staff, letting go of such behaviors should be the first priority of learning MI.[4] Finally, although many case managers advanced their MI practice, approximately 40 percent struggled to demonstrate even one or two fidelity measures (out of a possible five). This struggle to learn persisted even with monthly attendance in a peer learning group! Some agencies may have a higher proportion of strugglers than others. The finding that "site matters" is a reminder that the organizational context in which learning and service delivery occurs is an important ingredient in successful implementation of MI.[13]

The stated goal of MI-TIP is for CR/OARS case managers to systematically integrate MI into all behavior change conversations with fidelity. Now in its third year, themes of "practice-based evidence" are emerging and recommendations are offered for the current 2015-2016 contract year:

1) **Implementation planning**. Each agency should develop a strategic plan for how MI will be implemented into routine practice: What target behaviors will case managers address using MI? When will MI be utilized? How will MI be integrated into services? How will supervision be used to monitor and support case manager learning and integrating MI into routine practice? On a quarterly basis, the DHS forensic services specialists should check in with agency supervisors and staff to develop and revise the plan.

2) **Deepen learning**. Implementation planning should also address how to deepen staff's learning, especially the case managers who are struggling to integrate and learn MI. Beyond participation in the monthly learning group, what resources and supports can be made available to assist the strugglers? How can supervision be used to increase support as well as accountability? It is recommended that all case managers complete a monthly MI self-assessment to increase reflection on MI utilization. Also, the DHS forensic services specialists should regularly review submitted fidelity data to monitor progress.

3) **Protocol-guided delivery**. Development of a protocol for delivering MI may be a useful tool for implementation as well as accountability for case managers to utilize and integrate MI into practice. Each agency could develop and standardize their own version.

4) **Clinical consultation**. Consultation to CR/OARS case managers is routinely provided by the DHS forensic services specialists and thus allows an excellent opportunity to promote the application of MI. How can case consultations be provided through an "MI lens?"

References

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