City of Austin

Downtown Austin Community Court

Program Evaluation:
Targeted Case Management

March 23, 2012

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HISTORY

Community Court Established

According to the Center for Court Innovation:

> Community courts are neighborhood-focused courts that attempt to harness the power of the justice system to address local problems. They can take many forms, but all focus on creative partnerships and problem solving. They strive to create new relationships, both within the justice system and with outside stakeholders such as residents, merchants, churches and schools. And they test new and aggressive approaches to public safety rather than merely responding to crime after it has occurred. (http://www.courtinnovation.org/topic/community-court)

The Downtown Austin Community Court (DACC) was established in 1999. It was the eighth community court established in the United States, and the first established in Texas. The purpose of the Downtown Austin Community Court is to collaboratively address the quality of life issues of all residents in the downtown Austin community through the swift, creative sentencing of public order offenders. The court operates as a problem solving and rehabilitative court and provides referrals to supportive services for offenders who commit class "C" misdemeanor violations such as public intoxication, simple assault, aggressive solicitation, disorderly conduct, possession of drug paraphernalia and other public nuisance violations within a defined jurisdictional area. The Court is jurisdiction-based, so any offender who commits an eligible offense within the court's jurisdiction is served at DACC (see Exhibit A for a map of the court's jurisdiction). A majority of the offenses adjudicated through DACC are committed by defendants who are homeless, and a disproportionate number of offenses are committed by a small number of defendants who cycle through the criminal justice system at a high cost to all community services systems.

Frequent Offenders Identified

In fiscal year 2009 the DACC identified a targeted group of these individuals designated as Frequent Offenders. A Frequent Offender at DACC is defined as an individual who has had 25 or more legal cases with the Court and has had at least one active case in the last two years. In 2009 there were 245 Frequent Offenders, and the number has since risen to over 280 individuals. These individuals were initially identified because the Court noticed that a small group of individuals comprised a large number of cases at the Court. In 2009 Frequent Offenders represented about 4.1% of all Court offenders, but accounted for 29.8% of all cases filed at the Court that year. This group of defendants cycle in and out of the Court at a frequent pace, skirting the Court's and the larger community's efforts at providing services toward rehabilitation. They regularly opt for jail credit over paying fines or performing community service. While contributing to jail overcrowding, they tend to refuse rehabilitative services and tend to ignore Court mandates.

Data gathered by the Community Court shows that these individuals experience a high rate of mental illness, substance abuse, and co-occurring illnesses. About 65% of the 245 Frequent Offenders in 2009 had been screened at some point by Austin Travis County Integral Care, the local public mental health authority. Of those screened, 79%

received a mental health diagnosis, with 77 percent indicating a "priority population" diagnosis of BiPolar I or II, Major Depression, or Schizophrenia/Schizoaffective Disorder**.** Except for one, all of the mentally ill were homeless.

Based on Texas DPS criminal background checks of the 245 Frequent Offenders in 2009, at least **55%** had a conviction on their record that would disqualify them from most housing options in the Austin area, and a large majority had at least one felony conviction.

Court staff and its community partners gathered information on how Frequent Offenders impact other public support systems, in addition to contributing to disproportionate costs for policing, jail, and court appearances. For example, of the 245 Frequent Offenders in 2009, 64% had a record of EMS service calls at an estimated cost of $917,106 since 1999.

As of February 2012, there were 279 Frequent Offenders. Based on DACC clinical staff interactions with these individuals and a review of their legal history with the court, 97% of these individuals (270 out of 279) have issues related to substance use. Two hundred and sixty three of these individuals have received a charge at the Community Court related to substance use, representing 94.6% of the Frequent Offenders.

Targeted Case Management Implemented

Working closely with its Advisory Committee, it was decided in 2010 to begin focusing the Court's case management staff and rehabilitation budget on Frequent Offenders as the best way to impact costs to the City and other community entities, while reducing public order crimes in the Court's jurisdiction. Consequently, the Downtown Austin Community Court Targeted Case Management Program (TCM) was designed and implemented in fall 2010. Due in large part to the advocacy of the Community Court's Advisory Committee, two full-time employee positions were added to the Court's budget for fiscal year 2011. Community Court staff set out to recruit and hire these two individuals, and in November 2010 the first two targeted case managers were hired. Court staff worked with the case managers during November and December to plan the implementation of this new program, and targeted case management began in earnest in January 2011.

PROGRAM DESIGN

Data Tracking

The Community Court's primary database was developed by City of Austin personnel for tracking offenders and case outcomes suitable for a problem-solving court. However, in order to track case management activities completed with Frequent Offenders, court staff worked with computer programmers to create a new system capability to allow for more detailed case notes and more robust data tracking to capture deeper, more precise information deemed necessary to effectively quantify the problems confronting Frequent Offenders and the limitations of the current service delivery system.

In partnership with DACC's designated computer programmer/analyst at Municipal Court, DACC staff developed 160 separate data gathering points in the form of checkboxes that the case managers would check as they applied to case management

documentation narratives. The boxes tracked numbers for direct client contacts, attempted contacts, no shows, service plans created, assessments conducted, Homeless Management Information System (HMIS) profiles updated/created, direct assistance provided by the court, reasons for refusal of case management, utilization of substance abuse treatment and mental health treatment, service gaps in the community, and several other items. The boxes also tracked measures of client status, such as income level, medical condition, mental health condition, possession of identifying documents, etc. A full list of the 160 data gathering points is included in Exhibit B.

Client Engagement

The original design of the targeted case management program included two methods of client engagement: at the daily arraignment docket (defendants brought to court straight from jail) and during outreach in the community. Early on, however, it became clear that case managers were able to fill and maintain caseloads with the arraignment docket as the sole point of engagement. Enough offenders were willing to participate in case management that the influx of need prohibited the case managers from adding outreach to their activities. Case managers did periodically engage in outreach to locate specific clients with whom they were familiar, but there was no concerted effort to enter the community and meet Frequent Offenders for the first time in the field, rather than at the Court.

Being a new initiative, the TCM program had no baseline to judge how many Frequent Offenders could be engaged in services given their long history of living on the streets and cycling through the criminal justice system. From the start, the approach used by TCM was to be willing to work with each client on an individual basis no matter the person's current situation, level of motivation, or understanding of what would be expected of them. Stops and starts were expected, due both to the history of the clients and the state of the current service delivery system. Letting the individual know that the case manager was going to focus exclusively on them and work at the client's pace without coercion were regarded as key.

Case managers also shared the list of Frequent Offenders with other service providers in the community, and through these collaborations many Frequent Offenders were engaged in collaboration with other service agencies. For example, the Community Court shared many clients with the Mental Health Public Defender's office at the Travis County Courts.

Case Management Status

In order to differentiate between Frequent Offenders who had been engaged but refused ongoing case management and those who chose to actively work with a case manager, a case management status function was added into the Court's database. The following statuses were used:

1. Pending: A client has met with a case manager and has expressed an interest in case management, but has not yet attended an initial follow-up appointment
2. Active: A client who has completed at least one initial follow-up appointment and is working on goals with a case manager.

3. Inactive: A client who was either pending but never completed a follow-up appointment, or who was active but later disengaged from case management. As a general guideline, clients who were previously "active" became "inactive" after 30 days of no contact with the case manager.
4. Successfully Discharged: A client who was previously "active" and has disengaged from case management due to successful stabilization.

To maintain an intensive level of case management contact, targeted case managers were encouraged to maintain a limit of 10-15 active clients at a time. Sixty-six clients were "active" at some point in 2011 illustrating the rapidly changing nature of case management work with this high-risk, high-needs client population. At the end of 2011, a significant number of Frequent Offenders have been engaged, but only one had been successfully discharged per the requirement of being in a stable situation suggesting long-term success.

Service Provision

Targeted case management was delivered in an intentionally client-specific manner. In general, Frequent Offenders were engaged on the arraignment docket and asked if they would like to work with a case manager to achieve any goals and meet any needs they may have. If the offender agreed to case management, the case manager would notify the court's prosecutor, who would then make decisions about whether to include case management engagement as a condition of a client's sentence for his or her legal case, or cases. Once the offender pled on his or her cases and had been sentenced by the judge, the case manager met with the client to conduct an informal assessment of needs and develop a preliminary case plan. Judge, prosecutor, and case managers worked together to emphasize to the clients the Court's willingness to work with each person toward services that would improve their situations rather than impose further sanctions. Sanctions continue to be applied, as in remanding defendants to jail, but this has been done generally when a targeted case manager has reported that a client has disengaged by failing to make appointments or simply disappeared for a length of time.

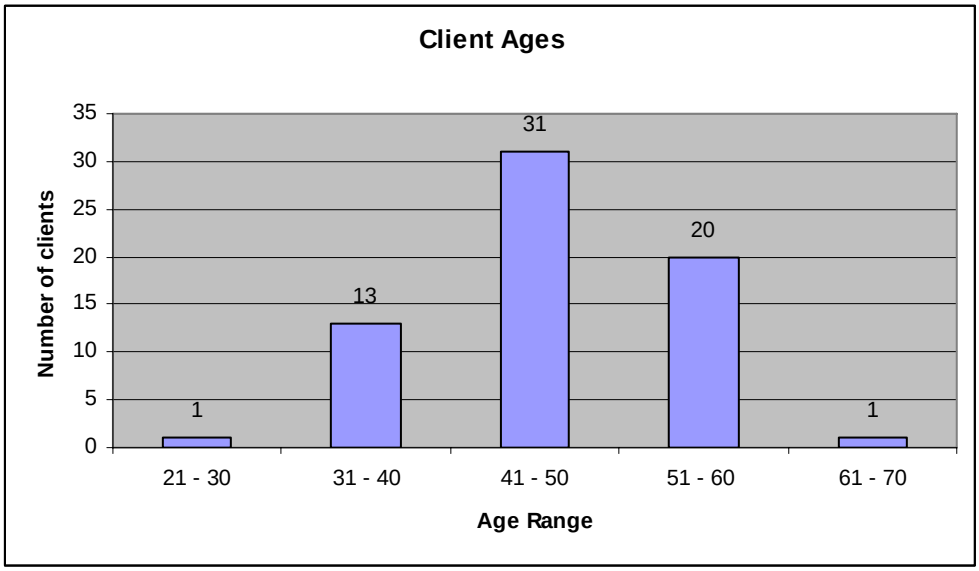
Substance abuse treatment was the starting point for most individuals who were willing to engage at the initial appointment, and that became the starting point of the case management plan. Others either did not struggle with substance use or were not ready to enter treatment, and for those, case management often began with planning for how to obtain medical coverage and identifying documents, which are the building blocks for helping a client meet his or her basic needs. Case management was sometimes completed in collaboration with other service providers, and the court's case managers participated in treatment team meetings, case management networking events, and trainings in order to increase their knowledge of and collaboration with other professional serving the same client population.

RESULTS

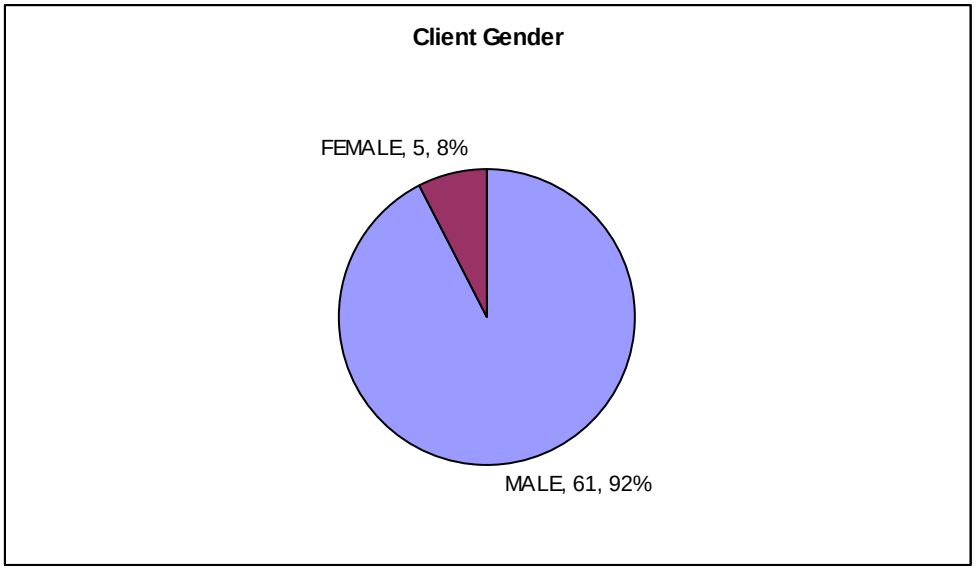
The following section summarizes the most significant results of the data captured thus far from the 160 data points from the TCM system.

Client Demographics

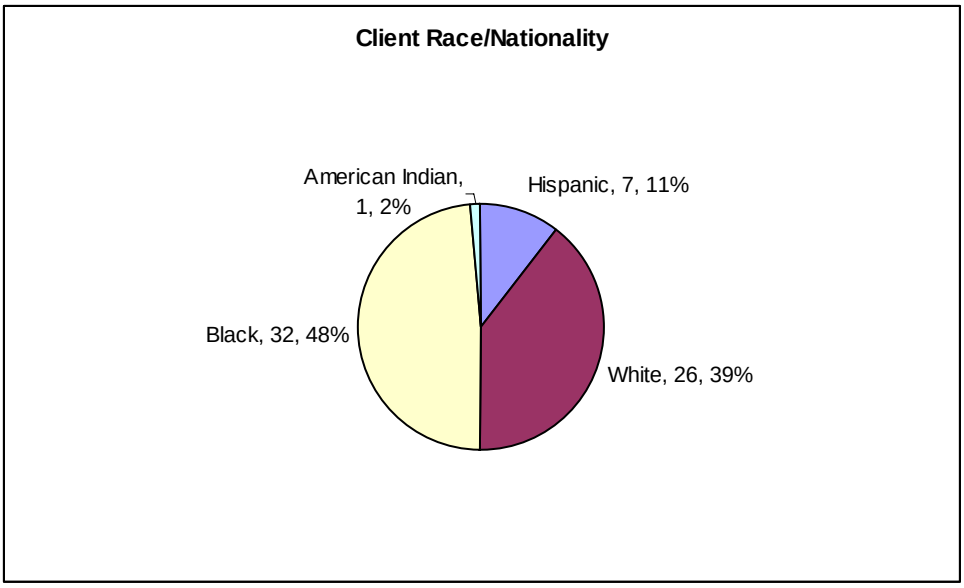
Using the system designed for this new program, the 66 Frequent Offenders engaged in case management were tracked according to demographic information. Only one individual was between 21 and 30 years of age, thirteen were between 31 and 40, thirty one were between 41 and 50, twenty were between 51 and 60 years of age, and one was between 61 and 70.



Of the Frequent Offenders, five were female and 61 were male.



The racial/ethnic breakdown was as follows: seven were listed as Hispanic, twenty-six White, thirty-two Black and one American Indian.



Of the 66 Frequent Offenders, 11 reported being veterans. Forty are documented as having a disability of some kind, and 28 of the disabled are documented as being chronically homeless, meaning they have a disabling condition and have either been continuously homeless for over a year or have experienced 4 or more episodes of homelessness in the past 3 years.

Offense Reduction

To calculate offense reduction, in January 2012 the evaluator determined the amount of time that had elapsed since a client engaged in active case management and used the same amount of time as a look-back period to compare offenses incurred before the client engaged in case management. Using this information, the evaluator calculated the number of offenses committed after engagement in case management divided by the number of offenses committed before engagement in case management, and subtracted that percentage from 100 to determine the percentage of reduction in offenses.

Sample calculation:

- Client became active in case management July 1, 2011.
- Evaluator runs report on December 31, 2011.
- Six months have elapsed since client became active, so the evaluator will also measure the six months before the client became active.
- "Before" period: January 1, 2011 – June 30, 2011.
- "After" period: July 1, 2011 – December 31, 2011.
- If the client had 5 DACC offenses in the "before" period and 2 DACC offenses in the "after" period, the client achieved a 60% reduction in cases.

In calendar year 2011, 66 frequent offenders engaged in active case management at some point during the year. These individuals had incurred 913 offenses with the Community Court during the time period preceding their entry into case management,

and this same group of 66 individuals incurred 308 new offenses following their first active case management contact. This represented a **66.3 % reduction in new offenses** for clients who engaged in active case management at some point during calendar year 2011.

In order to control for any overall trends in numbers of cases filed at the Community Court, data was gathered for two comparison groups: Frequent Offenders who have not yet been engaged by targeted case managers, and Frequent Offenders who were engaged but who never became active. Calendar year 2010 was compared to calendar year 2011 to capture general trends in the number of cases filed at the court. The results were as follows:

	2010 new cases	**2011 new cases**	**Percent change**
Never engaged (180 individuals)	1761	939	46.6% decrease
Engaged but not active (34 individuals)	713	316	55.6% decrease

These numbers indicate a general decrease in the number of new cases for these offenders from 2010 to 2011. This offers a comparison to the decrease exhibited by active clients:

	Cases before engagement	**Cases after engagement**	**Percent change**
Active clients	913	308	66.3% decrease

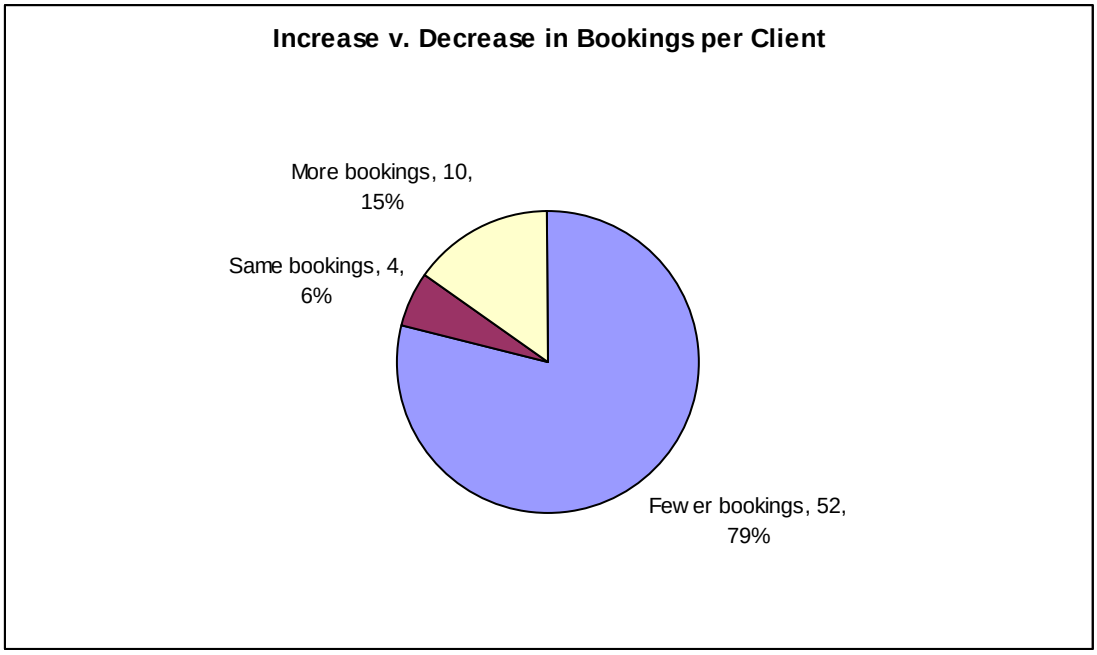
Clients who engaged in active targeted case management had the most significant decrease in new cases at the Community Court. Clients who were engaged but who never became active fared better than clients who were never engaged. The still significant decrease in new cases for clients who were never engaged could be due to a number of environmental factors, including a general decrease in ticket writing from the Austin Police Department in 2011.

Jail Bed Days

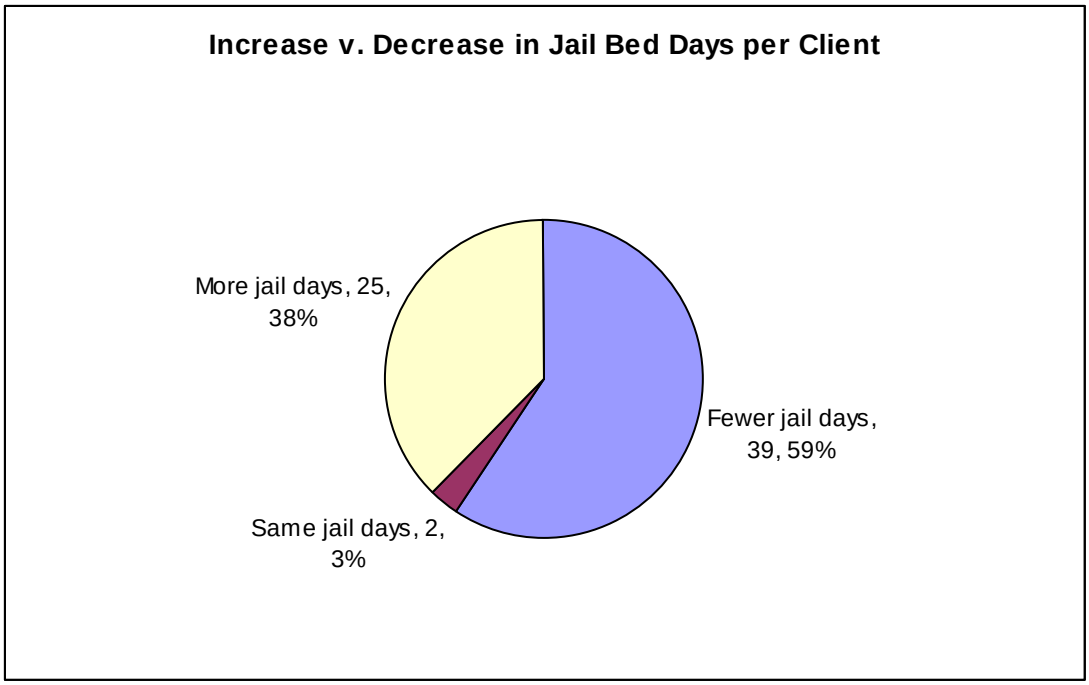
One common method to calculate cost savings or cost avoidance gained with case management of offenders is to measure jail bed days and jail bookings. DACC staff conducted a thorough review of the jail usage for the 66 offenders who engaged in active targeted case management in 2011. The results show that while these 66 offenders significantly decreased the number of times they were booked into jail, and most offenders had a decrease rather than an increase in jail bed days, there was an increase in the overall number of jail bed days used, primarily because of a small subset of offenders who were booked into jail on a higher charge. The results are as follows:

- In the look-back period before engaging in targeted case management (same method used to calculate reduction in DACC offenses), the 66 offenders were booked into Travis County Jail a combined 396 times. In the period following engagement in targeted case management, through December 31, 2011, the same

66 offenders were booked into Travis County Jail a combined 255 times, representing a **35.6 reduction in bookings**. Fifty-two offenders had fewer bookings following engagement, 4 had the same number of bookings, and 10 had more bookings.



- In the look-back period before engaging in targeted case management, the 66 offenders spent a combined 2383 days in the Travis County Jail. In the period following engagement in targeted case management, through December 31, 2011, the same 66 offenders spent a combined 2488 days in jail, an increase of 105 jail bed days, which represents a 4.4% increase. Thirty-nine offenders had fewer jail bed days following engagement, 2 had the same number of jail bed days (in this case, zero before and zero after), and 25 had more jail bed days.



- One reason for the overall increase in jail bed days consumed, even though only 25 of the 66 active clients increased their jail bed usage, is that these 25 individuals were booked into jail on higher level charges following their initial engagement with targeted case management. Below is a summary of some of the higher charges received by this group:

  - Theft <$1500 2 or more (3)
  - Prostitution (1)
  - Public Intoxication with three priors (6)
  - Obstruction (1)
  - Criminal Trespass (4)
  - Robbery (1)
  - Credit Card Abuse (1)
  - Burglary of a Habitation (3)
  - Burglary of a Building (4)
  - Burglary of a Vehicle (2)
  - Evading Arrest (1)
  - City Ordinance Violation (3)
  - Indecent Exposure (1)
  - Public Lewdness (1)
  - Assault that causes bodily injury/harm (2)
  - Public Intoxication (1)
  - Manufacture or Delivery of a Controlled Substance (3)
  - Injury to a child/elder/disabled person (1)
  - Interference with an emergency call (1)
  - Harassment of a Public Servant (1)
  - Tampering with Physical Evidence (1)
  - POCS (2)
  - Possession of Marijuana (1)
  - Failure to ID or provide false information (1)

For many offenders, incarceration on these higher charges led to a period of no contact with DACC targeted case managers, and they became inactive in case management services. This data highlights the chronic nature of offenders targeted for services by the Community Court.

Substance Abuse Treatment

The following results are aggregated from all Frequent Offenders engaged in 2011, both the 66 active clients and any client with whom the case managers had contact.

While the vast majority of Frequent Offenders have a charge related to substance use, not all are ready or willing to attempt treatment. Most Frequent Offenders also have a dual diagnosis of substance abuse and mental health, which complicates decisions regarding treatment.

The data shows that 52 clients were referred to substance abuse treatment, 16 refused, 37 were admitted to treatment at various locations, and 8 completed successfully. While this may seem to show that few complete treatment, the data hides the more complex truth of Frequent Offenders' stories. Several clients made progress in treatment or were successful after multiple treatment attempts. Even those who did not complete treatment made progress in reduction of tickets, getting ID, housing and working towards goals for stability.

Some clients engaged in case management for up to a year, working on problems while continuing to drink or use before they were ready to enter inpatient treatment. One client became homeless after losing his wife and kids, stayed on the streets for five years, and then began working with a case manager at Community Court while he was still drinking. After almost a year he became ready to enter treatment. That client is stable in aftercare and verbalized appreciation for being able to work on his immediate medical and financial needs with a case manager without being pushed into treatment before he was ready.

Many Frequent Offenders find it difficult to enter and complete treatment after years of living on the streets and in a homeless culture. Inpatient treatment is structured and intensive, presenting a stark contrast to the lives that offenders have become accustomed to. Community Court case managers began the engagement process with each client by building rapport, encouraging the client to work on issues when they are ready, and facilitating the change process by providing guidance, resources and support.

In addition to the factor of client readiness, there are systemic barriers to clients entering treatment. There were 17 reported occurrences of systematic barriers to clients entering treatment when they were willing, including unavailable detox beds, lack of insurance, and lack of timely information from providers. These difficulties further complicate the process of clients entering treatment. It can be very difficult to find available treatment beds once a client has a window of willingness in motivation to seek treatment. Once a client falls back to a point of pre-readiness, it may take months to get them ready to try again.

Even with barriers to treatment from within clients and within programs, Frequent Offenders are making progress. Clients are entering treatment, making incremental progress, decreasing drinking and using, stabilizing on medication, receiving fewer citations and returning to treatment if the first episode was not a measurable success.

Mental Health Services

Fifty three of the 100 Frequent Offenders engaged in 2011 have a priority population diagnosis. Priority population is a designation mandated by the state of Texas and used by Austin Travis County Integral Care (ATCIC), the local mental health authority, to prioritize clients for services. The priority population diagnoses are Major Depression, Bipolar Disorder, Schizophrenia, and Schizoaffective Disorder. Of the Frequent Offenders engaged in 2011 only 23 people were compliant with their prescribed mental health medication. Even with these serious issues, many clients do not see their conditions as debilitating and refuse mental health treatment and/or medication.

Case managers encountered clients in crisis, at the court, 24 times in 2011, and these crises ranged from incoherency to delusions and homicidal ideations. Case managers accompanied clients to get mental health medication, receive emergency mental health services, or go to a mental health appointment 44 times. When clients were willing to receive services they encountered documented barriers 16 times due to long waits, lack of beds, being dropped because they missed an appointment and lack of mental health care in jail..

One illustrative example is a veteran with over 50 DACC cases who had been homeless for 6 years and was diagnosed with alcohol dependence and Bipolar Disorder. He was able to complete detox and substance abuse treatment and went into transitional housing, but was not properly stabilized on mental health medication and relapsed. After becoming homeless again and reentering treatment he was discharged with no medication but eventually gained permanent supportive housing with the help of a targeted case manager. This client is successfully housed and is currently applying for disability, but continues to struggle with no income.

Physical Health

Along with substance abuse issues and mental health disorders, many Frequent Offenders also have physical health problems. Of those engaged in 2011, at the point of initial contact, 33 people had chronic health conditions, 37 had a MAP card (Medical Assistance Program for the uninsured and indigent), 16 had Medicaid/Medicare, and 12 had no health coverage. Case managers accompanied clients 45 times to clinic appointments, medication pick-ups and emergency room visits.

One Frequent Offender who was engaged in 2011 had substance abuse issues without mental illness or serious criminal background, and had been homeless for ten years. This client entered inpatient substance abuse treatment and was forced to leave due to having inadequate medication to treat ongoing health conditions. He was forced to go into the hospital, and was then able to gain reentry to treatment after a case manager advocated on his behalf. He was subsequently awarded disability income and was able to secure identification and permanent supportive housing with the help of Community Court targeted case management.

Housing Services

Targeted case managers facilitated clients gaining transitional housing 23 times in 2011. Clients face many barriers to all types of housing, including 23 instances of barriers for insufficient income, 5 for money owed to utilities, and 32 for criminal background. Criminal background is a huge barrier for clients seeking all types of housing, especially

permanent supportive housing. Case managers are active in the appeals process when housing is denied, helping clients obtain letters of reference, verification of treatment completion, and self-statement documents from the client, describing the circumstances contributing to his or her criminal history, to demonstrate progress made toward stability. Case managers describe a lack of permanent supportive housing and affordable housing in Austin, with waits that may take months or even years. At the time the targeted case managers were interviewed for this report, there was a wait list of 5 clients who were ready for housing but might need to stay in a shelter until they qualify for permanent supportive housing.

Without housing, it is difficult to work with homeless clients who frequently lose backpacks, identifying documents, MAP cards, and are difficult to locate to coordinate service delivery. Once a client is housed, this process is much easier and services are easier to access. It is still a difficult road and housing does not eliminate all problems, as some clients continue to struggle with lack of income. One client in permanent supportive housing has been homeless since his wife passed away from alcoholism. He is now stably housed but is feeling depressed and isolated in his new environment. He struggles with situational depression and the daunting application process to gain employment to utilize training he received through a specialized trade certification process while in long term treatment.

ID Documents/Income

Targeted case managers documented 50 incidents of working with clients to facilitate gaining income through employment, SSI/SSDI, food stamps and connections to other nonprofit employment services. Case managers reported 40 incidents of barriers that clients faced, including criminal background, lack of skills or education, lack of ID, lack of stable contact information, lack of work attire, and lack of transportation. A major issue for many clients is the lack of identifying documentation. Thirty-three clients reporting having no ID, and 23 had only a social security card. Case managers facilitated clients obtaining ID 28 times, which is a complicated and lengthy process for clients starting with no identifying documents.

Lack of photo identification is a huge barrier to gaining employment, healthcare, medications, disability income, and food stamps. Because identification is a necessary starting point to work towards other goals, it is a frustratingly slow process that requires money, transportation, a stable address to mail documents to, and knowledge of confusing processes. Without assistance, this alone can be a daunting barrier for clients with issues related to mental health, physical health, and substance abuse. Case managers sometimes serve as a document bank for clients who are not yet housed, holding onto original copies of identification to help the client maintain possession of these important documents.

General Case Management

Targeted case managers worked with clients to achieve many goals and were successful in coordinating services with other community case managers. Case managers documented 74 occurrences of providing clients with clothing and toiletries, 100 occurrences of providing bus passes, 19 occasions of providing food, and 12 occurrences of paying for ID documents. Case managers set boundaries with clients when providing

these types of direct support. They take care to not enable dependence, but instead to facilitate the process for a client to be able to help himself or herself.

Many clients who were offered case management refused: 35 were not interested, 10 believed they did not have a problem, 5 were leaving town and 2 claimed to already have a case manager. Because the point of engagement was most often the morning arraignment docket for clients brought to court from the jail, these case management refusals highlight the need for outreach case management to reach these clients in the community.

One targeted case manager gives the example of a client who lost his family through divorce, became homeless, and stayed on the streets for 13 years. After receiving services for a chronic physical condition he was led to permanent supportive housing where he has been living for almost one year. This was prior to the court's implementation of the Partnership Housing program, and this client was able to obtain a housing unit in another community program. While he participates in case management he has food stamps and is applying for disability. Formerly isolated, resistant to assistance and anemic, he is now healthier and brighter and is eating, sleeping, and socializing regularly. He recently came into an appointment proudly presenting a vegetable he grew at his community garden, announcing that he was a proud father of a baby tomato.

ADDITIONAL OBSERVATIONS

Point of Engagement and Need for Outreach

While case managers were able to maintain full caseloads through arraignment docket engagement, the court is still eager to add an outreach component to the program. When engaging offenders in custody who have just come from jail, case managers found that exhaustion, frustration, and the effects of recent drug and alcohol use often impaired offenders, to the point where they chose not to speak with a case manager. By adding outreach case managers, the court hopes to engage some of the harder-to-reach individuals who might otherwise continue to refuse case management services at the courthouse. The Community Court is planning to request the addition of two case managers dedicated to outreach in its department budget for fiscal year 2013.

Adaptation of Data Points

After reviewing the data points numbers from 2011, court staff learned that some checkboxes were underutilized, and some were no longer applicable to case management activities after a year of program evolution. The court's targeted case managers are working through a comprehensive assessment of the existing data points and will make recommendations on items to add, delete, or change.

Court staff is also working to add the data point tracking capability into the court's database for every court offender, not just Frequent Offenders. This change will allow any case manager at the court to capture detailed information on every offender who receives court assistance and case management, and will allow for more detailed comparisons between the Frequent Offenders and other court offenders. As the court's work with repeat offenders has progressed, the court has further categorized its offenders into four tiers:

- Tier 1: Frequent Offenders (same definition)
- Tier 2: Offenders with 15-24 cases, and offenders with 25 or more cases who have *not* had an active case in the past two years
- Tier 3: Offenders with 2-14 cases
- Tier 4: One time offenders

Targeted case managers will continue to focus on tier 1 Frequent Offenders, and all court resources will be geared to serve offenders in tiers 1, 2, and 3.

Ongoing Collaborations

In addition to extensive ongoing collaboration with its Advisory Committee, the Community Court continues to increase its level of collaboration with other community service providers, partnerships, and initiatives. Current collaborations include:

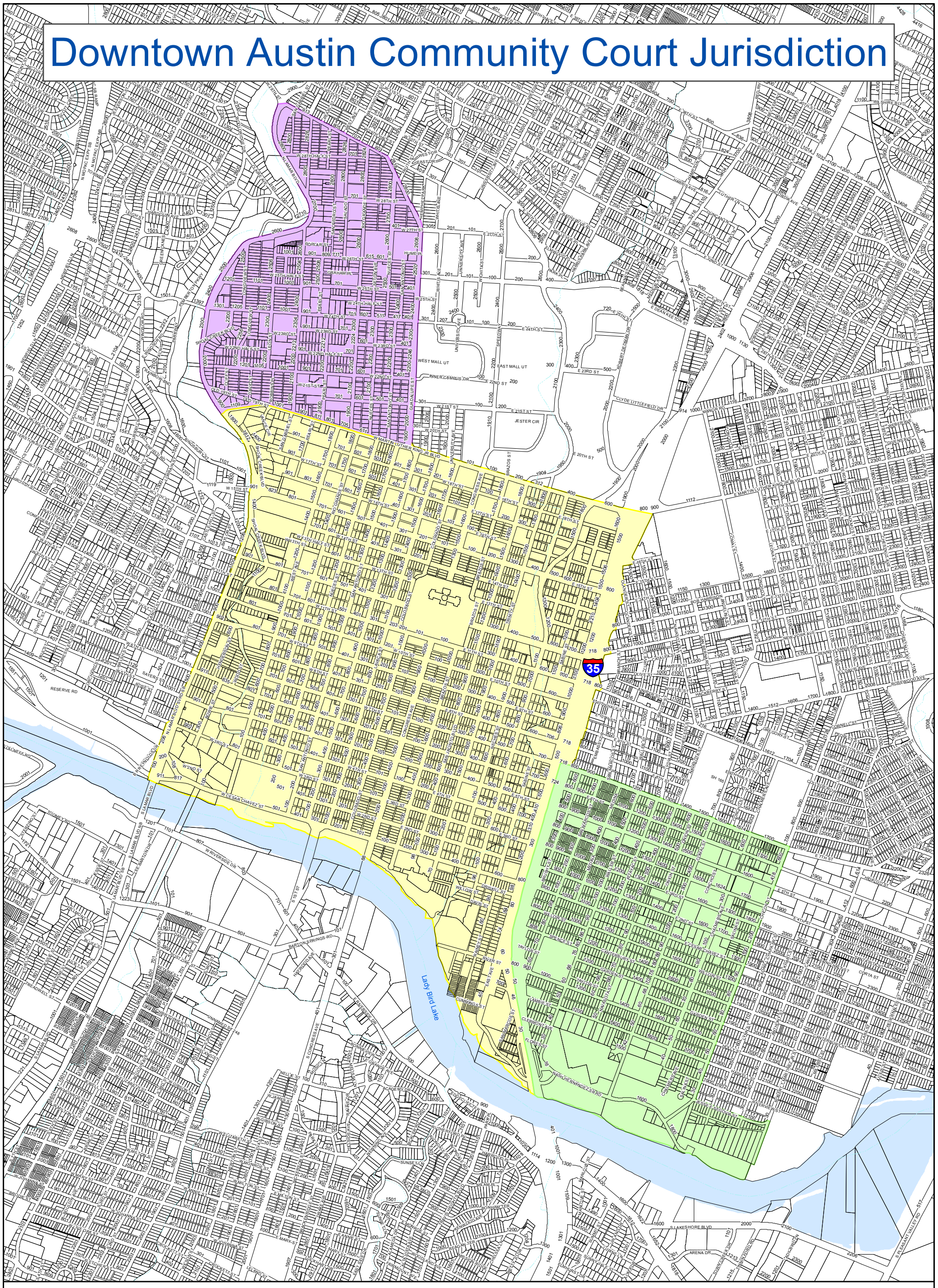
- Support of City Manager Marc Ott and Assistant City Manager Michael McDonald
- Membership in ECHO (Ending Community Homelessness Coalition)
    - Participation in ECHO Housing Work Group
    - Chairmanship of ECHO 100 Homes vulnerable client housing initiative
- Partnership in ROSC initiative (Recovery Oriented Systems of Care)
    - Participation in ROSC Policy Work Group
- Sharing of Frequent Offender list with Travis County Inside Out program at the state jail, to collaboratively case manage offenders exiting the jail
- Participation in ICC staffings (Indigent Care Collaboration) with medical providers
- Partnership in the ReEntry Roundtable
- Participation in the Community Justice Coalition
- Attendance at the Downtown Austin Alliance Security and Maintenance Committee
- Participation in the Community Consortium for a Travis County BJA grant application
- Participation in the Advisory Committee for a Travis County mental health planning grant application
- Participation in the Behavioral Health Planning Partnership, an issue area group of the Community Action Network (CAN)
- Caritas of Austin
- Foundation Communities, and through that organization partnership with Lone Star Circle of Care
- City of Austin Health and Human Services
- City of Austin Neighborhood Housing and Community Development
- Road to Recovery treatment program operated by Austin Travis County Integral Care and funded by the City of Austin and Travis County
- Austin Travis County Integral Care, including ServicePoint (HMIS)
- Travis County Criminal Justice Planning
- Austin/Travis County Emergency Medical Services
- Austin Police Department District Representatives
- Austin Police Department Downtown Area Command
- Travis County District Attorney's Office

- 5th Street Neighborhood Association
- krimelabb.com
- Center for Court Innovation

CONCLUSION

In the first year of the targeted case management program, court staff members have learned that change is possible for even the most difficult to engage offender. Frequent Offenders who are ready to work toward stability can succeed with the support and advocacy of an intensive case management relationship. Significant barriers exist for this client population, but through its community partnerships the court is working to identify and reduce those barriers. The Downtown Austin Community Court is eager to build on the early success of the program by continuing to engage offenders, adding outreach staff, increasing the court's resources for treatment and housing, and continuing to be a voice in the community to advocate for positive systemic change.

Downtown Austin Community Court Jurisdiction



11-4042

COMMUNITY COURT JURISDICTIONS

- DOWNTOWN
- EAST AUSTIN
- WEST CAMPUS

N

0 430 860 1,720 2,580 3,440 Feet

Produced by:
CTM - Geospatial Data Management & Analysis

February 18, 2011

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EXHIBIT B

List of 160 data gathering points

Measures of client status:

1. Number of distinct individuals contacted
2. Number of distinct individuals who receive income from employment
3. Number of distinct individuals who receive income from SSI/SSDI
4. Number of distinct individuals who receive income from social security
5. Number of distinct individuals who receive income from VA benefits
6. Number of distinct individuals who receive income from any other source
7. Number of distinct individuals with no health insurance coverage
8. Number of distinct individuals with a chronic health condition
9. Number of distinct individuals with MAP card medical coverage
10. Number of distinct individuals with Medicaid or Medicare coverage
11. Number of distinct individuals with VA medical coverage
12. Number of distinct individuals with employer-provided medical coverage
13. Number of distinct individuals with an ATCIC priority population diagnosis (Major Depression,
14. Bipolar, Schizophrenia or Schizoaffective disorders)
15. Number of distinct individuals with an Axis II diagnosis
16. Number of distinct individuals with a substance-related disorder diagnosis
17. Number of distinct individuals with a mental retardation diagnosis
18. Number of distinct individuals with any other mental health diagnosis
19. Number of distinct individuals who are compliant with prescribed mental health medication
20. Number of distinct individuals who are prescribed mental health medication but are non-compliant
21. Number of distinct individuals for whom mental health medication is not prescribed but is needed
22. Number of distinct individuals who receive mental health medication support services
23. Number of distinct individuals with no identifying documents
24. Number of distinct individuals who have a social security card
25. Number of distinct individuals who have a birth certificate
26. Number of distinct individuals who have a voter registration card
27. Number of distinct individuals who have an offender ID
28. Number of distinct individuals who have a service provider ID
29. Number of distinct individuals who have an expired state ID
30. Number of distinct individuals who have a state-issued photo ID

Measures of case management activities completed:

1. Number of direct client contacts
2. Number of attempted client contacts
3. Number of no-show appointments
4. Number of client service plans created
5. Number of client assessments conducted

6. Number of times a client's HMIS profile was created or updated
7. Number of referrals to substance abuse treatment
8. Number of admissions to Project Recovery
9. Number of admissions to Austin Recovery
10. Number of admissions to VA substance abuse treatment
11. Number of admissions to any other substance abuse treatment program
12. Number of program completions for Project Recovery
13. Number of program completions for Austin Recovery
14. Number of program completions for VA substance abuse treatment
15. Number of program completions for any other substance abuse treatment program
16. Number of partial completions of substance abuse treatment
17. For clients who did not complete a full substance abuse treatment program, average number of days completed
18. Number of incomplete substance abuse treatment episodes due to client leaving the program
19. Number of incomplete substance abuse treatment episodes due to the program discharging the client
20. Number of refusals for substance abuse treatment
21. Number of times clients experienced a substance abuse treatment barrier due to lack of timely intake information from ARC
22. Number of times clients experienced a substance abuse treatment barrier due to unavailable medical detox
23. Number of times clients experienced a substance abuse treatment barrier due to being rejected by available providers
24. Number of times clients experienced a substance abuse treatment barrier due to lack of bed space
25. Number of times clients experienced a substance abuse treatment barrier due to insufficient insurance coverage
26. Number of times clients experienced a substance abuse treatment barrier due to any other reason
27. Number of applications to Front Steps PSH
28. Number of applications to Caritas PSH
29. Number of applications to DACC Caritas PSH
30. Number of applications to VA PSH
31. Number of applications to Foundation Communities PSH
32. Number of applications to Green Doors PSH
33. Number of times TCM facilitated a client applying to PSH
34. Number of admissions to Front Steps PSH
35. Number of admissions to Caritas PSH
36. Number of admissions to DACC Caritas PSH
37. Number of admissions to VA PSH
38. Number of admissions to Foundation Communities PSH
39. Number of admissions to Green Doors PSH
40. Number of times TCM facilitated a client gaining PSH
41. Number of admissions to TCHA transitional housing
42. Number of admissions to ARCH case management transitional housing

43. Number of admissions to Salvation Army case management transitional housing
44. Number of admissions to TCHA transitional housing under DACC funding”
45. Number of admissions to any other transitional housing
46. Number of times TCM facilitated a client gaining transitional housing
47. Number of admissions to Housing Authority subsidized housing
48. Number of admissions to property-based Section 8 subsidized housing
49. Number of admissions to Section 8 subsidized housing
50. Number of times TCM facilitated a client gaining subsidized housing
51. Number of admissions to housing with family or paid by family members
52. Number of admissions to a Board and Care home
53. Number of admissions to a nursing home
54. Number of admissions to market-rate housing on personal income
55. Number of admissions to a hotel
56. Number of times TCM facilitated a client gaining any other type of housing
57. Number of times clients experienced a housing barrier due to insufficient income
58. Number of times clients experienced a housing barrier due to money owed to utilities
59. Number of times clients experienced a housing barrier due to criminal background
60. Number of times clients experienced a housing barrier due to an eviction on record
61. Number of times clients experienced a housing barrier due to money owed to a previous property owner
62. Number of times TCM facilitated a client gaining a source of income
63. Number of SSI/SSDI applications completed
64. Number of job search activities completed
65. Number of direct job referrals made by TCMs
66. Number of client connections to Goodwill
67. Number of client connections to Texas Worksource
68. Number of times TCM facilitated a client applying for a source of income.
69. Number of times clients lost income due to benefits being stopped
70. Number of times clients lost income due to losing a job
71. Number of times clients lost income due to any other reason
72. Number of times clients experienced an income barrier due to criminal background
73. Number of times clients experienced an income barrier due to lack of job training/skills/education
74. Number of times clients experienced an income barrier due to lack of proper ID
75. Number of times clients experienced an income barrier due to denial of an SSI/SSDI application
76. Number of times clients experienced an income barrier due to lack of stable contact information
77. Number of times clients experienced an income barrier due to lack of required work attire
78. Number of times clients experienced an income barrier due to lack of transportation
79. Number of times clients experienced an income barrier due to any other reason
80. Number of appointments attended at ARCH clinic
81. Number of appointments attended at Brackenridge clinic
82. Number of appointments attended at William Cannon walk-in clinic
83. Number of appointments attended at VA clinic
84. Number of visits to ER

85. Number of any other medical appointments attended
86. Number of times TCM facilitated a client obtaining medical coverage
87. Number of times TCM facilitated a client obtaining medication for a health condition
88. Number of times clients experienced a medical care barrier due to no available appointments in the next 30 days
89. Number of times clients experienced a medical care barrier due to having ARCH clinic assigned at PCP
90. Number of times clients experienced a medical care barrier due to being unable to afford a co-pay for an appointment or prescription
91. Number of times clients experienced a medical care barrier due to lacking a photo ID needed to be seen at ARCH clinic
92. Number of times TCM facilitated clients obtaining mental health medication
93. Number of client crises due to emotional distress
94. Number of client crises due to client's speech being incoherent
95. Number of client crises due to delusional thought symptoms
96. Number of client crises due to mania symptoms
97. Number of client crises due to paranoia symptoms
98. Number of client crises due to suicidal ideation
99. Number of client crises due to homicidal ideation
100. Number of client crises due to any other psychiatric symptom
101. Number of DACC-initiated interventions by ACT Team
102. Number of DACC-initiated interventions by Rudy Zapata or ACCESS
103. Number of DACC-initiated interventions to accompany client to PES
104. Number of DACC-initiated interventions by MCOT
105. Number of DACC-initiated interventions by Mental Health Deputy
106. Number of DACC-initiated interventions by Crisis Intervention Team
107. Number of times clients obtained an ATCIC intake appointment
108. Number of times clients obtained admission to ATCIC residential treatment
109. Number of times clients obtained counseling services
110. Number of times clients obtained ATCIC case management
111. Number of times clients obtained COPS-D case management
112. Number of times clients obtained services at a day treatment program
113. Number of times TCM facilitated a client obtaining mental health services
114. Number of times clients experienced a mental health care barrier due to a wait at PES longer than 4 hours
115. Number of times clients experienced a mental health care barrier due to being dropped from ATCIC services for a missed appointment
116. Number of times clients experienced a mental health care barrier due to lack of beds for inpatient psychiatric care
117. Number of times clients experienced a mental health care barrier due to lack of insurance to obtain medication
118. Number of times clients experienced a mental health care barrier due to being assigned a lower level of care due to insurance status
119. Number of times clients experienced a mental health care barrier due to no available appointments in the next 30 days

120. Number of times clients experienced a mental health care barrier due to not receiving needed mental health services while in jail
121. Number of times clients experienced any other kind of mental health care barrier
122. Number of times TCM facilitated client obtaining any form of identification
123. Number of times DACC provided clothing to a client
124. Number of times DACC provided toiletries to a client
125. Number of times DACC provided a bus pass to a client
126. Number of times DACC provided food to a client
127. Number of times DACC provided payment for ID documents to a client
128. Number of times clients refused case management services because they were not interested
129. Number of times clients refused case management services because client believes they do not have a problem
130. Number of times clients refused case management services because they are about to leave town
131. Number of times clients refused case management services because they are already engaged in other case management

Definitions:

SSI/SSDI: Social Security Income/Social Security Disability Income
VA: Veteran's Administration
MAP: Medical Assistance Program, healthcare for uninsured residents of Austin/Travis County
ATCIC: Austin-Travis County Integral Care, local public mental health authority
HMIS: Homeless Management Information System
ARC: Austin Recovery, a local non-profit substance abuse treatment facility
Front Steps: A local non-profit organization serving homeless individuals; provides shelter, case management, and housing services
PSH: Permanent Supportive Housing
Caritas: A local non-profit organization serving homeless individuals; provides case management and housing services
DACC: Downtown Austin Community Court
DACC Caritas PSH: Permanent Supportive Housing funded by a grant through which Community Court clients receive rent subsidies and case management from Caritas (program name is Partnership Housing)
Foundation Communities: A local non-profit organization serving homeless individuals; provides housing services
Green Doors: A local non-profit organization serving homeless individuals; provides housing services
TCM: Targeted Case Manager at Community Court
TCHA: The Clean House Austin, a provider of sober transitional living
Board and Care: Group living facility unregulated by any government agency
ARCH: Austin Resource Center for the Homeless, the day service center and men's shelter in downtown Austin operated by Front Steps
PCP: Primary Care Physician
ACT Team: Assertive Community Treatment, a program of Austin Travis County Integral Care

Rudy Zapata or ACCESS: Street outreach program of Austin Travis County Integral Care; Rudy Zapata is a member of this team and is the primary contact for Community Court
PES: Psychiatric Emergency Services, operated by Austin Travis County Integral Care
MCOT: Mobile Crisis Outreach Team, a program of Austin Travis County Integral Care
Mental Health Deputy: Specially-trained officers of the Travis County Sheriff
Crisis Intervention Team: Officers of the TCSO who serve as liaisons to the mental health system
COPS-D: Co-occurring psychiatric and substance disorder