Relationship-based Care Court Diversion

The Relationship-Based Care Court Diversion (RBC) model is an intervention that provides mental health care to people who have difficulty engaging with others and maintaining relationships. The primary clients are homeless adults who have had trouble with the law and have been diverted from the correctional system due to their severe mental illness. The RBC team helps them re-establish social ties and pursue opportunities for a better quality of life. The program incorporates motivational interviewing techniques as well as case management, health education, and relevant support services to encourage clients’ to take an active role in their recovery. The program also is structured to ensure client access to psychiatric and primary health care. RBC has been used in the Citrus Health Network jail diversion program since 2000.

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Population
Adults with severe mental illness who have difficulty forming relationships that causes them to have weak support networks, lack suitable housing, and often have reoccurring trouble with the law.¹

Key Components
In the Citrus Health Network jail diversion program, clients progress through four stages¹:

1. Engagement involving motivational interviewing to set a base for treatment;
2. Stability and commitment;
3. Awakening, at which point clients are moving beyond meeting basic needs; and
4. Growth and differentiation, when clients are ready to assume their place in mainstream society.

Activities progress in the following way²:

1. Engagement phase
   ♦ A trained worker engages with the individual in jail and assesses them to find out what services they will need. This happens within 48 hours of the referral;
   ♦ The client is released to Citrus Health Network and undergoes psychiatric and physical health evaluation within 24 hours;
   ♦ A case manager meets with the client and begins to develop a relationship and develop a service plan with them within 72 hours.

2. Stability and commitment phase
   ♦ The client agrees to the recommended psychiatric and medical treatment;
   ♦ The client participates in 50% of education sessions and searches for permanent housing.

3. Awakening phase
   ♦ The client participates in 80% of education sessions;
   ♦ Is assessed for vocational opportunities or continuing education support;
   ♦ Is discharged from the program to live independently, if this is found to be appropriate for the individual.

4. Growth and differentiation phase
   ♦ The client takes responsibility for psychiatric and medical treatment;
   ♦ Develops a budget and self-management plan;
   ♦ Becomes a peer mentor;
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- Shows evidence of improved social skills;
- Is discharged from the program.

Resources Required/ Feasibility
Human resources required for the program’s treatment team include:

- A community health practitioner;
- Medical professionals, such as a nurse and psychiatrist;
- A case manager; and
- A community health practitioner who relays information about the client to the treatment team.

Post-secondary education is required for these positions. The health practitioner is a master degree in social work or psychology and is licensed. The case manager should have at least 3 years of experience. All members of the treatment team receive training in motivational interviewing and other areas of the RBC program.

Evidence

One evaluation study was found that compared outcomes for homeless adults with mental health issues who were diverted to RBC or to usual care. The RBC group consisted of 151 individuals who were diverted from Florida’s Miami-Dade County jail to the RBC program. The control group consisted of 78 individuals who were diverted to other programs that provided supportive housing in assisted living facilities and psychiatric treatment as usual in community mental health centers. The researchers compared the RBC participants to controls in two ways:

- All 151 individuals diverted to RBC and the control group;
- A sub-group of 78 individuals diverted to RBC who were matched to the control group.

Referrals to the RBC program were based on program location and the preference of the diverted individual. Outcomes included number of arrests in the year before jail diversion and in the year after diversion.

In the year after diversion, individuals who received RBC had significantly fewer arrests compared with the year before they were diverted, while the arrest rate for the control group didn’t change significantly before and after diversion. However, 28% of the RBC group left the program within the
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first 30 days and re-arrest rates varied. Among individuals in the RBC program, re-arrest rates were lower for those who remained longer in the program and had more psychiatric contacts after being diverted.³

In summary, while the RBC-based program showed some success in reducing post-diversion arrest rates, the program participants may not be widely representative because they selected the program, and even with that, 28% dropped out within 30 days. With a non-randomized comparison group, other variables could have contributed to differences in outcomes between the study groups. Other potential outcomes, such as housing retention, were not assessed. Also, the evaluation did not assess whether the intervention was implemented as intended.

Readiness for Replication

Materials and training are available from CHN and include an implementation manual, which costs $30. Training and resources available include¹:

- A two-day, on-site training course at $500 per person with a maximum enrolment of 25 participants plus travel expenses for the trainer;
- A two-day, on-site consultation at $1,500 plus travel expenses; and
- Online training courses provided by Netsmart University, with costs dependent on the type of course.
- Various free resources, including a master set of handouts and phone/email support.

As the training is competency-based, managers are informed when their staff has not been successful in the training tests.¹ All training resources are available through Citrus Health Network. (Sarria, Manuel. Relationship-based Care Model. Message to Kim Karioja. 2013 April 16 [cited April 2013])

Fidelity measures include the involvement of a performance council, manager checklists for program workers and graduation standards for clients. But the Substance Abuse and Mental Health Services Administration (SAMSHA)’s National Registry of Evidence-based Programs and Practices (NREPP) raises questions about the reliability and validity of fidelity tools.¹

For RBC to be successful there needs to be cooperation among existing community services. There is little information available on how to adapt the program to the needs of the local community.
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Information is also lacking on how to set up the health education groups, establish a performance council, and initiate a performance improvement program.¹

Sustainability

RBC may be more effective in agencies that integrate several services (such as primary care, mental health, and housing) because this would allow coordinated access to and monitoring of the services that a client needs to successfully move out of the justice system.¹

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References

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We welcome your feedback!

This summary is one of a number of transition/continuity of care practice summaries developed by EENet and the Performance Measurement and Implementation Research (PMIR) team, which are part of the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH). The purpose is to support the selection of an evidence-informed intervention by Ontario’s Systems Improvement through Service Collaboratives (SISC) initiative. It was designed to give the reader a starting point in understanding the intervention along a number of dimensions.

The intervention summarized in this document was identified through a targeted search of the scholarly and grey literature, and key informant suggestions. The summary was developed from a selected review of reports and journal articles. The evidence review section examined quantitative effectiveness studies only. Other issues, such as acceptability to users and cost effectiveness, are also important to examine but were out of scope to review in the available time frame.

This summary is a living document and the information on which it is based may evolve over time. While great care was taken to prepare this summary, we acknowledge the possibility of human error due to search limitations and rapid timelines. Therefore, we do not warrant that the information contained in this document is fully current, accurate, or complete. If you have any comments or suggestions to improve its content, please contact us at eenet@camh.ca.