MOSH Justice Initiative

Phase 1 Evaluation Report

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Summary

This document sets out the findings from an evaluation of the Mobile Outreach Street Health (MOSH) Justice Initiative. Beginning in April 2022, MOSH began delivering Justice Initiative services to address the needs for primary care experienced by those leaving a correctional facility and re-integrating into community. The services were funded through a grant provided by Coverdale Courtwork Society, and included two key services[1]:

- **Intensive supports** for women-identifying people in two transitional residential settings
- A **transitional primary healthcare clinic** for people who are homeless or street-involved exiting a correctional setting to the Halifax area

The main goal of the Justice Initiative is to improve health and wellness for service users through coordinated inter-system processes and access to health care. Literature on similar initiatives elsewhere consistently indicates that ensuring continuity of health care immediately following release from incarceration is valuable for a range of client outcomes, so the Justice Initiative is grounded in existing evidence.

Evaluation Questions and Data sources

The evaluation of the Justice Initiative addressed four key evaluation questions: Is the overall model feasible? Is the initiative doing what it set out to do? How is the initiative impacting the people accessing these services? And, What gaps or needs remain, beyond what the model currently provides, which could be addressed within this model? The evaluation utilized several key data sources[2], including:

- **Program administrative data** collected directly by Justice Initiative staff from April 2022 to March 2023, related to client engagements
- **Costs related to the Justice Initiative** provided through budget data from MOSH
- **Staff and allied service provider perspectives** collected through interviews and focus groups with MOSH staff and allied service providers (service providers who regularly draw on, or work with, the services offered through the MOSH Justice Initiative)

Key findings

Since its first intake in April 2022 until the end of March 2023, the **Justice Initiative recorded 390 total contacts**, including 53 new client intakes and 347 follow-up appointments with a total of 85 different clients. Of these, **35 clients engaged with the Justice Initiative once** during the time period, and **14 clients accounted for half (195) of all total contacts**. The median number of client contacts during this period was three, but **usage patterns varied substantially** from one visit with no follow-ups to as many as 24 contacts during the 12-month period.

Examining the data collected in line with the evaluation questions, There was broad agreement from all parties that **the Justice Initiative provides value to the local service ecosystem.** The overall **service model appears feasible and valuable** from the perspectives of program staff and allied service providers, and

[1] Coverdale also provided funding for an opioid Safe Supply program, which is being evaluated separately.

[2] There are several limitations to the data used in this project, most notably the absence of client perspectives from the data. These are being collected in another project being conducted by researchers at Saint Mary's University. There are also limits to the program administrative and cost data, set out in greater detail in the evaluation report.

the Justice Initiative is **providing the kinds of services it originally intended** while generally meeting or exceeding expectations of key stakeholders.

The main impact – which should not be understated in its importance – is the **creation of a clear single point of contact** for local service providers that can ensure timely access to medical care for clients leaving a correctional facility. This fills a major gap in service provision in the Halifax area, and staff and allied service providers shared several stories about the benefits of this service for encouraging clients to seek needed health care and for supporting clients' ability to access other needed services. The creation of a single point of contact also regularly saves time and effort for allied service provider staff in navigating health care resources for clients.

In terms of gaps, staff and allied service providers consistently noted ongoing **challenges in developing formalized pre-release planning processes** with correctional facilities, and **the lack of a direct, formalized link** between the Justice Initiative and correctional institutions remains the main gap between the intended model and the actual service model. Staff and allied service providers also felt that the program could be expanded to additional populations in Halifax or elsewhere in the province, such as men in transitional residential setting, and to provide additional services such as opioid agonist therapy (OAT) witnessing. To address these gaps, additional resources and, potentially, policy changes (e.g., in correctional facilities or residential settings) may be needed.

Finally, it appears likely that the model was successful in its first year because it was established in an organization that had prior connections with other service providers and the community. Those connections allow trust to be established between the new point of contact (the nurse), allied service providers, and clients. Expansion of this kind of service to other places in the province or to other populations should be done in careful collaboration with existing ecosystem partners.

Introduction

This document sets out the first evaluation report for the MOSH (Mobile Outreach Street Health) Justice Initiative of the North End Community Health Centre (NECHC) in Halifax, Canada. The document first sets out the background and objectives of the Justice Initiative, followed by a review of the evaluation questions and data sources. The document then provides a brief literature review, examining academic and grey literature on other similar initiatives elsewhere. Following this, the document outlines the results of data analysis on the two main data sources – administrative data provided by MOSH and qualitative data from program staff and allied service providers – and discusses those results in relation to the main evaluation questions.

Background

In December 2021, MOSH received a donation to enhance services for a sub-population through the MOSH Justice Initiative. The MOSH Justice Initiative responds to identified needs and service gaps for people experiencing serious harms related to using opioids and those leaving correctional facilities in Nova Scotia, during their exit from the correctional setting and while they are resettling in the community setting. Specifically, the project aims to address the needs for primary care experienced by those leaving a correctional facility and re-integrating into community as well as to decriminalize addiction. This project is a pilot initiative intended to contribute to an ecology of support for adults involved in the justice system through provision of tailored, harm-reduction primary care health services.

The MOSH Justice Initiative pilots three health services focusing on people in the Halifax region of Nova Scotia who are homeless or street-involved and who use illegal substances or who are leaving correctional settings. These services include:

- **Intensive supports** for women-identifying people in two transitional residential settings (Holly House and Caitlin's Place), with on-site occupational therapy and nursing support for up to 25 beds across the two sites
- A **transitional primary healthcare clinic** for people who are homeless or street-involved exiting a correctional setting to the Halifax area of Nova Scotia, including nurses and physicians providing transitional health services and facilitating access through other clinicians. Services include in-person and virtual care visits, using existing office/clinical space, and with a nurse dedicated to overseeing this program. Limited telephone consultation is also available to support service users, agencies and clinicians outside of the Halifax area
- An opioid **safe supply program**, targeting up to 50 people of all genders who are criminalized for substance use and meet admission criteria will be offered through existing clinical space at the NECHC by existing MOSH physicians.

This evaluation focuses on the first two services (intensive supports and transitional primary care, collectively referred to hereafter as the Justice Initiative), and the safe supply program is being evaluated separately.

The main goal to be achieved through the Justice Initiative is to improve health and wellness for service users through coordinated inter-system processes and access to health care. This will be influenced by meeting the following key project objectives:

1. Establishing three prongs of service delivery

2. Impacting system and process changes for people leaving incarceration, particularly related to transitional health services
3. Positively impacting service users
4. Reducing gaps in people's care as they leave incarceration

This initiative is intended to be both a capacity building effort, expanding on existing services (such as provision of primary care and limited harm reduction prescribing to people who are homeless and street involved in the MOSH program), and also involves the establishment of new service mechanisms, creating a more robust transitional service model for people leaving incarceration.

Evaluation Questions

For this project, there are four key evaluation questions:

- EQ1: Is the overall model feasible?
- EQ2: Is the initiative doing what it set out to do?
- EQ3: How is the initiative impacting the people accessing these services?
- EQ4: What gaps or needs remain, beyond what the model currently provides, which could be addressed within this model?[3]

Each evaluation question involves several sub-questions, which are set out in the below table.

Evaluation questions	Sub-questions
EQ1: Is the model feasible?	Have required stakeholders bought into the model? Are program processes and staffing sufficient to meet the needs of clients? Is there sufficient demand to continue to provide these services after the demonstration phase? Is the program cost justifiable, relative to the level of service provided?
EQ2: Is the initiative doing what it set out to do?	Are the intended clients accessing these services as expected? Are the services being delivered as expected? Have any new services, referral pathways, or unexpected approaches to service delivery emerged? Did the program improve communications between stakeholders? What barriers has the program faced in becoming established as intended? What has helped/facilitated the program in becoming established? What, if any, unintended consequences (positive or negative) occurred as a result of this initiative?
EQ3: How is this initiative impacting the people accessing these services?	In what ways does the program improve the quality of life for clients? In what ways does the program create new challenges or negative experiences for clients?
EQ4: What gaps or needs remain, beyond what the model currently provides, which could be addressed within this model?	Are there additional service components that could be added to provide more-complete primary care access to intended clients? What additional supports might be needed to expand some or all aspects of this program to others (e.g. intensive residential support men-identifying people; people outside of the Halifax area)? Is there sufficient demand to increase service levels to serve a greater number of clients?

Data sources

The following data sources are used within this evaluation:

- **Program administrative data** collected directly by the program, related to client engagements. These were collected through the Electronic Medical Record (EMR) for each client, which is

[3] It will be important to ensure that, while the evaluation examines gaps related to a robust transitional health service model, the initiative avoids 'mission creep' by seeking to address a wider set of gaps in social services, at least in early stages of implementation.

maintained by physicians and staff associated with the Justice Initiative. For new clients, an Intake form is completed on entry into the Justice Initiative, and for subsequent Justice Initiative visits, a follow-up appointment form is completed by program staff. Data points collected through the EMR intake and follow-up forms include the following:
    - Demographic data relating to clients
    - Data relating to client visits with service components, such as reason for visit and referral information
    - Dates of referrals from the allied service provider to Justice Initiative services
    - Reason(s) for referral(s)
    - Client wellbeing indicators, e.g., changes in housing status, employment status, unmet needs
- **Costs related to the Justice Initiative** provided through budget data from MOSH
- **Staff and allied service provider perspectives** collected through interviews and focus groups with MOSH staff and allied service providers (service providers who regularly draw on, or work with, the services offered through the MOSH Justice Initiative).

The EMR data template and examples of interview and focus group guides can be found in the Appendix to this report.

Limitations

This evaluation is a first step in understanding the viability and effectiveness of the MOSH Justice Initiative. It provides information that should aid decision-making for future program management and resource allocation to continue to support individuals' medical care as they leave correctional facilities in Nova Scotia. It may also provide the basis for future analysis of impact of the MOSH Justice Initiative on desired outcomes, such as improved health, mental well-being, stable housing and employment, and reduced re-contact with the criminal justice system for Justice Initiative clients.

However, it is important to recognize that this evaluation is unable to make causal claims regarding the effectiveness or impact of Justice Initiative services. This is both due to timeline – as the Justice Initiative has just completed its first year of service – and data – as there is insufficient data on clients or availability of control group data – to conduct pre-post or experimental analysis. This could be a goal for future evaluations.

Additionally, it is important to recognize that this evaluation does not include perspectives of Justice Initiative clients, so the perspectives set out in the results are based primarily on program staff and affiliated providers. Another research project, being conducted by colleagues at Saint Mary's University, is gathering data on client narrative experiences, which should help to address this gap, but that data is not available at the time of reporting.

Finally, there are some important limitations to the EMR dataset as a source of data on client contacts. Many of the Justice Initiative clients had previously engaged with MOSH for other services, and continue to engage with other services offered by the NECHC. Additionally, Justice Initiative nursing staff regularly support other NECHC activities, which may include supports to Justice Initiative clients. In turn, there is likely a substantial amount of missing data from both the intake and follow-up form dataset, and it is hard to estimate the scope of the missing data at this stage. Developing more complete data will be important for future evaluation.

Literature Review

The MOSH Justice Initiative responds to identified needs in the local Halifax context, and is also grounded in existing evidence regarding effective interventions to improve health outcomes for people leaving incarceration. The following brief review of literature relating to similar initiatives elsewhere provides an overview of the evidence base supporting this kind of program, as well as key strategies for implementation that have been used elsewhere.

Literature consistently demonstrates that people released from correctional facilities typically have much greater health needs than the general population, which includes mental illness, chronic illness, infectious disease, and mortality (Faizel & Baillargeon 2011). This population also experiences more pronounced barriers to accessing care, including health literacy, access to transportation, and discrimination (Malebranche et al. 2020; McLuhan et al. 2023; Fahmy et al. 2015; Kinner et al. 2016). Further, research has demonstrated that other needs commonly experienced in prisoner re-entry, such as finding housing and employment, often overshadow and delay one's pursuit of healthcare (Shavit et al. 2017). However, in the weeks directly following release individuals are at a greater risk for morbidity and mortality (Hu et al 2020); in the United States, the two weeks following release represent a risk of death 12 times greater than that of the general population (Binswanger et al. 2007, as cited in Fox et al 2014). As such, initiatives that address the health needs of this population are of vital importance.

There are several programs in the United States and Canada designed specifically to address 'behavioural' health needs, which includes mental health and substance abuse treatment, immediately before or after release from prison (Watson et al. 2022; Kendall et al 2018; Kouyoumdjian et al. 2015; Public Safety Canada 2022). These programs are often targeted at those experiencing the most acute needs, who are more likely to be reincarcerated (Blank et al. 2014, as cited in Kendall et al. 2018). There is no mention of non-behavioural health needs on the Government of Canada's prisoner reintegration report (Public Safety Canada 2022). As all of those who have experienced incarceration are likely to have increased health needs and barriers to addressing them, particularly concerning continuity of prescription medications (Hu et al 2020), there is a need for programming, like MOSH justice, that is available to all formerly incarcerated individuals. Beyond promoting health equity, such initiatives also address barriers to employment and community participation posed by poor health, likewise reducing reincarceration (Link, Ward, & Stansfield 2018). Whilst many such programs exist in the United States, they are few and far between in Canada.

In the United States, prisoners re-entering the community face the additional barrier of access to medical insurance, which is not a common hurdle in Canada. America has a diffuse Transitions Clinic Network (TCN) with 48 locations across 14 states and Puerto Rico (Transitions Clinic 2023), for which one of the main objectives is to help releasees apply for and access Medicaid (Shavit et al. 2017). Similar but unaffiliated initiatives also exist, including one run by the John Howard Society of Toronto (McLuhan et al. 2023). Analyzing these programs reveals the importance of critical time intervention, in-reach, peer support, and motivational interviewing, though engagement and retention remain challenging.

Critical time intervention (CTI) refers to the ability for programs to engage individuals within the first two weeks of their release, which represent heightened risk for morbidity and mortality (Fox et al. 2014; Kinner et al. 2016; Held et al. 2012). In-reach is a common strategy for ensuring CTI that engages individuals in counselling and planning before their release, which eases the transition from prison to community as appointments and relationships with health workers are already made (Miller & Miller 2010). Though the

TCN recognizes the importance of in-reach for early engagement and continuity of care, particularly continuity of medications, there are barriers posed by corrections and medicaid that make it difficult to do so (Aminawung et al. 2021; Shavit et al. 2017; Wang et al. 2012). When in-reach is not possible, early intervention strategies like meeting individuals at mandatory parole meetings (Wang et al. 2012) or providing information pamphlets and weekly phone calls (Kinner et al. 2016) have also been used successfully, though these methods fail to reach all individuals.

Another engagement strategy is physical proximity; The John Howard Society service hub is located in the immediate vicinity of the Toronto South Detention Center, and provides a wide range of services and resources (McLuhan et al. 2023). Though no medical services are provided on-site, the service hub evaluates the needs and goals of clients and gives them referrals to services they require. The most robust engagement strategy, however, is that used by Healthcare for the Homeless Houston (HHH), which combines in-reach and physical proximity (Held et al. 2012). Case-workers with HHH create release plans with clients, and offer to walk with them to their appointment at the health center on the day of their release (Held et al. 2012). These strategies promote continuity of care, ensure that health needs are not overlooked, alleviate fears of discrimination in medical settings through relationship building, and may also provide opportunities for referral to other services.

Another key strategy for engagement and retention is the use of formerly incarcerated peer support workers who engage in strengths-based motivational interviewing. The TCN trains formerly incarcerated community health workers (CHWs) to help clients navigate the healthcare system, and access other services such as housing and employment (Aminawung et al. 2021; Shavit et al. 2017; Wang et al. 2012). Peer support workers are vitally important to engagement, retention, and reintegration outcomes, as these workers facilitate judgement-free interactions, and understand the needs of and barriers faced by their patients (Aminawung et al. 2021; McLuhan et al. 2023). Each of the aforementioned initiatives uses motivational interviewing, or similar strengths-based motivation to encourage autonomy and illness self-management. Hunter et al. (2016) recognize that focusing on personal deficits that are thought to be the cause of one's illnesses is not constructive. Rather, these authors stress the importance of setting goals and making plans to attain them, as well as motivating and empowering individuals to take control of their own health through promotion of health literacy and help with system navigation (Hunter et al. 2016).

Overall, these methods have led to increased CTI (Fox et al. 2014; Held et al. 2012), decreased emergency department visits and hospitalizations (Shavit et al. 2017), and expressions of patient satisfaction (McLuhan et al. 2023; Thomas et al. 2019). However, much of the literature expresses a need for greater collaboration between the prison and community organizations, as in-reach is important for CTI, and there is often difficulty in accessing correctional health records (McLuhan et al. 2023; Aminawung et al. 2021; Shavit et al. 2017; Wang et al. 2012). Additionally, there remain barriers to engaging those on remand or with very short sentences, as there is little opportunity for in-reach, and prisoners may be released with little or no notice (Miller & Miller 2010; Kinner et al. 2016).

Results

The evaluation conducted two focus groups with MOSH Justice Initiative staff and seven interviews with staff from allied service providers. The evaluation also reviewed administrative data from 390 EMR records from intake and follow-up visits from April 2022-March 2023, as well as budget data provided by NECHC.

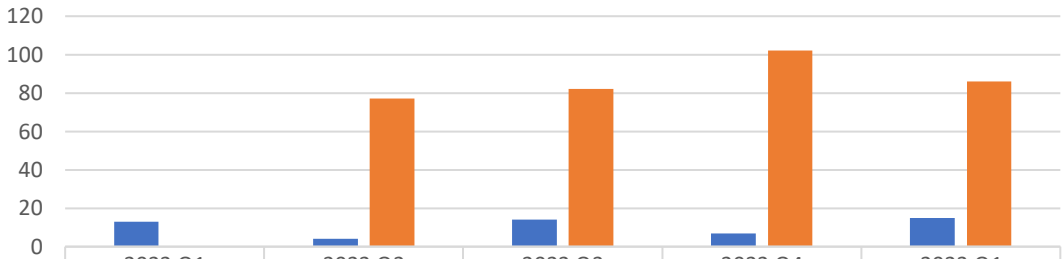
The following is based on quantitative analysis of administrative and cost data and qualitative analysis of interview and focus group data, supplemented where necessary by discussions with program staff to clarify interpretations of data collected by the evaluation.

Overview of administrative data

EMR data

Since its first intake in April 2022[4] until the end of March 2023, the Justice Initiative recorded 390 total contacts, including 53 new client intakes and 347 follow-up appointments with a total of 85 different clients. A breakdown of intake and follow-up appointments by quarter is set out in Figure 1.

Fig. 1: Intakes and follow-ups by quarter



	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1
Intakes	13	4	14	7	15
Follow-ups		77	82	102	86

Of these, 35 clients engaged with the Justice Initiative once during the time period, and 14 clients accounted for half (195) of all total contacts. The median number of client contacts during this period was three, but usage patterns varied substantially from one visit with no follow-ups to as many as 24 contacts during the 12-month period.[5]

[4] It is worth recognizing that the kinds of services provided by the Justice Initiative were previously provided by MOSH through other outreach mechanisms, so April 2022 marks the first time an intake or follow-up visit was specifically identified as a Justice Initiative client visit, but not the first time MOSH provided transitional health care support to someone leaving incarceration.

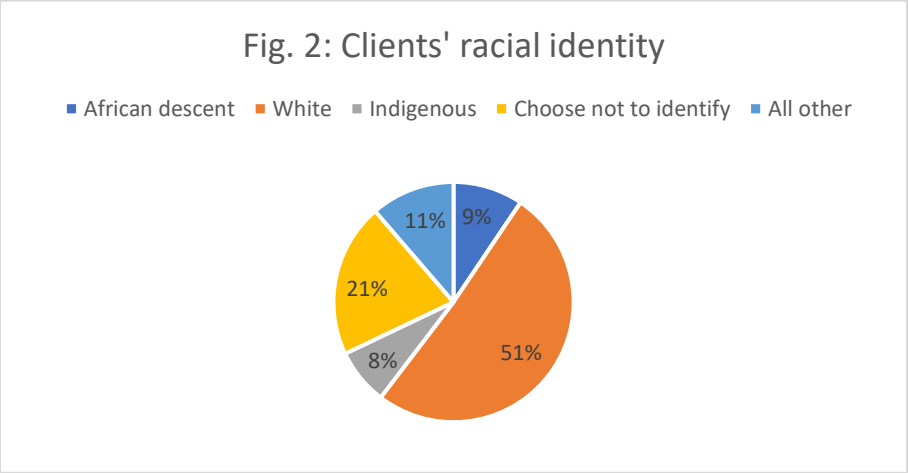
[5] There were several data collection challenges relating to linking intake forms to follow-up forms; for example, data collection processes were complicated in instances where Justice Initiative clients had pre-existing records with MOSH or were simultaneously receiving other MOSH services. As a result, data analysis at this stage does not merge key client information from intake forms (such as employment or housing status on intake) with equivalent data in follow-up forms, but such analysis could be conducted in the future if data collection processes are adapted to ensure intake data for all Justice Initiative clients.

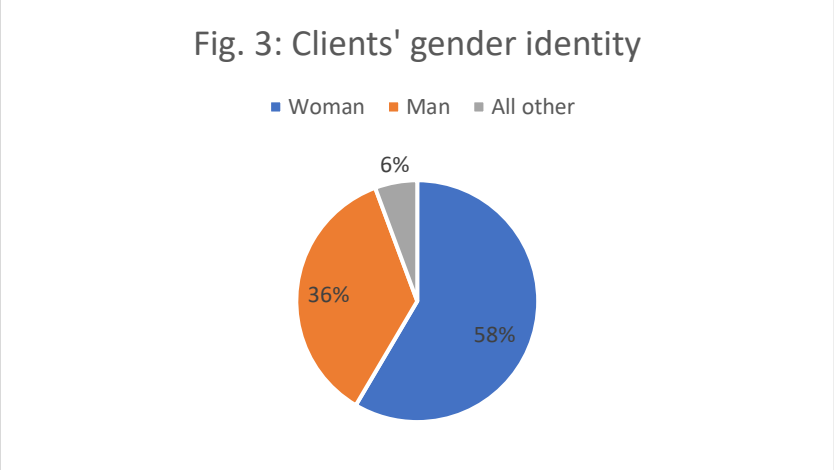
Intake data

Demographic data

The Intake form included key demographic information such as age (birth date), racial identity, and gender. Of those clients who completed an intake form, the average age was 34 years, with an age range from 21 years to 62 years. Just over half (27 of 53, 51%) identified as White, with five clients identifying as having African descent, four identifying as Indigenous, six identifying as having an Other racial identity (including mixed racial identities), and 11 choosing not to identify.

The majority of clients in the Justice Initiative identify as women, owing to the Justice Initiative's engagement with two residential facilities serving women-identifying people. 31 (58%) of 53 clients for whom intake form were completed were listed as women, with 19 (36%) identifying as men, and three (6%) providing no gender identify or another gender identity. Racial and gender identity data are presented in Figures 2 and 3.

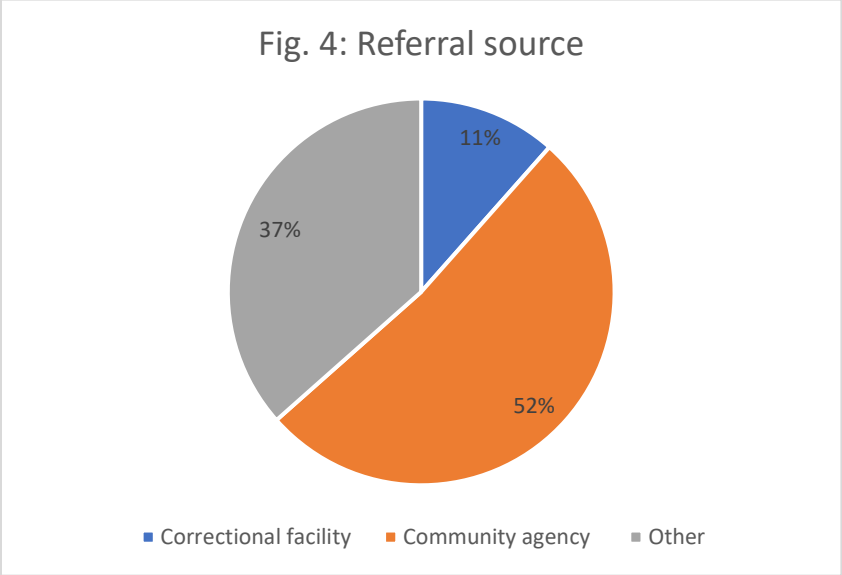




Referral pathways and service locations

Just over half of clients (27 of 53, 52%) were referred from community agencies such as Elizabeth Fry Society, Coverdale, and John Howard Society, reinforcing the importance of that referral pathway. Six (11%) were referred from a correctional facility, while the remaining 19 (37%) either did not have a referral

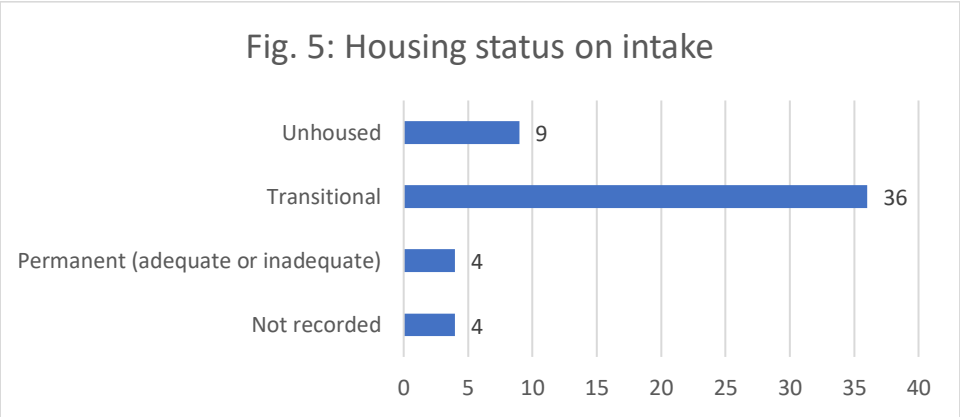
pathway recorded, were already clients of NEHCH or MOSH, or self-referred to the program. Referral pathways are presented in Figure 4.

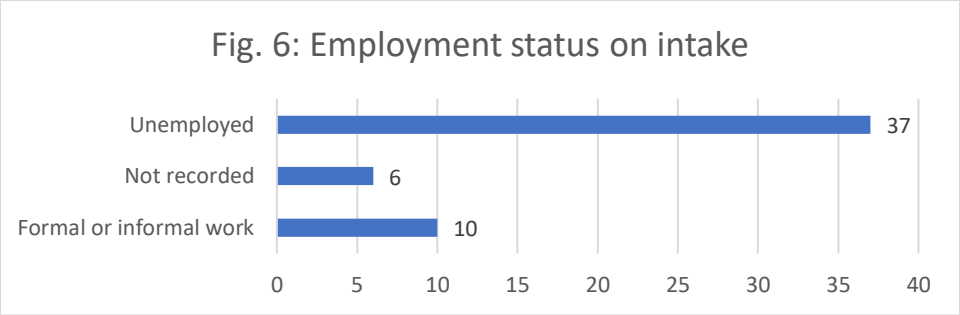


Client intake occurred at a range of locations, with relatively even proportions at NECHC (16 of 53 clients), at a transitional house (13), at a community or other location (9), or by phone/virtual appointment (11).

Housing and employment status on intake

Of the 49 individuals who provided information on housing status on intake, the majority (36) were in transitional housing, with 9 individuals who were unhoused, and 4 individuals who were in permanent housing. Of the 47 individuals who provided information on employment status on intake, most were unemployed (37 individuals), with ten in either informal or formal employment. Housing status and Employment status on intake are presented in Figure 5 and Figure 6, respectively.





Follow-up data

Demographic data

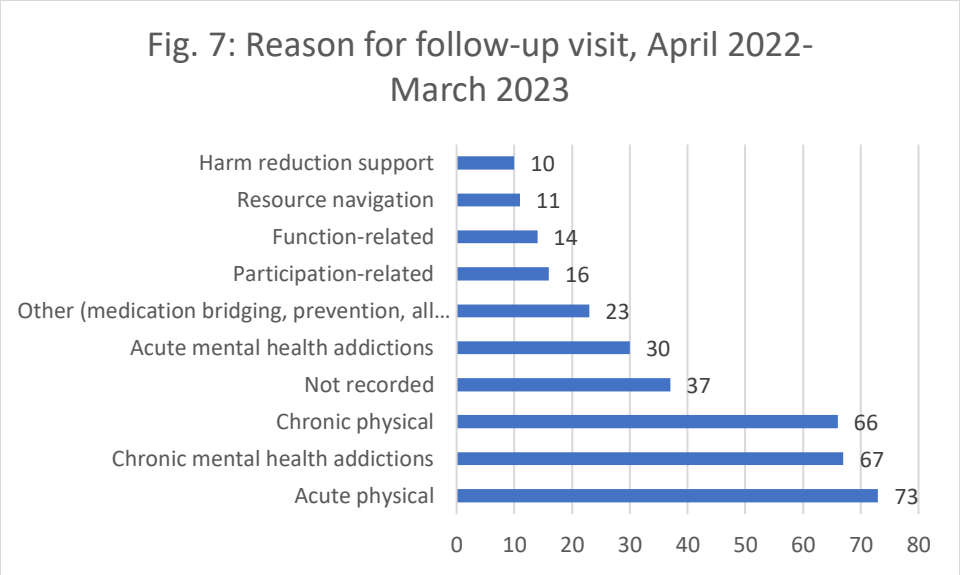
Demographic data in the follow-up dataset were similar to data in the intake dataset. In terms of recorded sex, there were 36 clients identifying as women, 17 identifying as men, and six clients for whom an Other or Unknown gender was recorded. Ages for clients accessing follow-up visits averaged 34 years old, with the youngest client at 21 years and the oldest at 62 years old. Racial identity data was not recorded at follow-up visits.

Services received

RN services (122 visits; 52 residential and 70 in the transitional clinic) and prescriber services (136 visits in clinic or by phone/virtual) comprised the majority of all visits. The balance of visits were for OT services (45 visits), and other services including visits that involved more than one service (e.g. RN and Prescriber services). 29 visits did not have a service recorded. Services provided are set out in Table 1.

Table 1: Service provided at visit	**Count**
OT	45
All other	15
Prescriber	136
RN	122
RN Residential	*52*
RN Transitional	*70*
Not recorded	29
Grand Total	**347**

Reasons for follow-up visits (Fig. 7) included management of chronic and acute conditions (mental health, addictions, and physical health), which accounted for the majority of reasons for client visits (266 of 347 visits), including 103 visits for acute conditions (30 mental health and addictions; 73 physical conditions) and 133 visits for chronic conditions (67 mental health and addictions; 66 physical conditions). Clients also accessed the Justice Initiative for function-related (14) and participation-related (16) supports provided by the OT, as well as a range of other needs including resource navigation, medication bridging, and preventative treatments.



Visits took place in clinic, in community, in residential (transitional house) settings, and by phone/virtual appointment. Distribution of visit locations can be found in table 2.

Table 2: Location of visit	**Count**
Community/Outreach Location	44
NECHC Clinic	121
Multiple locations recorded	5
Phone/Virtual	50
Transitional House	92
(blank)	35
Grand Total	**347**

Changes in housing, employment, or criminal justice involvement

Of 53 individuals for whom housing status was recorded during follow-up visits, 14 of them experienced changes in housing status while receiving services from the Justice Initiative. Of these, five recorded a move from a transitional housing to being unhoused, while four recorded a move from being unhoused to being housed either permanently or in a transitional setting.

Of the remaining 39 individuals for whom housing status was recorded, five reported permanent adequate housing; two reported permanent, inadequate housing, 25 reported transitional housing, and six reported being unhoused.

47 individuals provided information about re-involvement with the criminal justice system. Of these, 35 indicated that they had no re-involvement with the criminal justice system since their most recent release, while 12 indicated that they had some re-involvement.

49 individuals provided information about employment status during follow-up visits. Of those, 30 reported that they were unemployed, five reported formal employment, six reported informal

employment, and eight reported a change in employment status between follow-up visits (either having gained or lost employment as of their most recent visit).

Activities not captured by EMR data

The data collected represents the number of intakes and follow-up visits charted in the electronic medical records and is not fully representative of the reach of this initiative. This evaluation sought to understand additional work completed as part of the Justice Initiative, but not captured through EMR. Correspondence with project staff suggests that additional activities undertaken through the Justice Initiative include:

- **Consultation to allied service providers** including front-line staff at other community-based services, staff at institutions (hospital and carceral settings), and other referral sources, to raise awareness about the Justice Initiative, and to advise allied service providers to provide direct service to a client, and to build health literacy capacity in general.
- **Case management**, including indirect care activities such as obtaining medical records, advocating for client health funding, locating clients, reminding clients and staff of appointments, and anticipating and overcoming barriers to accessing care (related to conditions, transportation, health, etc.)
- **Brief client support** that did not warrant intake (e.g., navigating release by bridging medications and connecting with prescriber for client who had their own physician; providing wound care, for someone who presented to the outreach van who was recently released but not requesting follow-up, etc.).
- **System-level work** such as engaging with other service providers around common concerns raised by residential sites or identified across multiple client groups (e.g. access to daily-dispense medications when on house arrest; communication from carceral setting to community).

Initiative costs

The funding for this initiative was drawn from a $250,000 grant, with some of the grant funding supporting the residential support and transitional primary care activities evaluated in this report, and with the balance of the grant supporting the third element of the MOSH Justice Initiative, the Safe Supply initiative, not evaluated in this report. Because of several factors (including mid-year staffing changes, limits to documentation within the MOSH budgeting process, and mutual staff support between the Justice Initiative and other MOSH activities), it is not possible to precisely identify the costs associated with the Justice Initiative. However, the following estimates provide a good indication of the overall magnitude and distribution of costs, based on budget documents and discussions with staff.

The first-year cost of the Justice Initiative was approximately $160,000. This is primarily driven by wage costs for the nurse (at 1.0 Full-time Equivalent [FTE]) and Occupational Therapist (at 0.3 FTE), as well as management support at 0.1 FTE. These costs accounted for approximately $130,000 of the total initiative cost, with administrative, overhead, and materials accounting for the remaining approximately $30,000 in costs. MOSH also provided in-kind contributions of physician time to the Justice Initiative, at nine hours per week, valued at approximately $150 per hour, equivalent to just over $70,000 in in-kind contributions for the year. This amounts to just over $13,300 per month in direct costs, and approximately $19,670 in total direct and in-kind costs per month to operate the program.

Staff and Allied Service Provider perspectives

MOSH program staff and allied service providers shared a consistent message in interviews and focus groups, expressing broad support for the Justice Initiative services and the belief that the Justice Initiative is doing what it set out to do.

Discussions with allied service providers indicate that there is broad support for this initiative within the local ecosystem. Service providers who gave interviews for this evaluation suggested that the kinds of supports offered by the Justice Initiative have been clearly communicated, can be accessed as expected (i.e., through the Justice Initiative nurse), and are provided in a timely manner. Most importantly, the services within this initiative are new to the ecosystem and clearly filling a gap, and, based on the data gathered for this evaluation, appear to be adding value without introducing new burdens to clients or service providers.

Allied service providers indicated that having a single contact person who could help navigate medical support immediately upon release also served a valuable function for staff and clients. Based on discussions with allied service providers, there are several ways in which the Justice Initiative is perceived to be contributing to the local ecosystem of support in the ways originally intended. Having a single point of contact was widely perceived as time- and effort-saving for allied service provider staff, who previously would have had to make multiple calls to navigate health care resources for new clients. Additional, having a known and trusted point of contact for clients through the Justice Initiative was perceived by allied service providers as helpful in certain cases where clients mistrust the healthcare system. Allied service providers have indicated that the Justice Initiative staff have in several cases succeeded in encouraging reticent clients to access necessary care.

Program staff and allied service providers consistently indicated a need for better coordination from correctional facilities regarding the release process. As indicated above, in most instances, clients are referred to the Justice Initiative by sources other than a correctional facility, and it was regularly asserted by interview and focus group participants that efforts to coordinate with provincial Correctional Services had not been successful. A lack of a clear point of contact within Correctional Services was also noted as an ongoing challenge, and the recent establishment of a health social worker role within Correctional Services was seen as a positive development that, ideally in future, could provide the kinds of connections needed for a more collaborative pre-release planning process.

Program staff also noted some limits to their ability to provide services in locations where there was not an appropriate physical space where clients could be met confidentially, and noted that it was important to ensure allied service providers' policies allowed the kinds of services available through the Justice Initiative.

Several allied service providers indicated that the Justice Initiative created a challenge for them in relation to their own clients, where some clients who fit the inclusion criteria are allowed to access the Justice Initiative services (especially prescriber services), while others are not allowed to access those services (for example, because they already have access to a GP). In these cases, allied service providers indicated that clients can become jealous of the quality, convenience and regularity of care through the Justice Initiative, when compared to the care they are receiving through other healthcare providers.

Allied service providers also indicated that there is sometimes uncertainty among providers as to where MOSH Justice Initiative services end and other services begin, and this issue was also recognized by

program staff. A general perception exists that there is 'one MOSH' that now also includes a nurse and OT dedicated to post-incarceration support, rather than a set of distinct programs. This perception may also transfer to clients who have prior interactions with MOSH, and may not know when they are receiving 'Justice Initiative' services or other MOSH services. For example, the Justice Initiative nurse also works on the outreach bus, and Justice Initiative clients had accessed her through the bus as well as through Justice Initiative clinic time. This state of affairs is not necessarily negative or positive for service delivery effectiveness, but remains something to be aware of going forward.

A more minor issue identified by allied service providers and program staff relates to early confusion about what services the OT could provide. This resulted in instances where clients asked the OT to do inappropriate things (such as clean up their living space), or expecting more attention and direct or ongoing assistance than is appropriate for an OT to provide.

While allied service providers did not have data available to share to demonstrate the impact of the Justice Initiative, one provider suggested that the availability of transitional medical care for non-residential clients had increased their retention of clients (i.e., had increased the regularity with which clients accessed other services provided by the allied service provider). MOSH staff also provided anecdotes about clients who have attributed positive outcomes (such as staying out of jail, and improved ability to manage health conditions) to their contact with Justice Initiative services. Further research into this potential effect on client outcomes would be valuable in future stages of the evaluation.

Allied service providers and program staff also indicated ongoing challenges regarding the role of the Justice Initiative in supporting the delivery of opioid agonist therapies (OAT) in residential sites. Several justice initiative clients use OAT, and provincial policies require that OAT doses be witnessed by a pharmacist technician, meaning clients need to leave the residential setting to use OAT. While it is outside of the scope of the Justice Initiative to change provincial policy, finding a way to allow clients to ingest OAT within residential settings (possibly facilitated by Justice Initiative resources) was mentioned by several participants.

Lastly, allied service providers and program staff both felt that the kinds of services provided by the Justice Initiative could be usefully expanded to other clients, such as men in transitional residential settings, and to other areas of the province.

Discussion

The discussion is organized in line with the main research questions of the evaluation. To review, these are:

- EQ1: Is the overall model feasible?
- EQ2: Is the initiative doing what it set out to do?
- EQ3: How is the initiative impacting the people accessing these services?
- EQ4: What gaps or needs remain, beyond what the model currently provides, which could be addressed within this model?

It is important to interpret this discussion section in light of the caveats set out earlier in the evaluation report, and particularly with regard to the lack of data at this stage regarding client perceptions. Knowing more about how clients are experiencing these services will be necessary as the Justice Initiative matures within the broader service ecosystem.

Is the model feasible?

The service model of the Justice Initiative appears to be feasible. Key community stakeholders – specifically, allied service providers – have bought into the model, and demand for Justice Initiative services remains steady. Services have been delivered to clients as expected when the model was initially designed, and allied service providers clearly find the services valuable. Additionally, the introduction of the Justice Initiative does not appear to have de-stabilized or negatively impacted the delivery of any other services in the local service ecosystem.

A key challenge remains in establishing direct, formal and consistent links between correctional facilities and Justice Initiative services, to allow for better pre-release planning and transitions. The service delivery model does not rely on this pathway; the data reviewed for this evaluation demonstrate strong links between MOSH, allied service providers, and clients. However, the model was initially intended to involve a more direct link with correctional facilities, and these kinds of links are identified in the literature as important for ensuring critical time intervention (i.e., engagement with clients within two weeks of release). In turn, establishing this pathway in line with the original intention of the model remains a priority.

As noted earlier, the precise costs for the Justice Initiative cannot be calculated at a total or per-service (e.g., per nursing visit) level at this stage. Rather, it seems appropriate to understand the Initiative as providing direct support to approximately 85 individuals leaving a correctional facility during a critical time in their pathway out of incarceration, while also providing broader healthcare navigation supports for allied service providers. Whether the cost –in the area of $13,300 per month – is appropriate to the service level cannot be determined by this evaluation, but could be assessed in future evaluation.

Is the initiative doing what it set out to do?

Overall, the Justice Initiative appears to be providing most of the supports it intended to when it was established. The Justice Initiative seeks to provide transitional medical care for people who have recently left a correctional facility, and administrative data demonstrate that the clients who are receiving Justice Initiative services are the kinds of clients originally intended for the service model, with the bulk of nursing and all of the OT services being delivered to women-identifying people in transitional residential settings.

Clients access MOSH justice for a range of needs, including care for acute and chronic conditions, support in accessing medications, and health system navigation.

Allied service providers indicated that the Justice Initiative has, in its first year, generally met or exceeded their expectations. As noted above, the initiative has not been able to establish a consistent or formal link with correctional facilities, and this remains the main missing component regarding the Justice Initiative delivering services as intended.

How is this initiative impacting the people accessing these services?

Perhaps most importantly, the Justice Initiative provides a service that was not available prior to its establishment. While MOSH, several allied service providers, and corrections staff had previously made efforts to provide medical support to people leaving correctional facilities, the results of these efforts were inconsistent, which could lead to people not receiving essential health care and related supports immediately following release from incarceration. The inconsistency appears to have been at least in part due to the prior lack of a single centre of responsibility for coordinating transitional health care. Allied service providers described the Justice Initiative, and in particular the coordinating functions provided by the nurse, as vital in securing positive outcomes for clients, such as reduced wait times and supporting system navigation.

Further, especially for residential clients, having convenient access to medical supports can be particularly important for overcoming challenges – such as house arrest, and limited mobility – that could impede timely medical care during the post-incarceration transition. While firm data was not available to support this assertion, several allied service providers confidently indicated that timely access to health care has improved their client retention rates and succeeded in encouraging clients to seek medical care that they otherwise may have avoided.

Additionally, having OT support in the residential settings has been perceived as positive in helping clients learn to more independently care for themselves. While there were some challenges identified relating to how OT services were understood by clients, the inclusion of an OT role is a unique feature in the Justice Initiative, and was not something that appears to be common in the wider literature on similar programs. The relative benefits of the OT service within the wider Justice Initiative could be explored more directly in future evaluation.

What gaps or needs remain?

The Justice Initiative has faced two main challenges. First, due to an unavoidable change in staffing mid-year for the MOSH Justice nurse, the nurse position went from full-time to part-time, which reduced the availability of nursing support, and in particular reduced the ability of the Justice Initiative nurse to undertake proactive activities such as outreach to clients to ensure they attend necessary appointments. However, this is a temporary issue and did not substantially disrupt the core functions of the Justice Initiative, as the part-time nurse is still able to provide reasonably timely, predictable, and single-point-of-contact support for clients and allied service providers.

The second main challenge is structural in nature, and somewhat out of the control of MOSH staff. As noted several times above, MOSH staff and allied service providers indicated that the Justice Initiative has faced difficulties in establishing pre-release contact with potential clients. While contacts have been made with correctional staff to attempt to improve awareness about the Justice Initiative, and allied service providers have in some instances been made aware of a client's needs prior to release (which allows them

to make advance contact with the Justice Initiative nurse), there is not a consistent approach to release that ensures that medical information is effectively transferred and supports are in place on the day of release. This is in part due to the sometimes unpredictable release process, where release dates are not always known in advance. [note importance of establishment of a relatively new Health Social Worker role in the Burnside facility – could be leveraged as a key point of contact]

The Justice Initiative could also potentially be improved by finding additional ways to support witnessing of OAT doses, and by broadening support to other populations, such as men in residential settings and working with other transitional houses in the municipality. However, additional services would require additional staff and, in the case of OAT witnessing, could require changes to provincial policies or policies in residential settings. Those changes, like better coordination with correctional facilities, are outside of the control of MOSH and would need to be pursued in collaboration with government and community partners.

Conclusion

The MOSH Justice Initiative has established a new service that appears to be feasible and providing value to the care ecosystem surrounding people who are leaving correctional settings and in need of transitional or intensive health care and related supports. Based on the data gathered for this evaluation, there appears to be strong demand for the services provided through the Justice Initiative, and the Justice Initiative services fill a gap in a way that integrates well with allied service providers' service delivery models.

The central value of the Justice Initiative, at this stage, appears to be the establishment of a single point of contact through which allied service providers can connect their clients to medical care after leaving a correctional facility. While this evaluation cannot determine actual impact on short- or long-term outcomes for clients, the data collected by this evaluation – in line with prior literature on similar initiatives elsewhere – suggests that the Justice Initiative offers a valuable service through which clients' stabilization is supported post-incarceration. Clients are supported by reducing the time and complications involved with finding medical support, and by providing additional supports such as occupational therapy, which can assist in re-integration and wellbeing.

As the Justice Initiative services have now received financial support from the provincial government for the 2023-24 fiscal year, a key goal for MOSH, allied service providers, and the government should be to establish a consistent process for connection to appropriate services before and during the release process. This would, wherever possible, involve pre-release planning between the Justice Initiative services, correctional facilities, and allied service providers.

Additionally, from a research and evaluation perspective, it could be valuable to measure impact from the Justice Initiative services over time, to determine the impact of these services on clients' pathways after incarceration. However, this would require substantial advancements in internal data quality as well as access to other (e.g., provincial health and correctional) data, and challenges of attribution (e.g., demonstrating the specific role of the Justice Initiative in certain outcomes) may remain with better data. Given the known challenges related to data collection, it may be more efficient – depending on availability of evaluation and data collection resources – to focus on smaller-scale targeted studies of key components of the Justice Initiative, such as annual surveys of clients or studies related to specific activities (such as OT, expansion of service to other populations, or in-reach efforts to correctional facilities).

Finally, it appears likely that the model was successful in its first year because it was established in an organization that had prior connections with other service providers and the community. Those connections allow trust to be established between the new point of contact (the nurse), allied service providers, and clients. Expansion of this kind of service to other places in the province or to other populations (such as men in transitional housing) should be done in careful collaboration with existing ecosystem partners.

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Appendix: Evaluation Methods

This appendix includes an example interview guide for allied service providers and an example focus group guide for MOSH Justice Initiative staff members. These guides were used to facilitate discussion and were utilized in a semi-structured fashion, meaning that questions could be re-phrased or omitted, and new questions could be added, based on the direction of discussion and prior answers provided by the participants.

This appendix also includes the flowsheets used in the MOSH Electronic Medical Records (EMR) system when a client was taken into the Justice Initiative (the Intake Flowsheet) and when a client had a follow-up visit (the Follow-up Flowsheet). These flowsheets had previously included a 'Personal Wellbeing Index', comprised of questions regarding the clients' overall quality of life at the time of their visits. The Personal Wellbeing Index was removed early in the evaluation, as administering the Index questions proved to be impracticable for practitioners in the clinic setting.

Allied service provider interviews guide

Intro statement

Thank you for taking part in this interview. This interview is being undertaken as part of an evaluation of the MOSH Justice initiative, which I am conducting on behalf of MOSH. The purpose of the evaluation is to understand whether the Justice Initiative model is feasible, how it is impacting clients, and how it may be improved going forward. Your contributions in the interview will be treated confidentially and any statements you make will not be attributed to you or used in a way that can be used to identify you in any subsequent evaluation reports, presentations, or publications. Do you have any questions before we begin?

We would like to make an audio recording of the interview for our own records, as well as take notes during the discussion. Do you have any concern with this approach to recording? If you'd prefer not to be audio-recorded, please let us know and we can work from written notes alone.

Interview Guide

Theme: Current State

1. Pretending I have no prior knowledge of the MOSH Justice initiative or your organization, can you please explain to me your understanding of the Justice Initiative?
    a. What kinds of services and supports are available through the initiative?
    b. What do you think is the goal of the initiative?
    c. How do you normally engage with Justice Initiative services?

Theme: Feasibility

2. Tell me about any challenges or successes in getting the model started
    a. Has communication from MOSH been clear regarding the available services?
    b. Have you had sufficient opportunities to provide input and express ideas or concerns?
    c. Are your clients accessing the available services?
    d. Do the services provide value to your clients?
    e. How does your organization interact with the Justice Initiative services?
    f. Is there any overlap or role confusion between the Justice Initiative services and other available services?

Theme: Fidelity

3. Is the model working the way you had expected?
    a. If not, what is different?
4. Do you expect the model to stay the same for the life of the program?
    a. What might you want to see changed?

Theme: Impact

5. How do you believe access to Justice Initiative services is impacting the service's clients?
    a. What do you think the longer-term impacts to clients will be?
    b. What would be different if these services did not exist?
6. How do you believe the establishment of this service is impacting other service providers working with Justice Initiative clients?
    a. What do you think the longer-term impacts to other service providers will be?

Theme: Gaps

7. Are there any ways in which this program could be changed or expanded, to better meet the needs of current clients?
8. Are there other types of clients the service could support, beyond the clients who have already been identified?

Theme: Anything else

9. Is there anything else about the operation of the MOSH Justice initiative so far, that you think I should be aware of for the evaluation?

Staff focus group guide

Intro statement

Thank you for taking part in today's focus group. The focus group is being undertaken as part of an evaluation of the MOSH Justice initiative, which I am conducting on behalf of MOSH. The purpose of the evaluation is to understand whether the Justice Initiative model is feasible, how it is impacting clients, and how it may be improved going forward. Your contributions in the focus group will be treated confidentially and any statements you make will not be attributed to you or used in a way that can be used to identify you in any subsequent evaluation reports, presentations, or publications. Do you have any questions before we begin?

We would like to make an audio recording of the focus group discussion for our own records, as well as take notes during the discussion. Do you have any concern with this approach to recording? If you'd prefer not to be audio-recorded, please let us know and we can work from written notes alone.

Focus Group Guide

Theme: Current State

1. Since the last time we met, have there been any changes to delivery of the program?
    a. How many people are currently using the program?
    b. Has anything changed in the delivery model?
    c. Has anything changed in the staffing model?

Theme: Feasibility

2. What has been working well in delivering this program?
3. What have been the main challenges in delivering this program?
    a. What solutions have been planned and/or put in place?
    b. [Refer to list of systemic issues identified below for prompts]

Theme: Fidelity

4. Is the model working the way you had expected?
    a. If not, what is different?
5. Do you expect the model to stay the same for the life of the program, or will there be changes in the coming months?

Theme: Impact

6. How do you believe access to Justice Initiative services is impacting the service's clients?
    a. What do you think the longer-term impacts to clients will be?
7. How do you believe the establishment of this service is impacting other service providers working with Justice Initiative clients?
    a. What do you think the longer-term impacts to other service providers will be?

Theme: Gaps

8. Are there any ways in which this program could be changed or expanded, to better meet the needs of current clients?
9. Are there other types of clients the service could support, beyond the clients who have already been identified?

Theme: Anything else

10. Is there anything else about the operation of the MOSH Justice initiative so far, that you think I should be aware of for the evaluation?

MOSH Justice EMR Flowsheet

Intake flowsheet

1. NECHC Chart number: _____
2. Encounter date: (MM/DD/YYYY):
3. Provider:
    a. ☐ RN - transitional
    b. ☐ RN - residential
    c. ☐ OT
    d. ☐ Prescriber
    e. ☐ Other:
4. Encounter location
    a. ☐ Transitional house
    b. ☐ NECHC Clinic
    c. ☐ Community / Outreach location
    d. ☐ Phone / Virtual

Referral Section:

5. Initial RN referral source:
    a. ☐ Central Nova Scotia Correctional Facility
    b. ☐ Coverdale Court work Society
    c. ☐ The Canadian Association of People who Use Drugs (CAPUD)
    d. ☐ Direction 180
    e. ☐ Elizabeth Fry society (Efry)
    f. ☐ Jamieson Centre
    g. ☐ Criminal Justice Program
    h. ☐ John Howard Society of Nova Scotia (JHSNS)
    i. ☐ Mainline
    j. ☐ NECHC
    k. ☐ Self
    l. ☐ Wellness within
    m. ☐ Nova Scotia Health Authority (NSHA)
    n. ☐ Corrections Service Canada
    o. ☐ Other community agency:
    p. ☐ Other carceral setting:
6. Triage:
    a. ☐ Urgent
    b. ☐ Regular
    c. ☐ non-Urgent
7. Initial RN referral date (MM/DD/YYYY):
8. Initial RN encounter date (MM/DD/YYYY):
9. Timeliness to contact:

a. ☐ Adequate/need met
b. ☐ Somewhat timely
c. ☐ Inadequate

SOCIODEMOGRAPHICS:

10. Date of Birth: (MM/DD/YYYY):
11. Gender:
    a. ☐ Female
    b. ☐ Male
    c. ☐ Transgender
    d. ☐ non-binary/non-conforming
    e. ☐Prefer to self-describe _____
12. Race:
    a. ☐ African Decent
    b. ☐ Indigenous
    c. ☐ Caucasian
    d. ☐ Other:
13. Home community (lived prior to incarceration):
    a. ☐ Central zone
    b. ☐ Eastern zone
    c. ☐ Northern zone
    d. ☐ Western zone
    e. ☐ Out of province
14. Date of Incarceration (MM/DD/YYYY):
15. Date of Release of Custody (MM/DD/YYYY):
16. Source facility for release:
    a. ☐ Federal
    b. ☐ Provincial
        i. ☐ Central Nova Scotia Correctional Facility
        ii. ☐ Dorchester Penitentiary
        iii. ☐ Pictou
        iv. ☐ Springhill Institution
        v. ☐ Cape Breton
        vi. ☐ Western Canada
        vii. ☐ Central Canada
        viii. ☐ Other:
17. Wellness court involvement: ☐ Yes ☐ No
18. Sentenced on bail: ☐ Yes ☐ No
19. House Arrest Conditions: ☐Yes ☐No

20. Housing:
    a. ☐ Unhoused
    b. ☐ Transitional
    c. ☐ Permanent, inadequate
    d. ☐ Permanent
21. Employment:
    a. ☐ Unemployed
    b. ☐ Informal work
    c. ☐ Formal work
22. Literacy or language barriers: ☐Yes ☐No
23. Income assistance: ☐Yes ☐No Worker: _____
24. Health Insurance: ☐ None. ☐ Pharmacare ☐ NHIB ☐ Private:
25. Current Health Access to:
    a. ☐ Primary care prescriber: _____
    b. ☐ Mental health: _____
    c. ☐ MAP
    d. ☐ Safe supply
    e. ☐ Allied Health: _____
    f. ☐ Continuing Care / VON
    g. ☐ Specialist physician: _____
    h. ☐ Other: _____
26. Unmet needs:
    a. ☐ None
    b. ☐ Addictions support
    c. ☐ Cognition/Capacity
    d. ☐ Cultural
    e. ☐ Dental care
    f. ☐ Documentation support (taxes, ID)
    g. ☐Education/Literacy/Language
    h. ☐ Employment
    i. ☐ Food security
    j. ☐ Healthcare
    k. ☐ Home or personal care / community living support
    l. ☐ Housing
    m. ☐ Income support including med insurance
    n. ☐ Legal support
    o. ☐ Occupational Therapy
    p. ☐ Physiotherapy
    q. ☐ Psychotherapy/Trauma
    r. ☐ Social

s. ☐ Transportation
t. ☐ Other:

27. Notes:

Follow-up Flowsheet

1. Date (MM/DD/YYYY):

2. Provider:
    a. ☐ RN - transitional
    b. ☐ RN - residential
    c. ☐ OT
    d. ☐ Prescriber
    e. ☐ Other:
3. Encounter location:
    a. ☐ Transitional house
    b. ☐ NECHC Clinic
    c. ☐ Community / Outreach location
    d. ☐ Phone / Virtual
4. Reason for visit:
    a. ☐ Acute physical
    b. ☐ Acute mental health addictions
    c. ☐ Chronic physical
    d. ☐ Chronic mental health addictions
    e. ☐ Prevention
    f. ☐ Resource navigation
    g. ☐ Med bridging
    h. ☐ Harm reduction support
    i. ☐ Function-related
    j. ☐ Participation-related
    k. ☐ Other:

Sociodemographics/Social Determinants of Health (SDOH) update:

5. Housing:
    a. ☐ Unhoused.
    b. ☐ Transitional
    c. ☐ Permanent, inadequate
    d. ☐ Permanent
6. Employment:
    a. ☐ Unemployed
    b. ☐ Informal work
    c. ☐ Formal work

7. Health Access:
    a. ☐ Primary care – Attached
    b. ☐ Mental health

c. ☐ MAP
d. ☐ Safe supply
e. ☐ Allied Health
f. ☐ Continuing Care / VON
g. ☐ Under specialist care:

8. Any re-involvement with criminal justice system since the last visit intake? ☐Yes ☐No
9. Unmet needs:
    a. ☐ None
    b. ☐ Addictions support
    c. ☐ Cognition/Capacity
    d. ☐ Cultural
    e. ☐ Dental care
    f. ☐ Documentation support (taxes, ID)
    g. ☐Education/Literacy/Language
    h. ☐ Employment
    i. ☐ Food security
    j. ☐ Healthcare
    k. ☐ Home or personal care / community living support
    l. ☐ Housing
    m. ☐ Income support including med insurance
    n. ☐ Legal support
    o. ☐ Occupational Therapy
    p. ☐ Physiotherapy
    q. ☐ Psychotherapy/Trauma
    r. ☐ Social
    s. ☐ Transportation
    t. ☐ Other:
10. Notes: