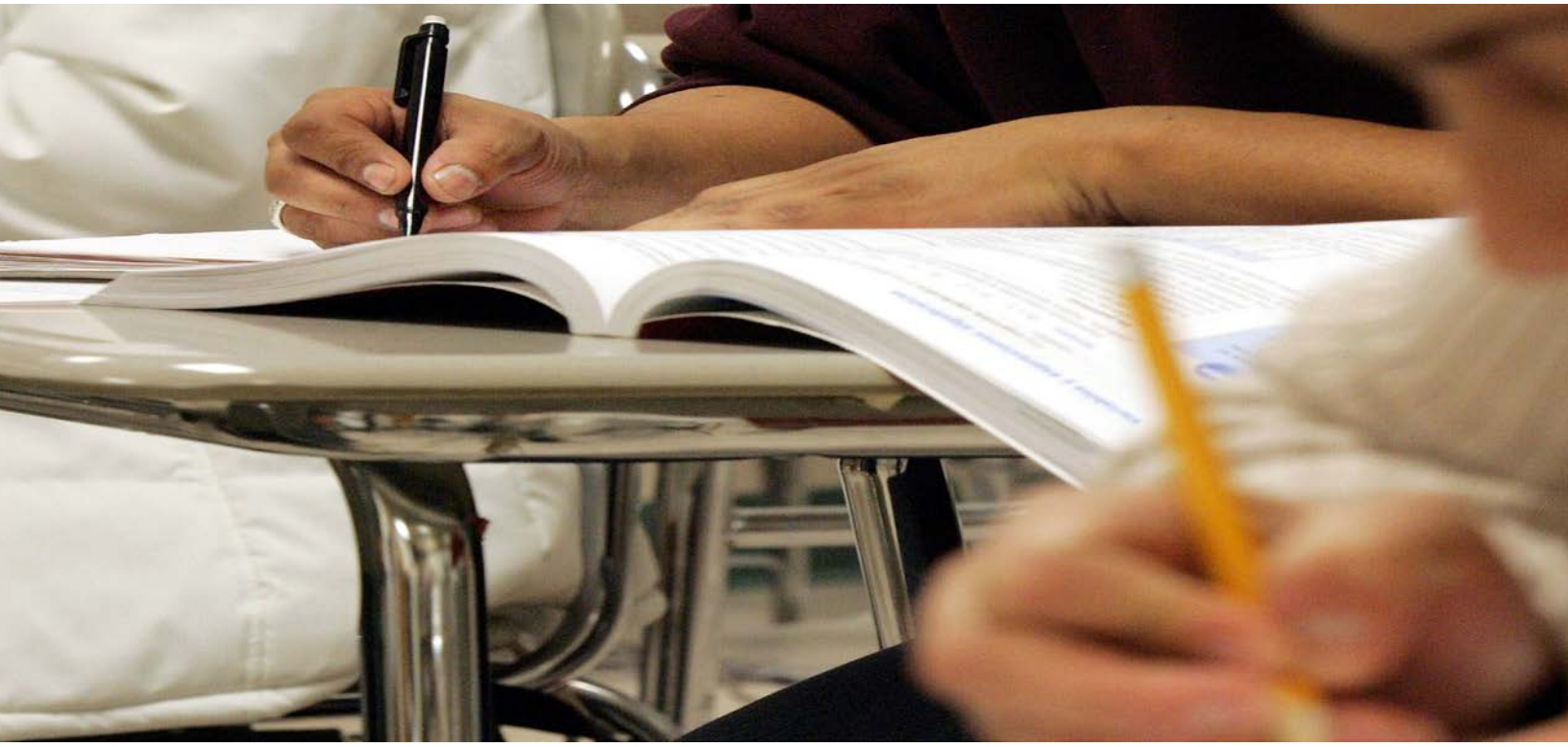

RESEARCH REPORT

Transition from Jail to Community (TJC) Initiative

Implementation Success and Challenges in Hennepin County, Minnesota

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Contents

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Glossary

AA—Alcoholics Anonymous

ACF—Adult Corrections Facility

ADC—Adult Detention Center

AFS—Adult Field Services

CBI—Cognitive-Based Interventions

CBT—Cognitive Behavioral Therapy

CJCC—Criminal Justice Coordinating Committee

CorrIS—Correctional Information System

CY—Calendar Year

DOCCR—Department of Community Corrections and Rehabilitation

DWI—Driving While Intoxicated

GED—General Educational Development

ESL—English as a Second Language

HCSO—Hennepin County Sheriff's Office

HCMC—Hennepin County Medical Center

HSPHD—Human Services and Public Health Department

IAT—Integrated Access Team

ICAS—Initial Custody Assessment Scale

JDAI—Juvenile Detention Alternatives Initiative

JMS—Jail Management System

LS/CMI—Level of Service/Level of Service/Case Management Inventory

LSI-R—Level of Service Inventory-Revised

NA—Narcotics Anonymous

NIC—National Institute of Corrections

OMS—Offender Management System

PO—Probation Officer

PPE—Policy, Planning, and Evaluation

S3—Statewide Supervision System

SILS—Subject Identification Locator Service

SPI—Service Priority Index

T4C—Thinking for a Change

TA—Technical assistance

TJC—Transition from Jail to Community

Urban—Urban Institute

Introduction

Nearly 12 million individuals enter the nation's approximately 3,100 jails each year (Minton and Golinelli 2014). With 60 percent of the jail population turning over each week, roughly the same number return to their respective communities. Many will recidivate (Roman et al. 2006; Uchida et al. 2009). This is not surprising given the many challenges faced by jail inmates: high rates of substance abuse and dependence (Karberg and James 2005), mental health issues (James and Glaze 2006), poor physical health (Maruschak 2006), low levels of educational attainment (Wolf Harlow 2003), and a high incidence of homelessness (Greenberg and Rosenheck 2008).

To assist local jurisdictions with facilitating successful reintegration from jail, the National Institute of Corrections (NIC) partnered with the Urban Institute (Urban) in 2007 to launch the Transition from Jail to Community (TJC) Initiative. The purpose of the TJC Initiative is to address the specific reentry challenges associated with transition from jail. During Phase 1 of the initiative, the NIC/Urban national TJC team, which also included Alternative Solutions Associates Inc., Corrections Partners Inc., and John Jay College of Criminal Justice, developed a comprehensive model to transform the jail transition process and ultimately enhance both the success of individuals returning to the community from jail and public safety in communities throughout the United States. More comprehensive than a discrete program, the TJC model is directed at long-term systems change and emphasizes a collaborative, community-based approach.

After designing the model, the national TJC team provided technical assistance (TA) to facilitate model implementation in six learning sites: Davidson County, TN; Denver, CO; Douglas County, KS; Kent County, MI; La Crosse County, WI; and Orange County, CA. A process and systems change evaluation in the six Phase 1 sites found that TJC model implementation was associated with significant, positive systems change (Buck Willison et al., 2012). Six additional Phase 2 learning sites, including Hennepin County (Hennepin), joined the TJC initiative in the fall of 2012, as well as two California jurisdictions receiving TJC technical assistance to assist them with managing the policy changes associated with Public Safety Realignment in that state.

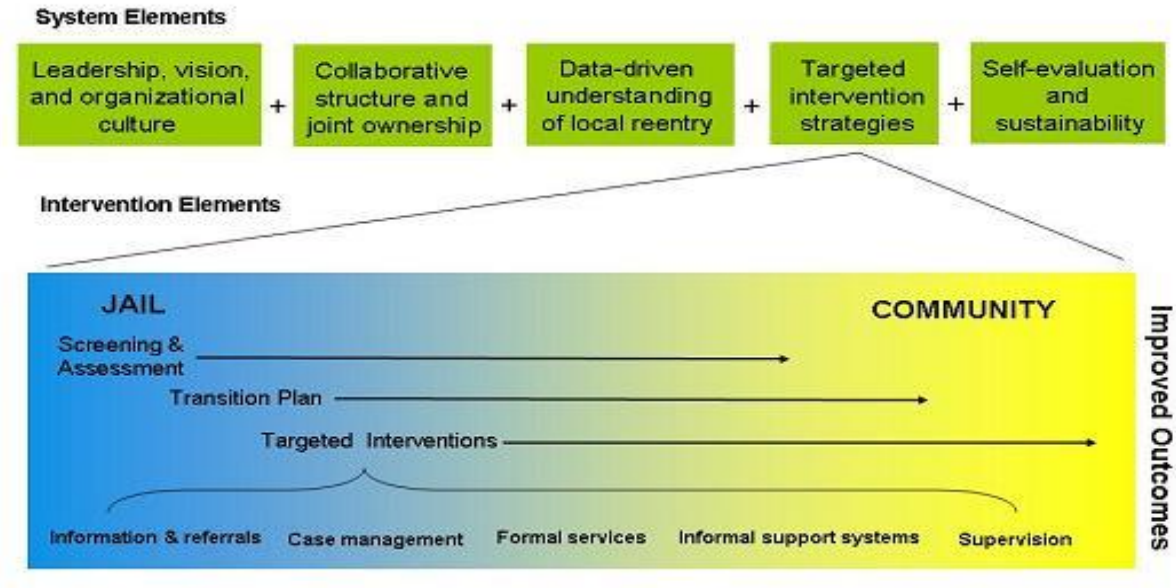
The TJC Model and Technical Assistance Approach

The TJC model was designed to help jurisdictions achieve two goals: (1) improve public safety by reducing the threat of harm to persons and property by individuals released from local jails to their home communities; and (2) increase successful reintegration outcomes – from employment retention and sobriety to reduced homelessness and improved health and family connectedness – for these individuals. Further, the model is

intended to be sufficiently adaptable that it can be implemented in any of the 2,860 jail jurisdictions in the United States (Stephan and Walsh 2011), despite difference in population size, resources, and priorities. The TJC model, depicted in Figure 1, contains both system level elements, at which strategic and systems change work occurs, and an intervention level, at which work with individual clients occurs.

FIGURE 1

TJC Model



TJC is a systems change initiative, rather than a discrete program. It represents an integrated approach spanning organizational boundaries to deliver needed information, services, and case management to people released from jail. Boundary-spanning collaborative partnerships are necessary because transition from jail to the community is neither the sole responsibility of the jail nor of the community. Accordingly, effective transition strategies rely on collaboration among jail- and community-based partners and joint ownership of the problems associated with jail transition and their solutions. The NIC/Urban team was committed to the TJC model and implementation approach being consistent with evidence-based practice regarding effective reentry, inclusive of both the types of interventions that needed to be available (e.g., cognitive-behavioral programming) and the structure of the overall intervention continuum (e.g., basing it on risk and need factors determined through application of valid risk/needs assessment instruments). The five elements of the TJC model are:

- *Leadership, Vision, and Organizational Culture*. The development of an effective jail transition strategy requires the active involvement of key decision-makers to set expectations, to identify important issues, to articulate a clear vision of success, and to engage staff and other stakeholders in the effort.

- *Collaborative Structure and Joint Ownership*. The jail and its community partners must hold joint responsibility for successful transition. A structure for the TJC work should facilitate collaboration and allow for meaningful joint planning and decision-making.

- *Data-Driven Understanding of Local Reentry*. In a data-driven approach to reentry, collection of objective, empirical data and regular analysis of those data inform and drive decision-making and policy formation.

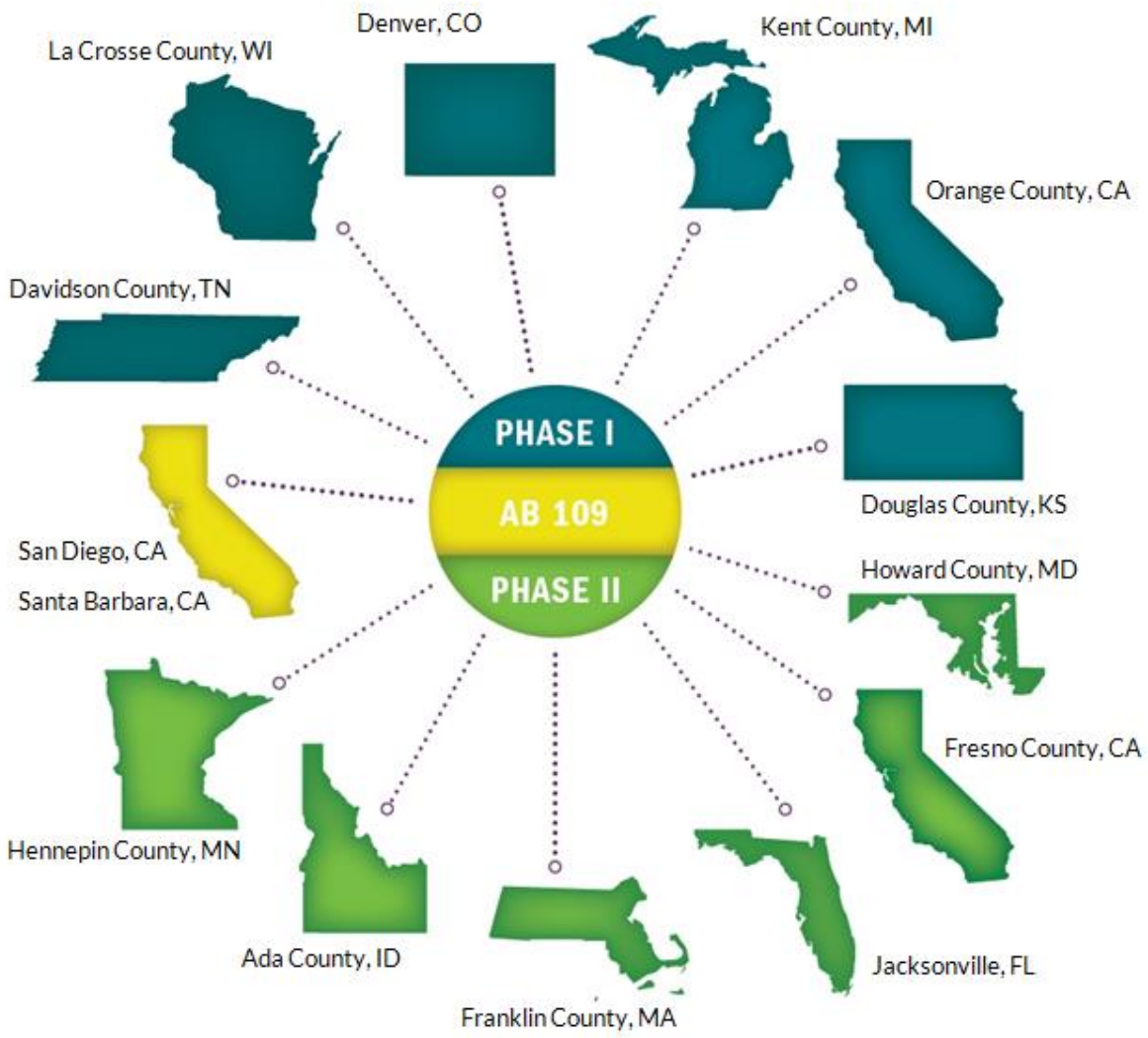
- *Targeted Intervention Strategies*. Targeted intervention strategies comprise the basic building blocks for effective jail transition. Targeting of program interventions should be based on information about an individual's risk of reoffending and criminogenic needs, information that is gathered through screening and assessment. Intervention delivery should also be guided and coordinated through case planning.

- *Self-Evaluation and Sustainability*. Self-evaluation involves the use of data to guide operations, monitor progress, and inform decision-making about changes or improvements that may need to be made to the initiative. Sustainability involves the use of strategies and mechanisms to ensure that the progress of the initiative is sustained over time despite changes in leadership, policy, funding, and staffing.

In order to test whether the model was in fact adaptable to different local contexts and to understand the shape model implementation could take in jurisdictions with different priorities and capacities, the NIC/Urban TJC national team provided 14 TJC learning sites with multi-year technical assistance around model implementation (Figure 2). Phase 2 TJC learning sites, including Hennepin County, received intensive technical assistance to support model implementation over the course of two and half years, starting in September 2012 and concluding in June 2015. The TJC TA included an analysis of gaps in reentry practice relative to the TJC model, a facilitated strategic planning process, and training in areas such as delivery of evidence-based programming, performance measurement, and sustainability planning.

FIGURE 2

TJC Learning Sites



Phase 1 TA Period, Denver and Douglas County: September 2008 through February 2012
Phase 1 TA Period, remaining sites: September 2009 through February 2012
Phase 2 TA Period: September 2012 through June 2015
AB 109 (Realignment) TA Period: December 2012 through June 2015

This report details the TJC implementation experience in Hennepin County, Minnesota. It discusses the development of the TJC strategy there, the policy and practice changes associated with its implementation, and the factors that facilitated or impeded successful TJC model implementation. TJC technical assistance to the sites was structured around the five model elements. Given the interrelated nature of the elements, this report discusses implementation of some of the model elements in single chapters. Chapter 2, for example,

discusses the structural, strategic, and collaborative aspects of TJC implementation encompassed in the model's Leadership, Vision, and Organizational Culture components and Collaborative Structure and Joint Ownership elements. Chapter 3 covers the Targeted Intervention Strategies component of the model, including practices employed to bring about behavior change at the client level. Chapter 4 discusses the implementation of the Self-Evaluation and Sustainability component of the model, building the foundation for maintaining and expanding the TJC work. As TJC is designed to be a data-driven approach, work relative to the Data-Driven Understanding of Reentry model element is interwoven with all the other model elements, and is therefore integrated into each report chapter.

Data Sources

This report draws on multiple sources of information collected in support of the implementation and systems change evaluation work undertaken by the Urban Institute:

- Data collected for the core TJC performance measures as well as any other data analysis conducted to inform TJC strategy development and implementation.
- Review of locally developed reentry materials such as procedural guidelines, program documents, and policy manuals.
- Two waves of Hennepin TJC stakeholder survey data. This brief online survey measured stakeholder perceptions of system functioning specific to collaboration, resource and information-sharing, interagency cooperation and trust, organizational culture, and the quality and availability of services available to individuals who transition from jail to the community. It was designed to detect and measure system-level change.
    - Wave 1, conducted in spring 2013 with 31 stakeholders representing 17 agencies throughout the Hennepin County criminal justice system and community. In total, 47 stakeholders were invited to participate in the survey, resulting in a 66 percent response rate.
    - Wave 2, conducted in fall 2014 with 49 respondents representing 17 agencies throughout the Hennepin County criminal justice system and community. In total, 77 stakeholders were invited to participate in the survey, resulting in a 64 percent response rate.
- Semi-structured interviews with Hennepin County stakeholders (e.g., the TJC coordinator, jail and facility administrator(s) and/or sheriff, members of the site's reentry council, jail staff, and staff from

key partner agencies) to capture the site's implementation experiences and document the progress of TJC implementation, the development and evolution of the site's local reentry strategies including the range of activities pursued, and critical lessons learned. Discussion topics included the individual's involvement in the initiative, reflections on the pace and progress of implementation, impressions about core elements of the model, anticipated challenges, and technical assistance needs. Two rounds of stakeholder phone interviews were conducted, the first in summer 2013 and another in fall 2014, with roughly seven criminal justice and community stakeholders selected from among the site's TJC core team.

Taken together, the information generated by the data sources and evaluation activities paint a rich portrait of Hennepin County's implementation experiences, strategies, challenges, and progress.

Hennepin County Jail Transition at Baseline

Hennepin County, Minnesota encompasses the city of Minneapolis and its largest suburbs. It is the largest county in Minnesota, with a population of 1.2 million. The county's jail system is uniquely bifurcated: the Hennepin County Sheriff's Office (HCSO) operates the county's pretrial detention facility (the Adult Detention Center, ADC), while the Hennepin County Department of Community Corrections and Rehabilitation (HC DOCCR) runs the Adult Corrections Facility (ACF) for individuals convicted and sentenced to a term of incarceration.[62] The ADC has a total of 839 beds and in 2011 maintained an average daily population of 683 inmates. The ACF has the capacity to house 477 inmates; in 2011, the ACF's average daily population was 429.

Each facility's population presents distinct reentry challenges. The ADC, for example, processes a large volume of cases that turn over frequently, leaving little opportunity to intervene: in 2011, the HCSO booked 34,503 individuals into the ADC, of which 74 percent exited the facility within 72 hours; the remaining 18 percent were detained, on average, for just seven days. In contrast, the DOCCR booked 4,531 individuals into the ACF in 2011. Although the ACF deals with a smaller population, their lengths of stay are considerably longer (42 days), and many have both significant past criminal justice involvement—49 percent had at least one prior ACF stay and 76 percent were under active supervision at the time of their ACF commitment—and substantial needs (Hennepin County 2013).[62]

BOX 1

Hennepin County Pretrial Practice

Pretrial services and supervision in Hennepin County are well-established going back to the 1970s. DOCCR's Adult Field Services (AFS) unit conducts pretrial assessments of individuals booked into the Adult Detention Center. According to the 2006 Pretrial Scale Validation Report, people who are "arrested on felony probable cause and charged by complaint, arrested on a complaint warrant, or arrested by tab charge for an alcohol or person-related offense, will be seen by the Community Corrections Pretrial Unit for review." This process includes a full bail evaluation, including calculating the pretrial point score from the Pretrial risk assessment tool, criminal history review, defendant interview, and phone calls to verify the information obtained in the interview. The old Pretrial Scale was designed by a cross-departmental committee in 1992 and revised after the 2006 validation report to correct non-valid items and racially biased indicators.

Prior to joining the TJC initiative, neither of Hennepin County's jail facilities screened inmates for risk of reoffending. Like many jails nationwide, the ADC and ACF collected basic demographic, criminal history, and physical and mental health data to inform inmate classification and housing assignments only. In the ADC, assessment was limited to a validated pretrial risk assessment and bail evaluation conducted by one of two DOCCR pretrial services officers who maintain office space in the ADC's booking area. At the ACF, officers conducted an "immediate need triage" on every person booked into the facility to determine whether he or she needed medical and/or mental health services. Although the ACF did not screen for risk to reoffend, probation officers (POs) located in the ACF did use the Level of Service Inventory- Revised (LSI-R) to assess the criminogenic risks and needs of selected individuals: those sentenced to the ACF for at least 30 days followed by a period of postrelease supervision. LSI-R results were used to identify needed pre- and postrelease services but did not clearly drive programming decisions. Rather, prior to TJC, ACF residents largely self-selected into programming.

Programming resources differed greatly between the county's two correctional facilities. The ADC's program continuum consisted of limited education programming for inmates aged 22 and younger, self-help groups (AA/NA), institutional work programs available to individuals with unusually long stays, and mental health housing/programming. In contrast, the ACF offered a relatively extensive array of evidence-based programming, thanks in part to active community provider in-reach, that included: gender-specific cognitive-based interventions (i.e., *Thinking for a Change*, T4C, for men and the *Moving On* curriculum for women); the *Telesis* chemical dependency curriculum; self-help groups (AA/NA); adult basic education (GED and ESL) provided by Hopkins Public Schools; an industries program and the private sector workforce program; and mentoring through the Greater Minneapolis Council of Churches. However, there was little "treatment

matching" in which programming and services were matched to an individual's assessed risks and needs. Service plans were also limited.

The DOCCR's Adult Field Services (AFS) unit served as the primary conduit for linking individuals on supervision to community-based services. In addition to supervision, AFS provided programming in the community, including cognitive-based interventions (CBI), and made service referrals to chemical dependency treatment, mental health services, and employment and vocational counseling. Moreover, Hennepin County had an established, resource-rich network of community-based services that spanned housing, employment, chemical dependency treatment, and mental health. Yet, when Hennepin applied to become a TJC learning site, stakeholders cited a lack of meaningful jurisdiction (authority) to provide long-term transition services to individuals released from the ACF without supervision; as noted in its TJC application, only 25 percent go on to supervised probation.

Preimplementation Strengths

Several critical elements for successful systems change were in place in Hennepin County prior to the launch of TJC.

Hennepin County's extensive track record of successful cross-system collaboration and criminal justice reform indicated the county was well-positioned to affect the type of practical policy and operational change envisioned under the TJC model.[62] An active Criminal Justice Coordinating Committee (CJCC) consisting of executive-level leaders from the courts, corrections, law enforcement, and municipal government meets monthly to address cross-cutting policy issues and initiatives. As such, this body provides critical leadership and vision on policy-level issues that cross jurisdictional lines and systems; it also has the ability to appropriate resources necessary to support policy implementation.

The county also had strong community partnerships and an extensive network of services and resources when it joined the TJC initiative. Hennepin County's criminal justice and Human Services and Public Health Department (HSPHD) stakeholders had developed a strong working partnership through prior initiatives, and its leaders recognized both that their respective systems shared many of the same clients and that resources could be better aligned. The county also maintained an extensive network of relationships with various community-based agencies and services providers. These existing working relationships and a relatively resource-rich service environment were two major assets to Hennepin's jail reentry work, particularly as it sought to strengthen linkages to postrelease services for individuals being released from its facilities.

Lastly, Hennepin County brought well-developed analytic capabilities and a commitment to data-sharing, analyses, and data driven-decision-making to the initiative. Hennepin County leaders provided financial support for the Hennepin County Justice Integration Program, an ongoing initiative designed to increase information flow between various county and state- justice databases. Local criminal justice data systems (the HCSO's Jail Management System (JMS), Offender Management System (OMS), the DOCCR's Correctional Information System (CorrIS), and a Statewide Supervision System (S3)) while not linked, include a common identifier, the Subject Identification Locator Service (SILS) number, that permitted linking and analyses across state and county corrections, courts, and law enforcement. At an operational level, analysts in the DOCCR's Office of Policy, Planning, and Evaluation (PPE) regularly compiled agency performance and outcome data including an annual recidivism measure. The PPE also generated annual reports on the ACF and AFS populations as well as special reports that facilitated performance management and planning (analysis of the ACF's classification instrument and LSI reports are two such examples). The HSCO, likewise, brought solid analytic capacity to the initiative, as did HSPHD; this capacity later proved critical for answering key questions about Hennepin County's reentry population.

Hennepin County's TJC Objectives

Through TJC technical assistance, Hennepin County stakeholders sought to increase public safety and improve client lives by aligning (1) available resources across county departments and relevant service systems and (2) facilities' operations and community services with evidence-based practices and principles of effective intervention in order to better address inmates' criminogenic risks and needs. Although Hennepin had a foundation of evidence-based programming on which to build, stakeholders pursued TJC technical assistance to enhance correctional operations and practice and to create a cohesive and comprehensive reentry strategy particularly for its sentenced population. Hennepin stakeholders set the following objectives for the TJC TA period:

1. implement risk screeners in both the ADC and ACF;
2. assess and refer inmates to programming based on risk;
3. develop and implement a common transition case plan;
4. implement cross-system case conferencing; review programming, and identify and address any gaps particularly around medical care benefits; and
5. design quality assurance processes. Accordingly, stakeholders pledged to review pretrial practices, facility operations, and programming and services, and to revise them as needed to better align reentry practices with recidivism reduction principles.

Importantly, and consistent with these objectives, Hennepin County stakeholders recognized that TJC was not a discrete program but a systems-change strategy that would introduce new ways of doing business. As such, stakeholders carefully cast TJC as a strategy when educating new audiences in order to avoid the perception that this reentry work was just another "flavor of the month" effort. This perspective and approach were critical to staff buy-in and sustainability.

TJC Structure, Leadership, and Collaboration

Development of an effective jail transition strategy requires the active involvement of policymakers from both the jail and the community to articulate a clear vision of success, set expectations, identify important issues, and engage staff and other stakeholders in the effort. This leadership is necessary to align the cultures of partnering organizations for the common purpose of facilitating successful transition into the community. Leadership must be engaged at multiple levels. Collaborative structures are needed to make strategic decisions about jail transition priorities and resource allocation and to create continuity of care and approach between agencies and across the point of release.

A TJC collaborative structure must achieve four things:

- Inspire, increase, and maintain support for jail transition from a broad array of community partners.
- Identify, prioritize, and build consensus around actions needed to improve the jail transition system.
- Ensure that these actions are taken.
- Monitor the transition process and practice to ensure accountability and improve the approach as needed.

Leadership

The Hennepin County Department of Community Corrections and Rehabilitation (DOCCR) served as the initiative's lead agency and provided critical leadership. DOCCR Director Tom Merkel was highly supportive of reentry and articulated a commitment both to review and refine agency operations, and, where needed, to further incorporate evidence-based practices, including risk assessment, to ensure the County's reentry strategy aligned with recidivism reduction principles. Director Merkel also obligated a full-time DOCCR position to serve as the initiative's TJC coordinator[62] and supported the involvement of several agency administrators, mid-level managers, and probation and security staff in the initiative's core team and working groups. Given DOCCR's broad mission—the agency provides oversight and services to criminal justice-involved individuals at all stages of the legal process from pretrial risk assessment and bond evaluation to short-term incarceration and postrelease supervision and services through its Adult Field Services (AFS) unit—the

involvement of staff from across the agency was critical to shape the initiative's work and facilitate buy-in. As noted earlier, the HCSO and HSPHD also designated staff for this effort.

BOX 2

Structural Challenges to Collaboration Led to Parallel Implementation Tracks

Despite the existence of strong and established relationships, Hennepin County stakeholders acknowledged at the outset that its bi-furcated jail system could pose challenges to its systems-change work. Reaching consensus on a coordinated jail reentry process would require the buy-in of two different authorities—the HCSO and the DOCCR—and tailoring key practices to the unique needs of those facilities and organizations. The newly created TJC Executive Team offered a critical forum for advancing these issues; the Sheriff also dedicated staff to the TJC core team to address operations-level implementation.

Rather than letting differing priorities hamper progress for both agencies in the county, the TJC core team made the conscious decision to address each facility as a separate entity, at its own pace. What resulted was a two-speed track: the TJC core team focused on changes to the ACF's practices at full steam while working with the HCSO more slowly, starting with revamping the ADC's screening process.

In reality, the initiative's work proceeded largely on separate, but similar, tracks at the HCSO and DOCCR. As in most TJC sites, Hennepin ultimately concentrated its reentry strategy development on the sentenced population at the DOCCR, and this report profiles much of that work. The HCSO, however, also made considerable strides during the TJC TA period. Consistent with the site's overarching goals, the HCSO piloted, validated, and ultimately adopted the Vera Institute of Justice's Service Priority Index (SPI) scale to predict risk of return to the ADC for both its male and female populations; the ADC intended to use the SPI to guide the development of prerelease services and postrelease service referrals for its population. The HCSPO also piloted a health care application process (benefits assistance) in partnership with Hennepin Human Services and launched the Integrated Access Team (IAT) initiative; using the SPI, the multidisciplinary IAT (housing specialists, case managers, and social workers) works to link individuals identified as high-risk/high-need to services.

Organizational Culture

Broadly speaking, organizational culture refers to, "the set of shared, taken-for-granted implicit assumptions that a group holds and that determines how it perceives, thinks about, and reacts to its various environments" (Schein 1996); it can also be described as "the values, assumptions, and beliefs people hold that drive the way

the institution functions and the way people think and behave" (Byrne 2005). Culture is often an unspoken driver of behavior.

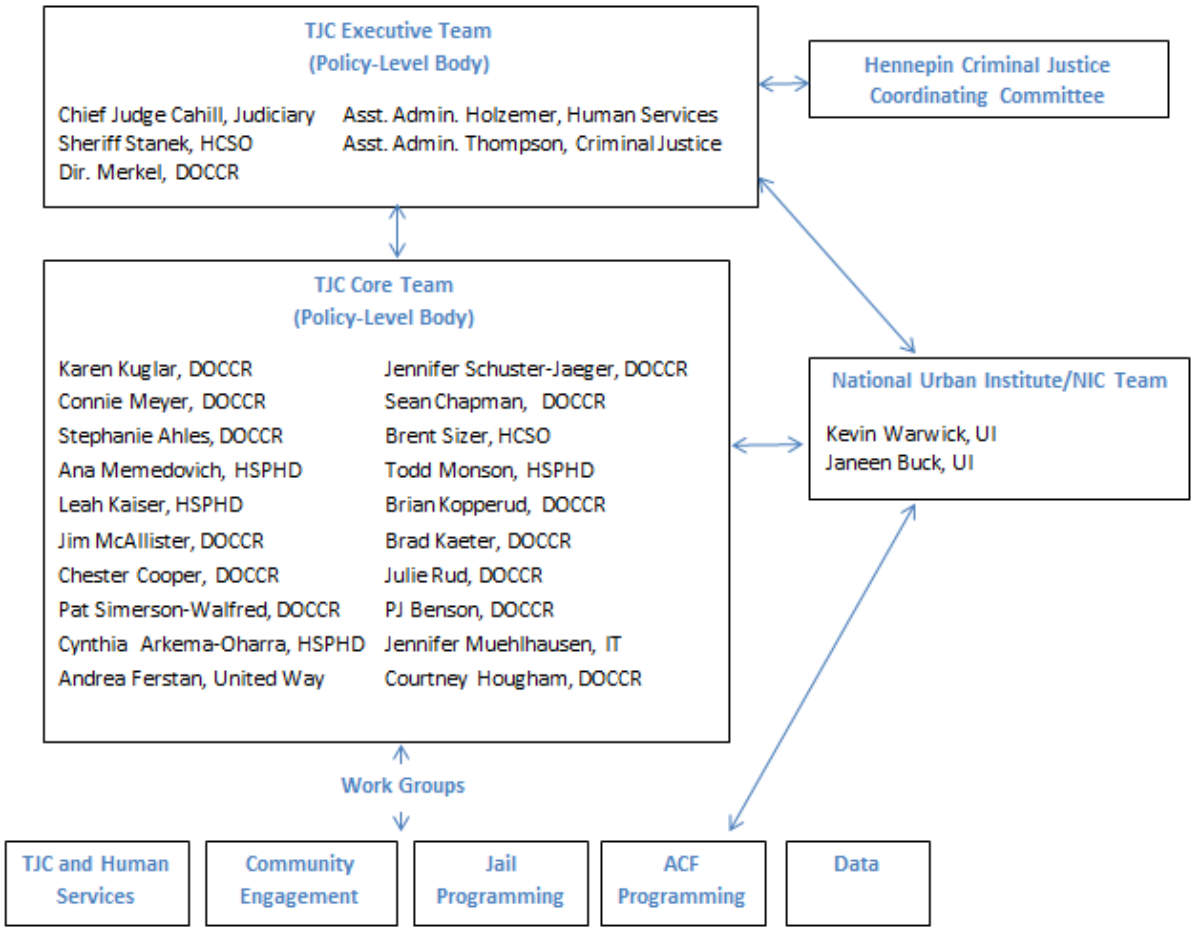
As documented early in the TJC TA period, organizational culture within Hennepin County appeared to be supportive of the TJC initiative and its overarching objectives, but the initiative's core leaders needed to raise awareness among key constituencies, including the Public Defender and County Attorney, and to secure buy-in from line staff, including correctional and probation officers. In response, Hennepin's core team designated key members with outreach to the Public Defender and County Attorney about the TJC initiative and keeping their respective offices and agencies informed of the initiative's progress; the core team would also ask for further participation from these stakeholders when needed or as a clear role in the initiative emerged. With respect to line staff, the national team encouraged Hennepin to share the objectives and potential benefits of transition activities with this group in order to increase awareness of and support for the overall initiative; doing so would also help to facilitate systems change at the operational-level as it would signal the ACF's move from a singular focus on custody and control to one that included reentry practices. To this end, the Hennepin core team incorporated greater shares of frontline staff—ACF correctional officers, HSPHD social workers, and probation officers at the ACF—into national TA team trainings on key practices such as screening and assessment and the risk/needs/responsivity principle. By the end of the TJC TA period, leaders and frontline staff alike reported that a culture of reentry practice had been embedded in the ACF. While not whole cloth culture change, a foundation had been established on which stakeholders could continue to build.

TJC Collaborative Structure and Joint Ownership

Consistent with the TJC model, Hennepin engaged policy-level executive leaders, agency and operations management, and direct services staff in its jail transition work. Figure 3 depicts Hennepin's TJC collaborative structure.

FIGURE 3

Hennepin County TJC Collaborative Structure



The TJC Executive Team provided policy-level leadership and oversight to the TJC initiative and a conduit to the CJCC. Members of the TJC Executive Team included the chief judge, DOCCR director, a representative from the HCSO, and the county administrators for public safety, human services, and health; several of these individuals also sat on the county's CJCC, thus providing the initiative with access to a broader set of the county's key criminal justice policymakers. The TJC Executive Team met quarterly to discuss TJC and other reentry priorities and played an instrumental role in institutionalizing the core team's policy and operational changes by aligning their respective agencies' policies and funding with Hennepin's new reentry approach. In late 2013, for example, the Executive Team cleared the way for a human services social worker to support transition planning in the ACF; housed at the ACF, the HSPHD social worker provided case management to the TJC target population pre- and postrelease and assisted with client health care applications.[62] TJC co-coordinator Connie Meyer described the significance of the Executive Team's efforts this way, "*The success [of TJC] is that we have so many people at such a high level of organizational leadership working on this ... they*

are involved in creating resolutions and coming up with innovative solutions to issues such as health care and getting photo IDs. The support across the board is very helpful."

BOX 3

Support for Reentry

Results from the national team's web-based survey of Hennepin's criminal justice and community stakeholders suggest strong support for and commitment to reentry issues over the TJC TA period: 88.9 percent of stakeholders in 2013 and 89.4 percent of stakeholders in 2014 agreed or strongly agreed that leaders in their agency were both aware of and committed to addressing jail reentry issues. Ninety-six percent strongly agreed or agreed their agency had a stake in addressing reentry. Importantly, 70 percent of stakeholders in 2013 indicated they personally had a clear understanding of the mission and goals of the TJC initiative; this figure increased to 89 percent by the second survey administration in the fall of 2014.

Development, oversight, and implementation of Hennepin's jail transition work occurred primarily through the site's TJC core team and its work groups. Convened early in the initiative, the core team's initial membership included management and line staff from the DOCCR's ACF, AFS, and PPE units, the deputy sheriff in charge of the ADC, and representatives from HSPHD. Recognizing the need to engage the broader community, the core team made the strategic decision to invite a representative from the Greater Twin Cities United Way. Ultimately, the core team would integrate representatives from a number of community-based service providers in its work.

Led by co-coordinators Connie Meyer and Brad Kaeter, the core team worked to advance a coordinated, seamless, evidence-based service continuum that spanned the jail and the community. Practically speaking, this group oversaw all aspects of TJC implementation, from implementing new screening procedures to developing a common transition case plan, to engaging new partners, expanding services, and conducting education and outreach to systems and community stakeholders across the county. To address key topics, the core team established five issue-oriented workgroups: TJC and Human Services, Community Engagement, Jail programming, ACF programming, and Data. This structure also permitted the group to engage new constituencies and stakeholders at key points in the process.

To guide the initiative's work, the core team drafted a Charter (Appendix A) and adopted a vision and mission statement (Appendix B). This statement also listed a set of shared values and goals for its reentry work, and these thirteen TJC core principles:

1. TJC is not a new program; it is a new way of doing business: improving the system

2. Jail, Corrections, and Human Services and the community must work together
3. Reducing recidivism will increase public safety
4. Direct resources to the highest risk/need clients
5. Short stays and the local nature of jail facilities mean that offenders move rapidly between being incarcerated and living in the community
6. Services continue no matter where clients are and where you start
7. Successful transition planning begins when they enter jail
8. All staff, regardless of position, play a role in encouraging client motivation to change
9. How staff interacts with clients has impact
10. Clients are responsible for their own behavior
11. Clients differ in their readiness for change and what they need to change
12. Staff will be respectful agents for positive change
13. In order to know if what we do works, we must measure what we do

Initially, the core team met twice monthly but soon moved to monthly meetings as the group's membership, vision, and agenda solidified. Meeting locations rotated among different partners including the DOCCR, HSPHD, and various service providers in order to build the groups' collective knowledge of key partners. Specifically, hosting a meeting provided the host agency with an opportunity to highlight their respective services and facilities as the meeting usually involved a tour of the location and brief overview of the organization's operations and mission.

In turn, the TJC core team took several concrete steps to educate and engage other public agencies, policy bodies, and community-based service providers. For the former, these efforts involved presentations at the CJCC to update county policymakers on the initiative's progress and outreach to key groups such as the Hennepin County Public Defender's Office, judiciary, and District Attorney.

The TJC core team also worked proactively to enlist a broader set of community-based providers in its reentry efforts. Hennepin County, in the words of one stakeholder, was a "social services mecca," with a variety of service providers that could meet a wide range of needs for the reentering population. Doing so, however, meant expanding the initiative's community connections. To this end, the core team strategically leveraged its own collaborative make-up and enlisted the aid of both its HSPHD and United Way representatives. According to one stakeholder from the DOCCR, partnering with HSPHD had major benefits in that HSPHD brought new faces to the table—public health had primary partners who differed from its own and who did not traditionally focus on the justice-involved population. The DOCCR was also able to develop new relationships in large part because of the Twin Cities United Way, who leveraged its reputation and existing relationships in the community to help engage new partners in the initiative. The United Way was

well-positioned to serve in this capacity as its work spanned a range of services, rather than a singular focus on one issue, such as housing. The United Way also brought a degree of "community credibility" to the effort. As one stakeholder explained, "*people pay attention when the [United Way is] involved.*"

As an active participant in the TJC core team, the United Way coordinated the initial engagement between the DOCCR and a variety of community agencies especially in the early phases of TJC implementation. The United Way also played a critical role in the initiative's efforts to form collaborative relationships with community housing and employment providers – key gaps in the initiative's partnership. By the end of the initiative, the collaborative had expanded substantially to include new partnerships in the areas of housing (St. Stephen's Housing Services, Catholic Charities), health (Portico Healthnet), and employment (AccessAbility, Inc., and a collaboration between Hennepin Health and the Minneapolis Foundation); the initiative also introduced mentoring in the ACF through a partnership with Amicus.

The initiative as a whole and the DOCCR in particular, made a significant commitment to growing one-on-one relationships with these community partners. To this end, the site's TJC coordinators and other core team members visited selected service providers on an individual basis both to learn more about the agency's services and programming and to present on Hennepin's TJC initiative. In turn, the DOCCR subsequently invited service providers to visit the ACF and to train DOCCR staff on their services; DOCCR leadership hoped these working sessions would encourage service referrals and meaningful connections. Specifically, Hennepin hoped that cultivating one-on-one relationships with key providers would improve its ability to connect the right clients with the right services. As one stakeholder reflected, *"our community doesn't want us to just hand [the client] a slip of paper to show up at their door, we want to identify appropriate clients for the services they offer and what [the client] wants.*"

Additionally, the initiative convened quarterly community provider meetings. Implemented in 2014, the site held two community provider meetings by the end of the TA period: the first meeting was held at the United Way's headquarters and the second was at the Minneapolis downtown public library. These meetings provided a forum not only for community partners to network and build relationships with each other as well as the TJC initiative, but also to address reentry-related issues, including service provider access to inmates and policy barriers to successful reentry. One stakeholder remarked on the energy that the collaborative work brought to Hennepin: "*We constantly have new people knocking on the door wanting to provide new services: housing, employment, etc. It was evident at the last site visit that took place, a forum with the different community providers in the room working with us or that would like to work with us. It was amazing the amount of people interested in this initiative and helping this population*."

Data from the stakeholder survey corroborate these reports of enhanced collaboration. Survey respondents answered four questions about the frequency (i.e., never, rarely, occasionally, or frequently) with which their respective agency or organization engaged in activities that required collaboration. The timeframe was the six months prior to the survey. Analyses suggest ample evidence of functional collaboration among Hennepin stakeholders at both points in time, but noted a number of substantial increases at Wave 2:

- *Resource-sharing*: At Wave 1, 83 percent of stakeholders reported some degree of resource-sharing in the six months prior to the survey; 44 percent reported that their respective agency frequently shared materials or resources with other agencies. At Wave 2, 97 percent of respondents reported some level of resource-sharing with 56 percent indicating it was a frequent practice for their agency.

- *Staffing*: At Wave 1, 86 percent of survey respondents reported having co-located or shared staff in the six months prior to the survey, and approximately 57 percent indicated this was a frequent or occasional practice. At Wave 2, these figures increased to 87 percent and 76 percent respectively.

- *Leveraging resources*: 85 percent of respondents partnered with other agencies to write grants or share the cost of a new resource to build capacity at Wave 1, with 60 percent doing so frequently or occasionally; 84 percent also reported partnering with other agencies in Hennepin County to provide training. While reports of cross-training remained largely the same at Wave 2, 92 percent of respondents reported that their agency partnered to leverage resources; 40 percent reported that it was a frequent practice up from just 20 percent of respondents at Wave 1.

Through these efforts, Hennepin succeeded in growing both the breadth and depth of its relationships between public agencies and community organizations. These relationships also reflected, in no small part, a sense of join ownership for the county's "shared client" population. As noted earlier, Hennepin County stakeholders sought to improve cross-system coordination and better align available resources across county departments through its TJC work. Leaders recognized that the justice a*nd* public health systems served many of the same individuals, yet there was little coordination. An August 2013 analysis of 23,658 individuals booked into the ADC in CY2011 underscored the importance of greater cross-system collaboration: 61 percent accessed HSPHD services after release, as did 59 percent for AFS; 49 percent accessed public benefits and health services while 9 percent received shelter services. As discussed in the next section of this report, the amount of cross-system overlap increased substantially for the site's designated TJC target population (see discussion on page 30).

These data made the notion of the "shared client" more concrete. In the words of one stakeholder, "*it is a big step for everyone to understand that these are all our clients…the Department of Human Services Public Health wanted to come into corrections, and corrections was saying no, we do public safety*." Through the TJC

framework, the DOCCR, HSPHD, HCSO, and AFS embraced the notion that they frequently serve the same "shared client." One stakeholder described the benefit of this new perspective:

> "One of the biggest gains is the collaboration between community corrections and human services. We had to come to consensus that we are all serving the same people; we are just serving them in different ways, and they have been siloed. We all have the same goal: stabilizing clients to not come back into the system. In this huge county, it's been one of the pivotal pieces, trickling all the way down, that these are our clients, not corrections' clients, or human services' clients. That is a big shift, county wide."

Targeted Intervention Strategies

Targeted intervention strategies are the basic building blocks of jail transition. Improving transition at the individual level involves introducing specific interventions at critical points along the jail-to-community continuum. Interventions at these key points can improve reintegration and reduce reoffending, thereby increasing public safety. Screening and assessment, transition planning, and program interventions are key elements of this strategy.

The TJC model employs a triage approach to prioritize interventions based on where resources are most needed or most likely to be successful for a rapidly cycling jail population with deep and varied needs. The TJC triage approach is consistent with the research literature that higher-risk individuals should receive higher levels of intervention (Lowenkamp et al. 2006), that interventions intended to reduce recidivism must target criminogenic needs, targets for change that drive criminal behavior (Bonta and Andrews 2007), and that individuals at low risk to reoffend should be subject to minimal intervention, if any (Lowenkamp and Latessa 2004).

Here, we discuss the changes Hennepin County undertook to create a coordinated system of targeted interventions.

Screening, Assessment, and the TJC Target Population

Central to the TJC model's triage approach is the implementation of a two-stage process for (1) determining which inmates are at the greatest risk to reoffend and (2) identifying the needs that must be addressed to reduce recidivism. As discussed earlier, like many jail systems, neither the pretrial (ADC) nor the sentenced (ACF) facility screened individuals for their risk to reoffend prior to TJC. In the ADC, assessment was limited to pretrial services, which used a locally-developed, validated assessment tool and jail intake classification, which relied on a common set of items to determine an inmate's security level for housing assignment only. In the ACF, assessment was largely limited to individuals whose sentences included a period of postrelease supervision; [62] probation officers located at the ACF used the LSI-R to assess those residents' risks and needs. Consistent with the sites' TJC objectives, selecting and implementing evidence-based risk screening and assessment tools were a critical first task.

Guided by the work of the Jail Assessment working group and its review of the research and available tools, the ADC piloted and validated a slightly modified Vera Institute of Justice's Service Priority Index (SPI)

early in 2013.[62] Hennepin's initial analysis of approximately 3,800 male admissions found a top charge for DWI or violent crime increased the likelihood of return to jail. The overall predictive ability of the SPI for the male ADC population was good: according to analyses, men with higher HC-SPI scores were more likely to return to the jail within 12 months of release, specifically 52.2 percent of men scored as high-risk and 73 percent of those scored as very high-risk were rebooked into the ADC within 12 months of release, per an internal Hennepin County PPE analysis in March 2013. The HCOS subsequently validated the SPI on the ADC's female population. By the end of the TJC TA period, the ADC had fully implemented the SPI and introduced an HSPSD social worker in the jail to work with individuals assessed as high-risk to reoffend; this work was further strengthened by the advent of the IAT, as described in earlier sections of this report.

The ACF made similar gains. There, the TJC collaborative elected to adopt a modified version of the Wisconsin Prescreener instrument, referred to as the Hennepin Prescreener instrument, to quickly sort and refer individuals scored as medium- to high-risk to reoffend for a criminogenic risk/needs assessment. While implementing the tool was significant, Hennepin realized that adopting the screener alone wasn't enough: the DOCCR needed to review and modify its practices to integrate both the risk screener and assessment tool into its service delivery and reentry case planning continuum. A particular concern was the ACF's classification and inmate movement process. The ACF's classification process, which determined housing levels, residents' movement within the facility, and eligibility for job-related programming and work release, used the Initial Custody Assessment Scale (ICAS)—a set of weighed risk factors and cut-off scores. The ICAS had not been reviewed or modified in twenty years: as stakeholders noted early in the TJC TA process, the ICAS had not been updated to include dynamic risk factors consistent with NIC guidance, and a 2011 analysis suggested the tool was not valid. Furthermore, the tool did not include criminogenic risk /needs factors consistent with extant research on recidivism reduction principles.

To address these issues, Hennepin requested and received additional technical assistance from NIC in 2013 to assess the ACF's classification process. Following in-depth assessment and training from NIC consultant and TJC Phase 1 Kent County (MI) stakeholder Captain Randy Demory (retired), the ACF restructured its processes to accommodate the Hennepin Short Risk Screener and the GAINS Center's Brief Jail Mental Health Screen, which were applied to all individuals booked into the ACF. Hennepin stakeholders also followed several of Mr. Demory's recommendations to strengthen the classification process such as reinstating face-to-face classification interviews, developing a decision-tree, adding classification staff, and training classification staff on these tools and processes, including the appropriate use of overrides, to ensure their proper implementation and application. The ACF subsequently allocated a Classification supervisor and three officers to the redesigned unit and provided training on the new procedures as well as the ACF's reentry strategy and core correctional practices.

At roughly the same time, the ACF shifted from the LSI-R risk/needs assessment tool to the Level of Service Inventory/Case Management tool (LS/CMI). This change mirrored those at the state-level and theoretically served to facilitate continuity in risk assessment measurement, application, and approach. ACF probation officers now target individuals screened as medium- to high-risk for reoffending (based on the Hennepin Risk Screener) for full assessment with the LS/CMI. Ideally, the LS/CMI is conducted within five days of booking; individuals with a completed LSI-R or LS/CMI on file in the last 12-months are not reassessed. By shifting assessment to occur earlier in the individual's period of incarceration, Hennepin's ACF POs and social workers can now use this information to determine programming and drive case management decisions.

Hennepin's core team identified its TJC target population (referred to locally as "TJC clients")—those inmates who would receive the "full package" of available transition services and interventions—according to assessed risk level and length of stay focusing on (1) ACF male residents screened and assessed as medium- to high-risk to reoffend with ninety days or more in custody and (2) ACF female residents screened and assessed as medium- to high- risk to reoffend with sixty days or more. In a 2013 profile report on its population presented to the CJCC, Hennepin found that approximately 12 percent (N=600~) of the ACF's annual bookings would qualify as TJC clients.

In early 2013, ten members of the TJC core team visited La Crosse County, WI, a Phase 1 TJC site, to learn about that site's experience with incorporating screening and assessment into its jail operations and reentry strategy. Hennepin returned from this trip with a clearer sense of how to move forward with screening and assessment and leads on new evidence-based curricula.

Prerelease Interventions and Transition Case Planning

In the first year of the TJC TA period, the Hennepin core team completed a case flow mapping process to document extant practice and conducted an inventory of existing programming and resources to determine both the prevalence of evidence-based practices and the range of criminogenic needs areas addressed (in order to identify any gaps). In 2014, the site also worked to develop, finalize, and implement a priority program schedule of core programs and incentives structures for individuals assessed as high-risk to reoffend early in 2014, and to implement transition planning and case conferencing.

The program inventory catalogued relatively few gaps with respect to topical issues but suggested the ACF did not have enough program slots to meet the needs of the facility's population. Prior to TJC and throughout the TA period, Hennepin offered a variety of services and evidence-based curricula at the ACF that ranged from adult education and GED programs, to employment training, mentoring, mental health

treatment, and chemical dependency treatment. Additionally, Hennepin offered cognitive behavioral therapy: *Thinking for a Change* (T4C, a curriculum developed by the National Institute of Corrections) for men and *Beyond Trauma* (a trauma-informed approach) for women. However, the ACF offered only limited gender-specific programs for women and hoped to expand this array; in turn, the program inventory identified a need to reach more clients with cognitive based interventions and an opportunity to link them to critical health benefits (see box 4).

BOX 4

Making Critical Connections in Health Care

Analyses indicate that more than half of all ACF residents do not have health insurance, compared to the 95 percent of the population who are covered in Minnesota. Recognizing that under the Affordable Care Act important resident needs such as behavior and chemical health treatment in the community are now covered at parity with other medical supports, Hennepin's DOCCR and HSPHD joined forces during the TJC TA period to develop, implement, and streamline a health care application system to provide ACF residents with health care coverage on release. In 2012, a team of employees from DOCCR and HSPHD designed a workflow that electronically identified ACF residents needing health care insurance on release. In 2013, community volunteers were enlisted to help qualifying ACF residents fill out health care benefits applications prior to release. In 2014, DOCCR and HSPHD staff reached an agreement with Portico Healthnet for a trained MNsure navigator to provide weekly face-to-face application and enrollment assistance to ACF residents. ACF residents may be referred for health insurance assistance by their probation officers or ACF social workers; residents may also self-refer through the ACF electronic kiosk. As of March 2015, 461 ACF residents had completed the process and health care coverage on release (Brad Kaeter, unpublished data).

Stakeholders reported that the TJC framework helped them determine the right level of service for the right clients; previously, stakeholders found it difficult to negotiate the limited program space and competing demands on clients' time. The TJC framework helped alleviate these issues by providing clear guidance on who to prioritize for services (high-risk/high-need) and what to prioritize (cognitive-based interventions as a core component, followed by areas of greatest need). As one stakeholder explained, "*By identifying the high-risk, high-need for programming and getting the right people to the right level of programming, it has caused us to look at how we share residents for programming so we are not competing for them, but sharing them.* "

In December 2013, the site initiated a pilot focused on serving the identified TJC target population. A June 2014 analysis of the first six months of 2014 indicated that 275 ACF residents qualified as TJC cases but that just 30 percent (N=67) had been enrolled in *Thinking for a Change* (T4C). It was evident from the analysis and

subsequent discussions that the ACF lacked the capacity to provide more cognitive behavioral therapy. Armed with this information, stakeholders obtained approval and resources from the TJC Executive Team to train additional POs in the T4C curriculum; doing so allowed the site to increase the number of T4C groups offered and thus, the number of individuals served at the ACF. Early analyses of pilot performance also indicated other issues for investigation and possible correction as highlighted in box 5.

BOX 5

Monitoring and Modifying Reentry Procedures

Once Hennepin stakeholders defined the eligibility requirements for the county's target TJC population, it took time and additional effort to ensure programming and service delivery aligned with these guidelines. Through its data collection and reporting mechanisms, the core team determined that a relatively significant portion of the target population were not receiving case management, referrals, and programming. Initial analyses of January-June 2014 data indicated that nearly 42 percent of individuals who met the target population criteria had been excluded by ACF-based POs. A review of the reasons cited for these excluded cases indicated that while some portion was excluded for "end of sentence" or because they qualified for work and school release, others just declined services. Armed with this knowledge, Hennepin reviewed these data with the ACF-based POs and discussed the issues around such exclusions. In this manner, Hennepin used its data to monitor and make midcourse corrections that would bring actual operations more in line with the intended reentry strategy.

Analysis of the pilot data (N-275), however, generally indicated processes were functioning as intended: 98 percent of male residents and 100 percent of female residents had a prescreener risk score on file with 85 percent of males and 81 percent of females scoring as medium- to high-risk. Of those numbers, 74 percent of males and 100 percent of female residents had been assessed with the LS/CMI. In turn, both populations fell within the designated length of stay (men averaged 99 days and women 65 days). A closer look at the data did reveal a possible discrepancy between screening and assessment: 61 percent scored as low-risk on the screener but high-risk on the LS/CMI, indicating a potential training issue.

In addition to expanding T4C programming, Hennepin County enhanced prerelease services in a number of other ways. In January 2014, the ACF began online GED testing; the facility also installed state ID equipment necessary to allow residents to obtain a state ID prior to release. The addition of HSPHD social workers streamlined transition case planning, and Portico Healthnet began MNsure Health Insurance Applications at the ACF. The site also implemented a new parenting curriculum introduced to the core team on its visit to the Phase 1 TJC learning site in La Crosse County (WI) and worked to increase the prevalence of transition case plans and the menu of community-based transition services.

The TJC initiative is successfully targeting medium and high-risk individuals with finite government and community resources in order to improve public safety and client outcomes. In 2014, 444 medium- and high-risk sentenced individuals were referred to the TJC program. These residents accounted for 2,297 program enrollments in the Adult Corrections Facility, including referrals to CBT (Cognitive Behavioral Therapy), chemical dependency treatment, education, employment, housing placements, and HSPHD social services (Brad Kaeter, unpublished data).

Under the new case flow process, individuals who fit the target population criteria meet with an ACF probation officer (PO) within five days of booking to complete an LS/CMI. The PO is then responsible for developing an individualized transition plan (see Appendix C). The HSPHD led the core team in developing this document, which serves as the main case planning feature for TJC clients. The transition plan identifies the client's high criminogenic needs and functional needs, ranging from chemical and mental health needs to addressing other common challenges, like health insurance enrollment, housing referrals, and identification cards. Each individual in the TJC population receives a physical plan to guide their program enrollment and goals at the ACF. The transition plan went through several pilot tests, allowing staff to give feedback and create revisions before the core team finalized the plan in late 2104.[62] Staff members at the DOCCR and HSPHD can both access the client's case plan through a secure, access-restricted electronic platform. This common transition plan is key for prioritizing program access and placement such that clients receive the services and programs they need most.

BOX 6

Incentives

ACF residents largely self-selected into programing prior to the TJC initiative. This often meant that low-risk/low-need residents—those least likely to need services—used the facility's limited resources. The site's new triage process meant the high-risk/high-need and often harder to engage residents would receive priority for services and programming. To engage these clients, Hennepin leveraged the ACF's six month reclassification process as an incentive: residents who did well could move to a lower security status, which meant more freedom and possibly work release. In turn, residents who enrolled in T4C received blue badges which also resulted in additional recreation time.

Once a client's needs are identified and transition plan drafted, the ACF social worker helps the client to focus on a range of services available in the ACF to start preparing them for their transition into the community. TJC stakeholders were especially proud of their progress in providing the opportunity for health insurance enrollment and health care appointments in the community. The DOCCR cleared Portico, a health services navigator, to visit the facility on a weekly basis to enroll individuals in health insurance and a community health worker to set up clients with health care clinics in the community, as discussed earlier.

Surveys conducted in 2013 and 2014 suggest stakeholders feel the services available to individuals in the jail are solid and have improved over the TA period.[62] As indicated in the figure below, stakeholders rated Hennepin's jail-based services higher in 2014 than in 2013—two years into the period of TA, in four categories: range (the number and type of services), quality, accessibility, and matching clients' needs to

services. Respondents rated all four categories above the midpoint in 2014, suggesting an improvement in the satisfaction with services for individuals in the jail.

Case Handoff and Continuity of Care

Creating continuity of care from inside of the facility to the community is a crucial aspect in the jail transition approach. Appreciating this important linkage, HSPHD social workers follow the same individuals with whom s/he works in the facility into the community to provide upwards of 90 days postrelease case management. Meeting with each individual on his or her caseload prerelease enables social workers to build rapport with residents prior to release, increasing the chances that clients will maintain this critical connection after release when support is most needed.

With the same aim of seamless service provision that begins in the ACF and continues into the community, Hennepin invested substantial time and energy facilitating community in-reach at the ACF. As described in the chapter on collaboration, the core team invested heavily in working with the United Way to network with community-based organizations and build relationships. Beyond inviting community providers into the DOCCR to train corrections staff on their resources, the DOCCR took the coordination a step further by "clearing" community providers to enter the facility and work with ACF residents prior to release. Thanks to these efforts, community-based providers, including EMERGE, St. Stephen's Human Services, and Catholic Charities visit the ACF to provide classes, one-on-one client support, and case conferencing around housing assistance and employment. TJC co-coordinator Brad Kaeter described how these connections between providers and TJC clients are helping to ensure individuals returning to the community see the same face when they walked in the service provider's door that they met in the ACF: "*the people seeing the clients on the inside are the people seeing the clients on the outside. That's a huge thing. We never had social workers before…the case management continuum continuing after clients walk out the door, meaning continuity of the person they saw on the inside, is great.*"

In addition to transition case planning and establishing relationships between clients and providers, the TJC core team wanted to advance the county's goal of aligning all jail transition work with evidence-based reentry and recidivism reduction practices. To ensure key partners and staff—ACF probation officers and social workers, AFS probation officers, security staff, community agencies, and other providers—were on the proverbial same page and speaking the same language, Hennepin enlisted the TJC national team to present and review principles of effective intervention, including the research on criminogenic risk, the responsivity principle, and using criminognic risk/needs assessment results to guide treatment decisions and dosage, and

how assessments like the LS/CMI complement other assessment processes, particularly those for specialized needs (substance abuse, trauma, mental health, etc.). One stakeholder from the DOCCR described how these issues came up and the team's efforts to work through these barriers to align with the evidence base:

> I know that [assessment information] is new because I had a meeting about the transition plan/case plan form, and the human services group drove the creation of the form. I was asked to take a consult look at it from the TJC angle, and there were a series of checkboxes they should make goals for, and not one of them was leading with stuff that was LS/CMI domains. They were close, but they were written in social services language. It hadn't translated yet clearly. During the conversation, we talked about how the language aligned with LS/CMI language, and how the LS/CMI should be guiding the needs of the clients and the additional, individual responsivity. It was an hour long meeting, and light bulbs went off in the room. The social workers though it was productive. It was a mystery before and took some time to sit down and explain from a different angle.

Although creating buy-in for risk assessments was an initial challenge, stakeholders reported that partners ultimately came to embrace the assessments: "*they have seen these people in the community, they recognize that the specific domains are key to reducing recidivism and they are on board with that. And that is why they are at the table with us. There is definitely buy in.*"

Securing commitment to share clients and using criminogenic risk/needs information across providers was invaluable for providing comprehensive services, but collaborating across agencies presented yet another barrier: sharing client data across HSPHD and DOCCR. To address this issue, the TJC core team secured a court order permitting probation officers at the ACF and social workers to share transition plans and additional client information between the agencies.

In late 2014, Hennepin took case coordination a step further and begun limited collaborative case conferencing with individuals approaching release. During interviews, one Hennepin stakeholder remarked that partners were already naturally starting to coordinate better even just through one-off conversations in the hallways of the ACF — conversations facilitated by the co-location of POs, social workers, and program facilitators at the ACF and which allowed partners to discuss cases and troubleshoot on an as-needed basis. Hennepin wanted to encourage these types of connections and make them more systematic. Under TJC, case conferencing brings together the TJC client, probation officer assigned to provide postrelease supervision, ACF social worker, and other community providers to discuss the TJC client's progress and needs prior to his/her release. Although the case conferencing process was still developing as the TJC TA period concluded, stakeholders expressed enthusiasm for the collaborative opportunities case conferencing would afford but acknowledged the logistical difficulties (caseload size, coordinating schedules across multiple staff and agencies) in doing so.

Community-Based Interventions

As part of Hennepin's jail transition strategy, ACF social workers provide case management to released ACF residents (TJC clients) for at least 90 days in the community. To promote continuity of care, ACF social workers refer individuals being released to employment, housing, and mental health services through many of the same providers with whom the client interacted prior to release. T4C aftercare is also available to clients in the community.

Self-Evaluation and Sustainability

Self-evaluation uses objective data to guide operations, monitor progress, and inform decisionmaking about changes or improvements that may need to be made to the initiative. Sustainability is the use of strategies and mechanisms to ensure that the gains or progress of the initiative continue regardless of changes in leadership, policy, funding, or staffing. Self-evaluation and sustainability are interlinked and reinforce one another. Here, we examine Hennepin County's use of data to inform, monitor, and refine its jail reentry processes and guide decisionmaking. We also explore the steps taken to ensure the sustainability of its jail transition work. Remaining priorities for implementation are also discussed.

Self-Evaluation and Data-Driven Approaches

As discussed earlier in this report and as illustrated throughout, Hennepin County brought critical data and analytic capacity to the initiative. The HCSO's Jail Management System (JMS) and the ACF's Offender Management System (OMS) both collected standard operations data necessary to compute length of stays and to create population profiles; the latter also housed basic assessment (LSI-R aggregate score) and programming data (attendance, but completion was limited to a Yes/No response). The DOCCR's Correctional Information System (CorrIS) largely captured AFS supervision information including client demographics, assessment, programming and compliance. The Statewide Supervision System (S3) platform pulled criminal justice data from across the state, including information from local police departments, jails, and probation. These databases could be linked by a unique client identifier, the SILS number, to permit analyses across state and county corrections, courts, and law enforcement. Notably, Hennepin County's HCSO and Hennepin County Medical Center (HCMC) also shared information allowing the ADC to check emergency records to verify health information for many of its inmates. In turn, HSPHD collected a wealth of information on its clients and service utilization.

Despite Hennepin County's substantial data holdings, stakeholders struggled with many of the same information flow issues that plague other jurisdictions: siloed data systems; a lack of data-sharing mechanisms and/or agreements; old technology that complicated data extraction and/or linking; and systems that did not readily support analyses and performance measurement. At the outset of the TJC initiative, much inter-system communication relied on personal contacts and networks. During the TJC TA period, stakeholders worked to formalize data-sharing in order to ease and standardize client information at both the client and agency level;

they also worked to create a common or shared language that bridged systems and reflected the site's new shared reentry practices.

BOX 7

Barriers to Collaboration

When surveyed by the national TJC team in 2013, Hennepin County stakeholders rated incompatible data systems (3.30) as the second most problematic barrier to collaboration among a list of ten common factors; this number dropped to 3.00 when surveyed again in 2014, suggesting modest improvements in Hennepin's sharing mechanisms but further room for growth. Barriers to collaboration were measured by asking respondents to rate 10 factors on the degree to which they affected how agencies worked together in the six months prior to the survey. Respondents rated each factor using a four-point scale in which 1 signified "not a problem" and 4 signified a "serious problem." Scores were averaged to calculate an overall measure of intensity: the higher the average score, the more problematic the factor.

Despite these challenges, Hennepin stakeholders systematically conducted analyses aimed at monitoring and improving operations. The DOCCR's PPE unit generated a number of performance and outcome measures prior to TJC, including an annual recidivism report that captured rearrests as well as reconviction; operational data reports tracked case flows, caseload counts and characteristics, and outcome per 1,000 bed days (escapes, injuries, etc.). The core team leveraged the expertise of PPE's analysts to generate a number of critical analyses to support the initiative's work.

Early analyses under the TJC initiative focused primarily on answering key questions about the ADC and ACF populations and their characteristics. Analysis of the cross-over population or "shared client" population—those clients served by both the ACF and HSPHD—proved critical both in terms of leveraging greater buy-in across health, social services, and criminal justice stakeholders, as well as for resource acquisition as discussed earlier in this report. These analyses took on even great significance once the site defined its TJC target population. Figures 4–8 below illustrate the extent to which high-risk/high-need ACF residents crossed the criminal justice and human services systems. The analysis examined the service use of 634 high-risk/high-need individuals booked into the ACF in CY2011.

FIGURE 4

TJC Clients Shared between HSPHD and the ACF – Shelter Use

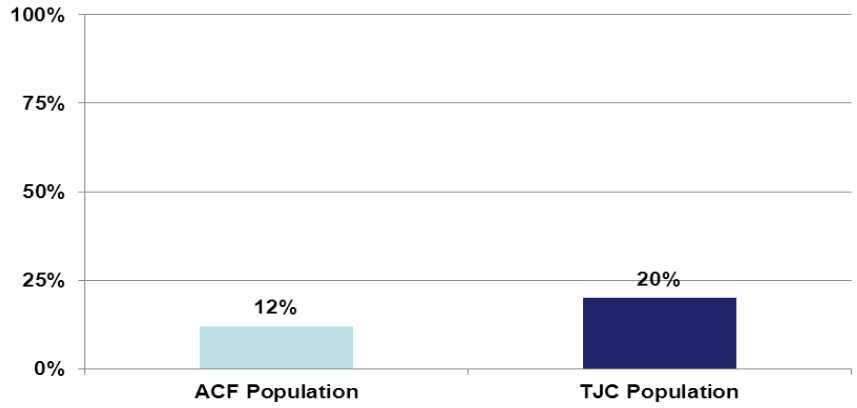


FIGURE 5

TJC Clients Shared between HSPHD and the ACF – Public Assistance Use

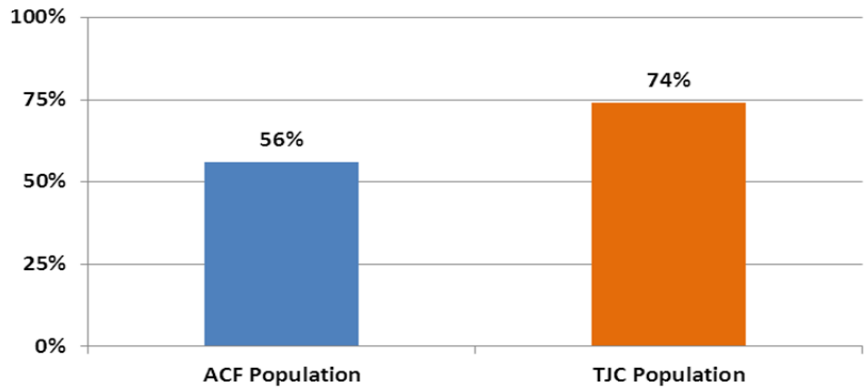


FIGURE 6

TJC Clients Shared between HSPHD and the ACF – Mental Health Use

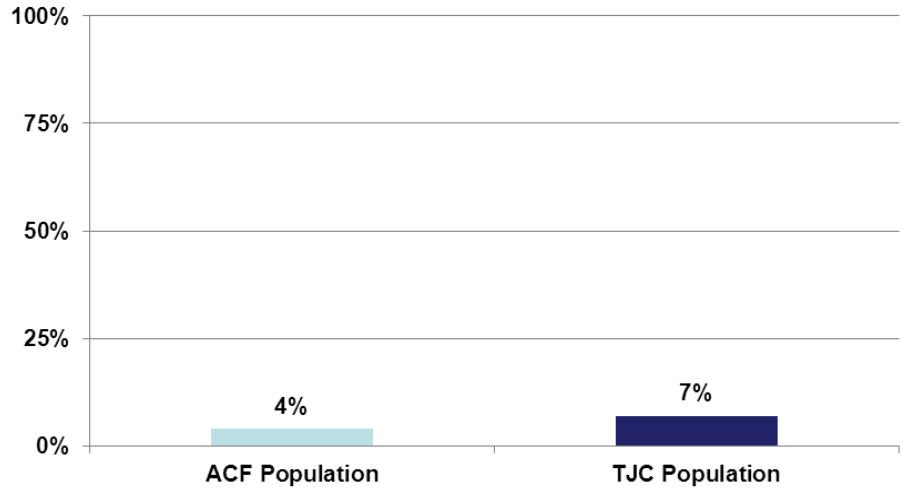


FIGURE 7

TJC Clients Shared between HSPHD and the ACF – Chemical Health Use

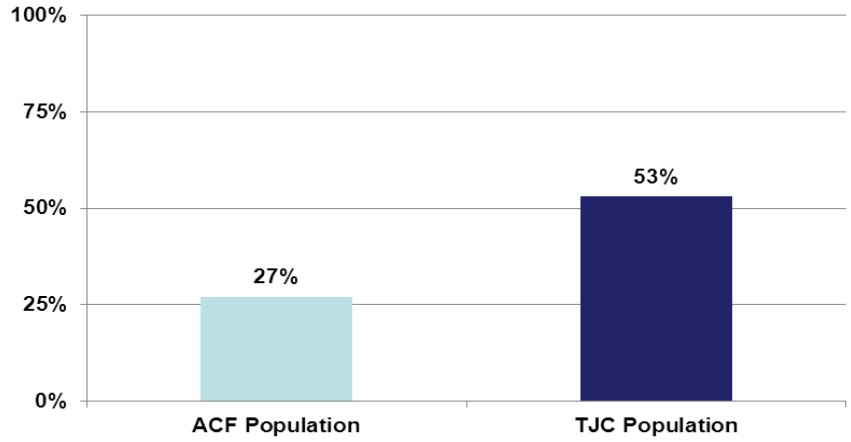
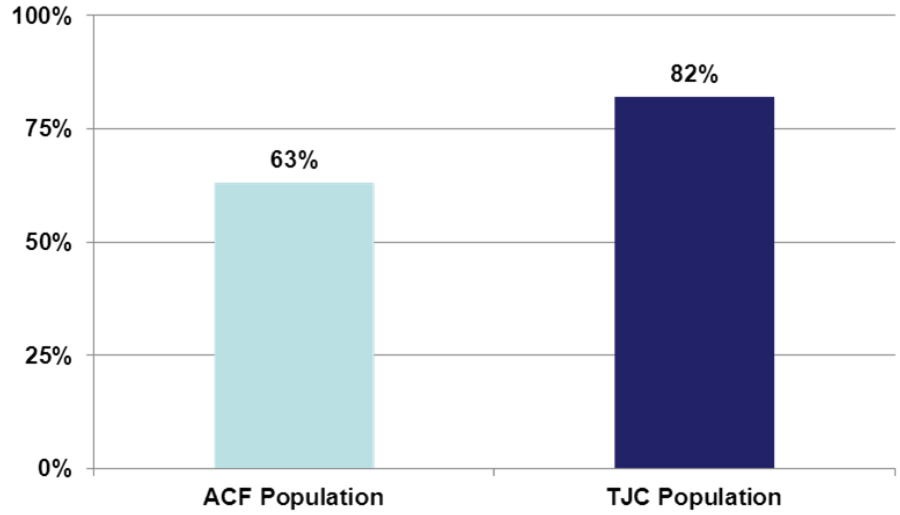


FIGURE 8

TJC Clients Shared between HSPHD and the ACF- Any HSPHD Use



These analyses both solidified Hennepin's understanding of its "shared client" and confirmed that the TJC triage framework devoted resources to the county's highest need individuals. As Figure 8 illustrates, 82 percent of individuals identified as eligible for the TJC population received services in HSPHD before or after being committed to the ACF in 2011 compared to 63 percent of the remaining ACF population. This analysis also provided a more nuanced understanding of the TJC population's human services usage (e.g., shelters, public assistance, HSPHD health care, chemical and mental health involvement).

Over time, consistent with Hennepin's core TJC principles that "in order to know what we do works, we must measure what we do" and the pace and progress of implementation, analyses shifted to performance monitoring and measurement. The county approached self-evaluation with two objectives: (1) improving its individual-level service delivery, and (2) refining its system-level processes. To facilitate the former, the DOCCR developed the point-in-time "TJC Report." This report allows the DOCCR to sort individuals in the target population by probation officer, and includes information on criminogenic risk and needs and program enrollment. The TJC Report also indicates if individuals are included in the TJC population and have a transition plan. By developing the TJC Report, Hennepin was able to triage both the ACF and ADF population by risk and need. With this valuable information, the team reallocated its resources to target sentenced individuals at medium-to high-risk for reoffending.

Hennepin also utilized the TJC report in conjunction with program data to monitor clients' access and engagement with jail-based interventions. With time, the team took additional steps to refine these reporting processes. Hennepin engaged the national team in discussions with relevant department IT (DOCCR and

HSPHD) to discuss data extraction and integration, as well as operational upgrades to facilitate reporting and analysis.

As Hennepin found better ways to integrate data systems, share information across providers, and systematically collect data from the DOCCR (including the AFS and ACS) and HSPHD, the site was able to routinely track the TJC Core Performance Measures and engage in analyses aimed at monitoring and improving the system's operations. Stakeholders described the fruit of this labor in our semi-structured interviews: *"[Data] has informed how we allocate resources (like staffing) and informed us about how many people it is realistic to manage in a target population at one point in time. For example, our probation staff has a manageable caseload (because often there is a probation officer in the community who can handle it there), whereas the social worker's caseload is ever expanding. They follow individuals into the community*."

Although the site succeeded in collecting many important measures, information and data exchange remained challenging. To ease information sharing between the DOCCR and HSPHD and facilitate client-level information exchange and analyses, Hennepin stakeholders obtained a court order permitting the two agencies to share information for evaluation purposes – a key accomplishment. Yet, other challenges remained. Hennepin needed to identify new, secure platforms to store and share client information between partners. For example, the core team wanted to share clients' transition plans between the DOCCR and HSPHD's social workers but they needed a platform that could accommodate multiple users and frequent updates while also maintaining clients' privacy and confidentiality. The core team identified a potential interface that would allow staff from both agencies to access these documents, but at the point of TA closeout, the county was still working through technical and legal issues associated with the proposed interface.

On a related note, the two agencies also recognized the need to develop a "shared language" to ensure consistent data collection and reporting. To that end, the initiate developed an extensive set of process and outcome measures with definitions for each indicator. By the conclusion of the TJC TA period, the site had generated a performance measures report focused on prerelease processes. Hennepin was still trying to determine the best method for tracking postrelease service receipt and completion. At the conclusion of the TJC TA period, Hennepin's stakeholders were manually tracking clients' postrelease linkages to community-based partners – a time intensive task that presented opportunities for inconsistency.

Quality Assurance

Consistent with the TJC model, Hennepin County introduced a number of quality assurance processes to monitor and enhance fidelity with its new reentry strategy. In August 2014, PPE analysts completed a formative evaluation of Hennepin's TJC reentry pilot within the ACF which examined how closely operations aligned with the new system of reentry practices. Analyses focused on nine processes, summarized under the following six practices: (1) intake; (2) facility risk classification; (3) risk screening; (4) criminogenic risk/need assessment; (5) release of information and transition case planning; and (6) needs-matching/service linkages by key position. PPE analysts observed key processes, reviewed how key data were recorded and stored in the ACF's OMS, and analyzed operations data to identify gaps in actual and intended practice and potential barriers to future performance monitoring. Recommendations were also made. The formative evaluation found that a number of key processes were in place and operating as intended, yet there were opportunities to strengthen reentry practices (revise processes, train staff, and update the department's IT systems to limit overwrites and data entry errors). A copy of the full formative evaluation report and its findings can be found in Appendix D.

In addition to identifying areas for improved implementation, the formative evaluation report and core performance measures data provided a format that supports ongoing quality assurance. Collecting and reviewing these data on a regular basis will allow stakeholders to track performance and enhance effectiveness.

Lastly, Hennepin County stakeholders initiated a quality assurance process for the ACF's core cognitive intervention, *Thinking for a Change* (T4C). Using a checklist provided by the TJC TA team, stakeholders observe T4C program facilitators in action to monitor fidelity to the curriculum. Implemented soon after the train-the-trainer sessions, the checklist aids both fidelity and consistency of program delivery across different facilitators.

Sustaining Jail Reentry in Hennepin County

A central goal of the TJC initiative is to build jail-to-community transition efforts that endure. Sustainability involves the use of strategies and mechanisms to ensure that the gains or progress of the initiative are sustained over time despite changes in leadership, policy, funding, and staffing. There are a number of mechanisms to facilitate sustainability such as formalizing new procedures in written policy, signing partnership agreements that specify partner roles and responsibilities, and leveraging financial support.

Hennepin took several steps to sustain the progress made during the TJC TA period. First, the site committed to advance its reentry work through the core team and Executive Team; both groups planned to continue to meet as scheduled. Partners also committed resources to sustain core interventions. For example, after locating social workers at the DOCCR on a temporary basis, the HSPHD ultimately introduced full-time equivalent funding into its budget to support social workers in both the ACF and ADC. This funding enables the social workers to continue serving full caseloads in the facilities and out into the community for the foreseeable future. Hennepin also expanded T4C at the ACF and will consider other opportunities for expansion. Finally, the DOCCR worked closely with community providers, who obtained numerous federal and local foundation grants in fall 2014 to expand service provision at the ACF and in the community. Lastly, Hennepin integrated core correctional practices such as risk screening and assessment into key operations, making these practices "business as usual" or standard operating procedure.

Conclusion

Hennepin County joined the TJC initiative as a learning site to expand reentry practices and bring its jail operations more in line with research-based principles of effective correctional intervention in order to increase public safety and reduce recidivism. Hennepin stakeholders sought to achieve these objectives by implementing risk screening and objective risk/needs assessment; using risk/needs assessment to drive programming; expand its continuum of evidence-based interventions pre- and postrelease; develop transition case plans and seamless case management; and use data to drive decision making.

As detailed in this report, Hennepin County made substantial progress in realizing these objectives. The site integrated the SPI (pretrial facility) and Hennepin Risk Screener (sentenced facility) into its respective jail booking processes such that risk-to-reoffend data exist for every individual who enters the ADC or ACF. The ability to quickly sort the jail population by risk to reoffend, as opposed to sorting by charge or institutional security risk, is foundational for any local recidivism reduction approach. Further, the site used its risk screening data to monitor population characteristics and to refine its classification and assessment procedures. Hennepin then advanced its efforts to create a coordinated reentry approach that begins in the facility and continues into the community by using its LS/CMI assessment to prioritize programming, expand needed interventions necessary to meet clients' multiple needs, and develop a shared transition plan responsive to clients' assessed needs.

In turn, Hennepin began collaborative case conferencing, involving the client and actors that spanned the criminal justice and human services systems and community. Training correctional officers, probation officers, and social workers on T4C and making cognitive-based interventions a core component of its reentry strategy for individuals assessed as high-risk/high-need represents another critical milestone. Colocating external partner staff—specifically HSPHD social workers and Portico Healthnet nursing staff—at the ACF while clearing community-based providers to meet with clients prior to release further advanced Hennepin's goals of creating a seamless transition process and increasing client success in accessing critical supports postrelease.

In keeping with Hennepin's established commitment to data-drive decision-making and quality assurance, stakeholders continue to track, measure, and review critical processes and outcomes to strengthen performance and effectiveness.

Lastly, the county succeeded in engaging staff at all levels —from front line corrections, probation and social services staff to executive-level leaders—in the development and implementation of its new jail reentry model. Importantly, Hennepin's Executive Team is fully invested in the new reentry model, a critical element for long-term sustainability.

Despite these considerable gains, Hennepin stakeholders are well aware that work remains. Recommended action steps include:

- **Strengthen and grow partnerships with the HCSO and other criminal justice stakeholders to advance the county's vision for comprehensive systems change.** The HCSO played a key role in the initiative, instituted foundational practices for the pretrial population, and can play a central role in creating a comprehensive recidivism reduction strategy that encompasses "no entry" as well as reentry goals. Along these lines, Hennepin should continue to conduct outreach and education to strengthen case handoff from the facility to the community and ties to the community; this includes periodic presentations to Adult Field Services on the TJC model and available resources.

- **Continue to engage community partners in leadership roles.** Community-based agencies are well represented in the collaborative, and the initiative recognizes that engaging community agencies in a broader leadership capacity is critical to sustain their involvement in the jail to community transition work. Hennepin had made progress in this area prior to the conclusion of TA and should continue to do so. Additionally, stakeholders should work to solidify relationships and continue to convene quarterly to sustain the relationships and collaborate—rather than compete—for institutional and community resources that support TJC.

- **Systematically gather data from community partners to measure TJC clients postrelease.** Collecting and measuring postrelease data and outcomes is challenging for many communities. Hennepin County should continue its quest to regularly obtain data from its community-based providers to compute and review postrelease outcome measures. Hennepin does a very good job of using internal jail and facility-based program data to monitor and refine prerelease processes; however, to assess overall performance, Hennepin needs to enhance its monitoring and measurement of both transition processes and community-based service linkages and utilization.

- **Advance quality assurance procedures including compilation and review of core performance measures data.** The formative evaluation report and core performance measures data provided a ready format that supports ongoing quality assurance. Collecting and reviewing these data on a regular basis will allow stakeholders to track performance and enhance effectiveness. Both should be reviewed with staff and used to solicit staff feedback and determine where any adjustments to the reentry strategy could be made. Additionally, Hennepin should report critical outcomes for the TJC population including, but *not limited* to, recidivism, as well critical process measures such as client engagement, compliance, and completion of services in the community postrelease.

- **Utilize technological platforms to enhance communication between the TJC core team and its community partners.** Platforms such as Basecamp may be useful forums to quickly notify partners about immediate client needs (e.g., transportation for individuals being released) and to enlist the proper partners to provide for those services; it is a handy tool for coordinating large partnership efforts.

- **Continue to use and expand collaborative case management and client-focused case conferencing.** As described earlier in this report, these processes had just begun to be implemented as the TJC TA period concluded. Hennepin should continue both processes, applying them to every qualifying case as doing so will strengthen "case hand off" from the ACF to the community.

- **Strengthen the use of evidence-based practices and expand core program services both in the jail and in the community.** Hennepin County made tremendous strides in delivering targeted, evidence-based programs to the high-risk/high-need sentenced population, as well as in developing a functional and effective partnership between criminal justice and community agencies, including HSPHD and the United Way, connecting clients prerelease to services and care to ensure continuity into the community, and instituting quality assurance processes necessary for the initiative's long-term sustainability. Although much has been accomplished, work remains to be done. Hennepin County stakeholders recognize that systems change is an ongoing endeavor that requires times, resources, and leadership. Accordingly, critical elements, including leadership at multiple levels, are in place to ensure Hennepin's continued advancement on these important issues.

Appendix A

Hennepin County Transition from Jail to Community – Principles

March 2013

Transition from Jail to Community (TJC)

Vision

Creating a safer Hennepin County while improving the lives of clients

Mission

To embed TJC in Corrections, Jail, Human Services and Public Health, and Community Agency operations.

Values

Increasing public safety while improving lives

Sharing responsibility across systems for people we serve

Collaborating more efficiently and effectively

Empowering staff to affect positive change in the people we serve

Supporting diversity and inclusion

Goals

Utilize valid risk-need assessments

Develop and implement seamless case plans

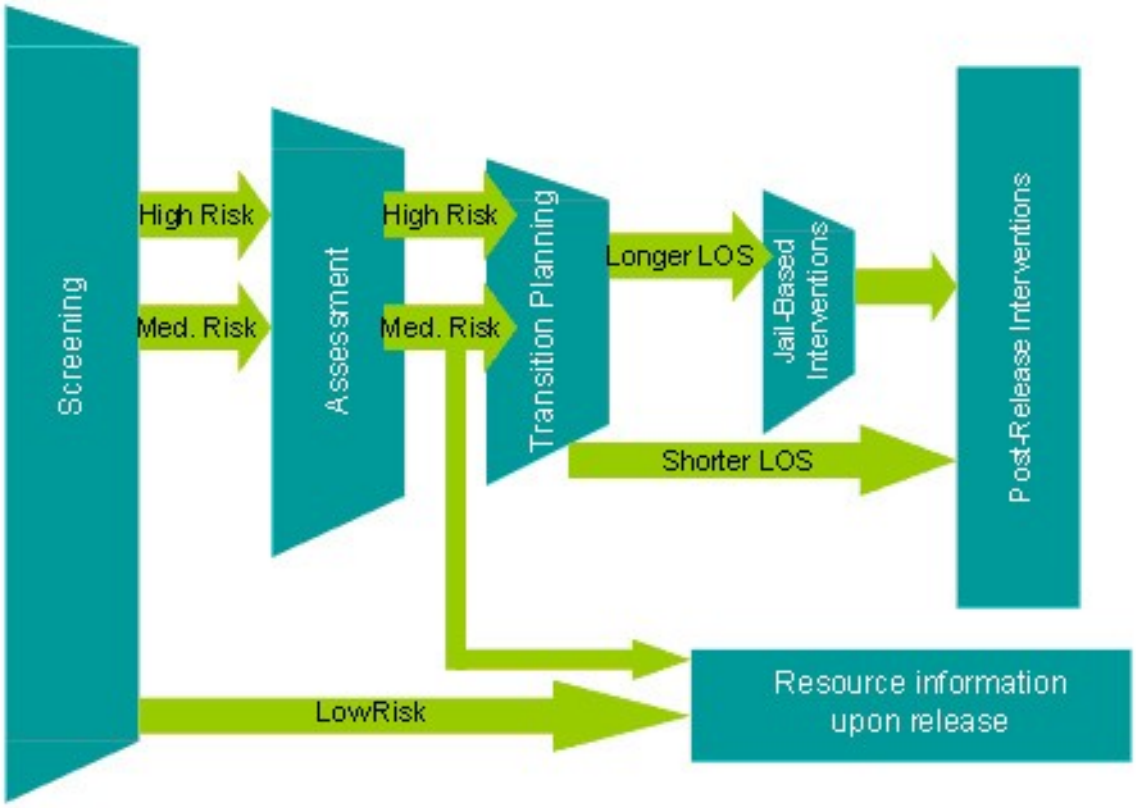
Identify and target effective interventions

Collaborate with stakeholders

1. TJC is not a new program; it is a new way of doing business: improving the system.
2. Jail, Corrections, Human Services and the community must work together.
3. Reducing recidivism will increase public safety.
4. Direct resources to the highest risk/need clients.
5. Short stays and the local nature of jail facilities mean that offenders move rapidly between being incarcerated and living in the community.
6. Services continue no matter where clients are and where you start.
7. Successful transition planning begins when they enter jail.
8. All staff, regardless of position play a role in encouraging client motivation to change.
9. How staff interacts with clients has impact.
10. Clients are responsible for their own behavior.
11. Clients differ in their readiness for change and what they need to change.
12. Staff will be respectful agents for positive change.
13. In order to know if what we do works, we must measure what we do.

Appendix B

Hennepin County Transition from Jail to Community (TJC) Model



Vision *- Creating a safer Hennepin County while improving the lives of clients.*

Mission - *To embed TJC in Corrections, Jail, Human Services and Public Health, and Community Agency operations.*

Appendix C

SharePoint Newsfeed OneDrive Sites PO xx xx

Client Last Name *

Client First Name *

Client Middle Name

Date of Birth *

SILS Number *

ACF Probation Officer *

Out Date *

Adult Field Services Probation Officer

AFS PO Phone Number

Probation Discharge Date

Booking Number

LS/CMI

Criminal History

Education/Employment

Family/Marital

Leisure/Recreation

Companions

Alcohol/Drug Problem

ProCriminal Attitude

Anti-Social

Alias(es)

Address Upon Release

City

State MN

ZIP Code

Phone Number

Other Phone Number

Goals Prior to Release

- ☐ Physical Health/Medical Care
- ☐ Education
- ☐ Criminal History
- ☐ Employment
- ☐ Identification Documents
- ☐ Family/Marital
- ☐ Leisure/Recreation
- ☐ Companions
- ☐ Alcohol/Drug Problem
- ☐ Procriminal Attitude/Orientation
- ☐ Antisocial Pattern
- ☐ Criminal/Legal
- ☐ Mental Health
- ☐ Financial Supports
- ☐ Housing
- ☐ Social/Family Functioning
- ☐ Community Integration
- ☐ Support System
- ☐ Personal Growth/Development
- ☐ Other

Prior to Release Comments

Goals After Release

- ☐ Physical Health/Medical Care
- ☐ Education
- ☐ Criminal History
- ☐ Employment
- ☐ Identification Documents

- [ ] Family/Marital
- [ ] Leisure/Recreation
- [ ] Companions
- [ ] Alcohol/Drug Problem
- [ ] Procriminal Attitude/Orientation
- [ ] Antisocial Pattern
- [ ] Criminal/Legal
- [ ] Mental Health
- [ ] Financial Supports
- [ ] Housing
- [ ] Social/Family Functioning
- [ ] Community Integration
- [ ] Support System
- [ ] Personal Growth/Development
- [ ] Other

After Release Comments

Adult Correctional Facility Social Worker

Community Case Manager

ROI on File ☐

Date of ROI

Exclusions? ☐

Archived No

Appointment(s)/Next Steps

Save Cancel

Appendix D

Hennepin County
Department of Community Corrections and Rehabilitation
Office of Policy, Planning and Evaluation

Transition from Jail to Community

A Formative Evaluation of the TJC Pilot Initiative at the ACF

July 2014

Introduction

The Department of Community Corrections and Rehabilitation's (DOCCR) Adult Corrections Facility (ACF) is in the process of making significant changes on how business is conducted by implementing the Transition from Jail to Community (TJC) pilot initiative. The purpose of this report is a formative evaluation of the TJC pilot initiative within the ACF. A formative evaluation focuses on the process of implementation while it is still forming. This will ensure that the processes in place will allow for future measurement and evaluation of effectiveness.

In order to know if what we do works, we must measure what we do. This report is one step towards building an understanding of whether or not TJC works. It is important to note that the observations are based on three visits with ACF line staff. Managerial changes to address these items were not evaluated, thus recommendations made throughout the report may already be in progress.

Transition from Jail to Community

TJC is not a new program; it is a new way of doing business: improving the system.[1] Increasing public safety while improving lives, sharing responsibility across systems, and empowering staff to affect positive change in clients are just some of the core values of TJC in Hennepin County. The ultimate goals are to enhance public safety, decrease recidivism, and assist an individual's reintegration to the community. These goals can be reached by following the TJC model: using screening and assessment to determine risk level, developing and implementing "seamless" transition plans with effective interventions based on assessed risks/needs, and collaborating with community stakeholders. In order to show that the TJC initiative is effective, it is important to be able to measure whether there has been a decrease in offending, substance abuse, and homelessness, with an increase in health, employment, and family/community connectedness. Part of evaluating those outcomes will be to determine whether the interventions were linked to the assessed needs. The ability to measure these results is strongly connected to the processes/workflow that will make the TJC pilot a success.

It is clear that the TJC pilot has brought in many new pieces and to date there have been many achievements with the new initiative:

- Piloted a new Classification Unit
- Hennepin County Prescreener
- LS/CMI utilization
- Began Transition Planning
- Social Worker from HSPHD has started with two more to start soon
- Healthcare screening protocols in effect

[1] Hennepin County Transition from Jail to Community – Principles, March 2013

- Employment/housing community resources available
- Ability to complete Sentence To Service – a restorative justice initiative - while in custody
- Collaboration with Department of Vehicle Service; ability to get an ID card while in the ACF
- Incentives for T4C participants – blue IDs

As with any new initiative that involves organizational change, not only will there be changes to the daily workflow, but there will also need to be changes to workplace culture. The first step in organizational change is to communicate the vision – TJC is about system change and targeted intervention. However, communicating the vision is not enough. The goals need to be translated to the team – what new responsibilities will this mean and how will this initiative change the workflow? With this, individuals on the team must understand their role and how their actions can impact the success of the TJC pilot. Behaviors and values consistent with the initiative should be reinforced and rewarded, while those that are not consistent should be addressed.[2]

Although the long-term goals of the TJC pilot are clear, the observation is that there is some confusion among the staff regarding their role and the purpose behind TJC. In order to have data integrity, the vision needs to be clear and staff has to subscribe to the vision. Without data integrity, the outcome measures will not be reliable measures of the work put in place at the ACF to carry out the TJC pilot.

The remainder of this report will review nine key input areas that when fully implemented will assist in answering the question: does TJC work? These areas include: Intake, Facility Risk Classification, Eligibility Criteria, ACF Staff- Probation Officers including Release of Information and Transition Plan, Social Worker, Community Case Manager, and Community Service Providers. In each area the report provides the TJC standard/philosophy from the Urban Institute, discusses facility observations, and recommends process and technical changes necessary to implement a successful pilot and to measure that success.

Intake

Standard:

The Urban Institute TJC model focuses on those who are assessed as moderate or high risk whether the stay is long or short. If they have a short length of stay, the intervention occurs outside the facility. The current target population at the ACF is a pilot, focused on services to the moderate to high risk residents with longer lengths of stay in-house.

Observations:

In the ACF, determination of Length of Stay (LOS) is two-fold: commitment letter and ACF standards. Often times, this means that the LOS in-house is different from the LOS set out in the commitment letter.

The observed workflow is as follows:

- The court e-mails the commitment letter to the ACF. The commitment letter is scanned and attached into the booking tab of OMS by Admissions and Records.
- The 3-11 Duty Officer triages all the next-day bookings; he/she sees what the judge wants, but also applies the ACF standards. For example:
    - A judge may sentence someone to work release, but if there is no history of violence, the Duty Officer will change the commitment to Electronic Home Monitoring (EHM).

[2] Heckelman, W.L., Unger, S., & Garfano, C. (2013). Driving Culture Transformation During Large-Scale Change. Organization Development Network, Inc.

        - Someone who may have been eligible for the TJC pilot population based on the LOS in-house might not be eligible after triage

- The Booking Officer on the day of arrival uses the Booking Wizard in OMS to book in the resident. Some information is already filled in, but the Booking Officer will fill in:
    - Adm Type – matches the triage commitment assigned by Duty Officer; does not necessarily match what is on the commitment letter.
        - Adm type never changes once it is entered.
    - Status type – originally matches Adm Type, but may change throughout the commitment.
        - Status type may change; a new status is added and does not remove the old status.

Recommendations:

In order to get an accurate representation of who is part of the TJC pilot population, it is essential to have accurate LOS data. This ensures that the focus is on those who will be best served by the TJC philosophy. Release date does not provide a good measure since the type of commitment may change from booking to release or may be only partially in-house.

- Admission Type should reflect the commitment letter.
    - Any changes that take place after that, including triage, should be included as a status change.
    - This change in workflow will allow for the evaluation of movement within statuses i.e. how many move from Straight Time to Electronic Home Monitoring.
- Expected length of stay "in-house" as determined by the commitment letter should be calculated.

These changes should take place early in the workflow, possibly during pre-booking.

Technical Needs:

Based on the above recommendations, certain changes would need to be made to OMS in order to accurately capture expected length of stay in-house.

- OMS fields should capture the details of the commitment letter.
    - This includes capturing the original commitment prior to triage.
        - Ideally, Adm Type should reflect the commitment letter.
- Field to indicate how many days of the commitment is expected to take place "in-house" would help the workflow and extraction of the TJC pilot population.
    - In-house length of stay should reflect the 2/3 standard and any furlough time from the commitment letter.
    - This information will be used to determine who may have been eligible for the TJC pilot population based on length of stay, but later had a status change that precluded them from the pilot population.

Facility Classification

Classification determines where the resident is housed within the facility and ability to work outside the facility.

Standard:

TJC philosophy would use program engagement and completion as a way to get to the ultimate incentive, reclassification to less and less security options over the length of stay.

The technical assistance report by Captain Randy Demory set the standard for the ACF's classification system. Captain Demory recommended an objective classification conducted using face-to-face interviews. The interview enables the classification officer to become more familiar with the resident, to "obtain additional and accurate information," and the ability to make an informed judgment regarding housing or program placement. [3] The formal interview also gives the resident an opportunity to address any ambiguities in his history and resolve any issues or concerns.

In addition to how to conduct the assessment, Captain Demory also suggested training staff on proper use of overrides and the ability to monitor the number of overrides occurring. "An override should occur when the classification instrument suggests a custody designation which, in the judgment of the classification officer, does not accurately represent the true level of risk presented by the inmate." The face-to-face interview becomes important in the override process as the Classification Officer will have access to both records and interaction with the resident. Finally, Captain Demory recommended that a screener assessing risk of re-offense be administered at the time of the face-to-face interview to assist in the TJC process.

Observations:

The current system in use at the ACF Classification Unit is assembly-line in nature. The day shift does the in-house classification for men and women by accessing separate databases to respond to the Initial Custody Assessment Scale (ICAS) questions; night shift does the Hennepin County prescreener and the PREA assessment in a face-to-face interview. It is not known if the night shift overrides any classifications from the day shift after the face-to-face interview is conducted for the Hennepin County presecreener and the PREA assessment.

A resident is reclassified every 60 days. When the resident is reclassified, the new score is input over the old score with a text-based note to indicate the change. The old data is no longer accessible.

Recommendations:

- Captain Demory would recommend that all three instruments be completed by the same officer during a face-to-face interview in order to get the most complete information about the resident prior to determining classification.
    - If the classification remains as a day shift/night shift balance, then there is a need for further integration to ensure transfer of knowledge and overrides to initial classification based on all elements reviewed during classification process.
- Follow the user manual for scoring the ICAS consistently to ensure inter-rater reliability. Changes in classification score will be one of the elements in TJC evaluation, so it is important that the data be accurate.

Technical Needs - Facility Risk Classification:

Theoretically, successful TJC clients (completing programs, no discipline, etc.) should move through the institution to lesser security levels. Lower security levels, allowing for more privileges within the facility, should be used as incentives. In order to track if reclassification is being used appropriately as an incentive:

[3] Demory, R. (2013). Inmate Classification System Technical Assistance Report.

- Important that the change in score is captured in a way that is not text based; the new data does not replace the old data but we see a history of what happened for each resident.
- Need to be able to see old classification fully and new classification with changes.
    - A drop-down with 3-4 main reasons why someone's level would change either up or down and the option to write in reasons that don't fit with the drop-downs would help track if reclassification is being used as an incentive and used appropriately.
- Disciplinary actions need to be electronically accessible for data evaluation; cannot be in a note. Preferably there would be a number of fields including elements such as date of offense, rule violated (drop down), informal/formal hearing results, and sanction imposed (drop down).
        - The hypothesis is that those in the TJC pilot population will have a reduced number of disciplinary incidents, so it is important to capture data regarding disciplinary incidents accurately.
            - A reduced number of incidents is beneficial to the ACF staff and the ACF as a whole.
- Need to be able to monitor the use of overrides in order to ensure the objectivity of the classification assessment with a field indicating the score has been overridden and the reasons why in a drop down.
    - Absence of overrides would indicate the system is not working as intended.
    - Psychometric theory would say overriding over 10% of the population suggests that the process is not objective enough.

Technical Needs - Hennepin County Prescreener:

- Continue making progress on the integration of OMS and the system that holds Hennepin County prescreener information:
    - Until that is completed, it is important to see as much information about the prescreener in OMS as possible.
        - The prescreener data will add a layer to the evaluation of the TJC pilot and will help to properly classify a resident.

Eligibility Criteria

Standard:

The Urban Institute TJC model focuses on those who are assessed as moderate or high risk whether the stay is long or short. If they have a short length of stay, the intervention occurs outside the facility. If the caseload within the ACF is overwhelmed, the TJC model would suggest that the focus be on those with the highest risk/needs and the longest length of stay. These residents would be considered the priority within the larger target population.

A successful evaluation of the TJC initiative will rely on accurate data regarding who is included in the pilot population. The evaluators of the TJC pilot will assume that if the minimum service requirements are met, that the individual received the transition planning, facility based interventions, and post-release interventions described by the TJC model.

Current criteria for TJC pilot eligibility at the ACF are:

- Moderate or high risk/needs on the LS/CMI
- Length of in-house stay 60+ days for women, 90+ days for men

Observations:

The criteria being used in the ACF to determine the TJC pilot population matches the standard as described by the Urban Institute. There is both a screening instrument and full assessment process in place with quality assurance. The pieces are in place for a successful implementation of the TJC pilot initiative.

Despite the solid criteria:

- Some residents who meet the criteria are being excluded from the TJC pilot population for reasons such as low motivation or full-time work release.
    - Those with full-time employment are talked about as low-risk.
- In some cases, the prescreener is being used as final criteria for the TJC pilot population, not as an initial screening tool.
    - Based on the TJC model set out by the Urban Institute, the prescreener should only be used to determine who needs further assessment with the LS/CMI.
        - Limited resources require reliance upon existing LS/CMIs and Adult Field Service agents following assessment policy to be able to execute other elements of TJC.
        - The LS/CMI overrides the prescreener risk/needs assessment.
- Those who meet the TJC eligibility criteria are being noted as "TJC" under the programs section of OMS.
    - This reinforces the idea that TJC is a program that the resident is enrolled in and not a philosophy.

Recommendations:

In order to track and evaluate the goals of the pilot initiative, it is important that the target population is identified consistently based on the criteria set out. If the resident meets the minimum requirements described above, he/she is included in the TJC pilot population.

- If an LS/CMI is not available for a client, one should be completed as soon as possible.
- If domain scores are not available due to another county restricting viewing authorization, total score should not be entered into OMS. A full LS/CMI should be completed.
- Although someone with full-time employment may be seen as low risk within the facility, the LS/CMI may show the resident as moderate to high risk of reoffending.
    - The LS/CMI will identify needs that need to be met in order to decrease the chances that the resident will return. Even with full-time employment, if these needs are not addressed, the goals of TJC will not be achieved.
        - One goal is employment retention. If needs are not addressed, someone with full-time employment may not be able to retain a job, which may increase risk of re-offense.

- Criminogenic needs such as poor decision making skills, anger management issues, lack of impulse control, family stress, and substance abuse strongly predict recidivism.[4]
    - Someone with full-time employment is still vulnerable to these types of needs.
    - Interventions that address multiple needs lead to better outcomes.

- "Risk" is used to describe residents as part of classification and the risk/needs assessment.
    - Use of language and common understanding of meaning is an important part of organizational change.
        - Opportunities to discuss and clarify the different meanings of "risk" used in the ACF could assist solidifying the TJC philosophy.
- Use motivational interviewing techniques to address those who lack motivation, but do not exclude them from the pilot population.

Technical changes:

Length of stay data:

- LOS is calculated off of release date. This may change due to early release to home monitoring, furloughs, etc. which are expected but stored only on the scanned commitment letter. This restricts the ability to accurately identify the TJC population in an automated way despite excellent clear-cut criteria.
    - If circumstances drop the length of stay to less than the 60/90 day criteria, need to be able to note the early exit from the TJC pilot population in fields within OMS.

LS/CMI:

- Need to be able to see the domain scores, not just the final score, regardless of whether the LS/CMI is coming from another database or being completed in-house
    - Domain scores are used in the creation of the transition plan to match appropriate services to the highest criminogenic needs of residents who are at moderate to high risk of reoffending.
    - The proposed integration of databases will assist this process only in part; any LS/CMI used from another agency will still need to have total and domain scores entered into OMS directly.
- The ability to see full domain scores will assist in self-evaluation and sustainability.
    - The domain scores need to be used to drive decisions – the ability to see the domain scores will allow for evaluation as to whether residents are being referred to the services that match their highest needs.
        - This will help provide oversight of the TJC pilot to ensure a fully responsive strategy:
            - Will ensure that services are being matched to criminogenic needs
            - Will identify gaps, areas where services are lacking for specific needs.

Automatic assignment to TJC pilot population:

- Remove TJC from "programs" and place the designation on a more general OMS tab.

[4] Carter, M.M., & Sankovitz, R.J. (2014). Dosage Probation: Rethinking the Structure of Probation Sentences. Center for Effective Public Policy.

- When a resident meets the basic criteria for TJC (LOS and moderate to high risk as determined by the LS/CMI), would be ideal if a TJC "field" was automatically populated with the word "yes" or a checkbox.
    - This eligibility would not be removed even if the person later becomes ineligible due to early release or some other reason:
        - Assists the workflow that identifies and initiates resident interaction under the TJC model.
        - Allows for evaluation of all who *were* eligible upon intake, but had a change in status.
            - Need to see the reason for change of status – was it a change in LOS or some other reason?
        - Can compare to those who were eligible and completed their time in house.
        - If there is a reason a PO chooses not to go forward with the TJC pilot initiative with a particular client, need a way to indicate that information in OMS that is not a text-based note or journal entry.

ACF Staff – Probation Officers

Standard:

The Probation Officers will likely be the first interaction the resident has with the TJC initiative. They will use the LS/CMI to determine risk and needs. Using the assessment, the PO will develop the transition plan to prepare the individual for release and reintegration, tailoring the services received in-house and those that will continue after release to the needs established by the LS/CMI. This occurs in a partnership with the resident, enhancing internal motivation to meet established goals. The PO will also be responsible for having the resident sign a Release of Information form.

Observations:

TJC is viewed, and referred to, as a program and not a philosophy. There was some confusion about TJC and what the role of the PO is during the pilot and beyond. In some cases, it was noted that the attitude was more in line with old habits, standards prior to the TJC implementation. It was also observed that inclusion in the TJC pilot initiative was at the discretion of the PO.

Recommendations:

The main recommendation is to communicate the mission and vision of TJC in order that line staff appreciate and understand their role in the TJC pilot and the impact they will have on the outcome.

- Use the "BEAR model" – Beliefs, Experiences, Actions, Results - to shape culture[5]:
    - Ensure individuals clearly see the link between beliefs/actions and organizational results
    - Assess individual beliefs through surveys, focus groups, or direct conversation and address situations where beliefs do not line up with the values established by the TJC initiative
    - Leaders of the organization/initiative must show they are committed to the change
    - Leaders need to shape and reinforce desired beliefs by providing incentives and follow-up learning programs to staff – encourage behavior change

[5] Heckelman, W.L., Unger, S., & Garfano, C. (2013). Driving Culture Transformation During Large-Scale Change. Organization Development Network, Inc.

- Additionally, staff needs to be reminded that they all play a role in encouraging client motivation to change and interaction with clients has an impact.[6]

Release of Information (ROI):

Standard:

The TJC model suggests that ACF Probation Officers should be working with the highest risk/longest length of stay residents as the targeted group. In that respect, anyone working with an ACF PO should sign the ROI. The ROI will be essential in the TJC evaluation process. Part of the agreement with the Urban Institute is to track referrals and utilization. The evaluation will also collaborate with outside partners to track usage of programs and outcomes such as employment, housing, health, etc. The social security number will be the best way of tracking this information; however, this is confidential information under the MN Data Practices Act.

Observations:

There was some confusion regarding how to fill out the ROI. The ROI was being signed and a hard copy placed in the file. POs are now scanning it in and attaching it to the booking page.

Recommendations:
Filling out the Release of Information:

- Resident should understand what he/she is signing
- All boxes should be checked if resident agrees
- Date signed should be filled in
- "This consent expires" _____ should be left blank
- Will need to work with AFS to get a new release signed when original expires

Technical changes:

- Need to see who has signed an ROI via reports
    - Scanning the item into OMS is a start; for effective evaluation, need a way to see who has an ROI completed without having to open an attachment.
        - To be able to get data from community partners regarding resident progress post-release, we must be able to first know whether we have permission on file to share their information. Having the elements of an ROI in fields within OMS, instead of scanned, will allow us to pull just those clients we have authority to release information on and still meet reporting requirements to TJC community service providers.
- Need to see the date signed and the date it will expire (a year out from the date signed); as well as any deviation from authorization for full release of all elements on the ROI.
    - The goal will be to generate a report that shows who has signed an ROI and which ROIs are soon to expire.
    - If the client is still under supervision, this report will be shared with AFS who can get their client to sign a new ROI.

[6] Hennepin County Transition from Jail to Community – Principles (2013)

Transition Plan:

Standard:

The transition plan is key in TJC pilot evaluation. The Urban Institute discusses three components to the transition plan:[7]

1) In-custody – covers the period of incarceration; developed in jail
2) Discharge plans – covers the period immediately following release; developed in jail
3) Post-release – covers the mid to long-term transition period; developed in jail, revised in the community

The transition plan is expected to be a coordinated and living plan that follows an individual from pre-release to post-release. The transition plan should be "clear and concise and should specify the client's risk level and identified criminogenic needs."[8] The transition plan outlines the strategy for continuity of care from pre-release to post-release. The aim of TJC is to reduce recidivism and increase reintegration to the community by using detailed risk of re-offense assessments (like the LS/CMI) to determine which services would best match the criminogenic needs of the resident and addressing those needs in the transition plan. Residents will be tracked based on the services to which they are referred to determine service utilization and long-term outcomes. Additionally, outside providers will want to know that clients are being referred to their services.

Observations:

Although the LS/CMI is being used, it is not clear whether it is being used to drive the decision-making when it comes to referred services. The transition plan seemed like another step in the work flow, disconnected from previous steps. The transition plan process is a very new one. Currently, ACF POs have completed between 70 – 100 transition plans. They are shared with clients and then scanned and attached in OMS.

Another observation is that the T4C program is only accepting residents who have been court-ordered to complete the program due to lack of resources. This suggests that even if the LS/CMI indicates that a resident would benefit from the T4C class, he/she may not get in unless court-ordered. The T4C program is not offered in the women's facility – they offer Beyond Trauma.

Recommendations:

The transition plan is connected to other areas of the TJC model:

- Use the LS/CMI interview and resulting domain scores to determine criminogenic and functional needs; focus on the highest needs and match to available and appropriate services.
    - Regularly check to ensure that transition plans are being constructed with a focus on matching highest criminogenic needs to services.
- Determine the resident's goals using motivational interviewing techniques.
    - If the resident seems unmotivated, use motivational interviewing to increase internal motivation.
- Determine the programs that the resident will participate in while in the ACF with the resident.
    - If there is a wait list for programs in the ACF, the TJC philosophy would suggest prioritizing those with highest risk scores and longest lengths of stay; not prioritizing based on court order. Residents with a court order are likely to have a community PO and opportunity to

[7] Urban Institute Triage Matrix
[8] Warwick, K., Dodd, Hannah, & Neusteter, S. Rebecca. Case Management Strategies for Successful Jail Reentry. http://www.urban.org/UploadedPDF/412671-Case-Management-Strategies-for-Successful-Jail-Reentry.pdf

complete T4C outside of the facility. Residents without a court order, but still high risk, may not have that same opportunity.

- Determine the definition of "completion" for various programs.
- Determine the services/resources the resident will be referred to upon discharge and post-release.
    - Due to limited programs and seats available within the ACF, a greater focus should be on post-release and transition to community.
        - Will need to collaborate with community PO to ensure follow-up and continuity.
- Arrange for outside providers to meet with the resident while in the ACF.

Technical changes:

The transition plan will be built from the criminogenic needs as determined by the LS/CMI. The theory says that if you target multiple criminogenic needs, there is a greater reduction in recidivism.[9] Information contained in the transition plan will be crucial in the evaluation of the TJC pilot. As part of the evaluation, there will be a need to link the assessed high risk areas to the services referred and the services completed. Part of the evaluation will be looking at recidivism rates for the TJC pilot population. If it is determined that someone was referred to services not indicated by the assessment or if only one domain was addressed rather than multiple, we can explain why the person returned to jail – their pressing needs were not targeted. However, if multiple criminogenic needs were targeted and there is still a return to jail, we will need to investigate why as part of the evaluation. Additionally, the interest will not be in how many received help from a specific community provider, but how many who *needed the help* received help from the community provider.

A successful pilot will be one in which the transition plan can be linked to the LS/CMI, multiple needs are targeted, the resident attends and completes programs to meet those needs, and does not return to jail. As such the data entered into OMS regarding the transition plan is of highest importance.

The transition plan should:

- Be entered into OMS, not scanned
- Contain checklists as well as text fields
- Contain information on the programs attended while in the ACF
    - Referred? Yes or No? Date
    - Started? Yes or No? Date
    - Court-ordered? Yes or no?
        - This information is currently found in the commitment letter, which is scanned into OMS and attached to the booking page
    - Completed? Yes or no? Successful completion? Date
        - If the program was not completed, there should be a way to indicate where the resident left off and why.
            - This will allow for follow-up post-release.
- Contain information on the services:
    - Which services the resident is referred to

[9] Carter, M.M., & Sankovitz, R.J. (2014). Dosage Probation: Rethinking the Structure of Probation Sentences. Center for Effective Public Policy.

- Whether the resident meets with an outside provider while in the ACF and how many times
- Date referred, date placed, date ended
- Status of referral

Social Worker

Standard:

The social worker will play a key role in building the transition plan with the PO and linking clients to services that are needed based on the LS/CMI.

Observations:

The Social Worker has access to information regarding previous utilization of services and health records. Currently, the Social Worker is "clearing" the TJC eligible pilot population:

- If the resident has previously accessed services, he/she is being added to the SW caseload automatically
- If the resident has not had previous access to services, relying on referrals from the PO
- The SW has a current caseload of approximately 90 on Part Time Employment, although two new social workers are expected to start at the end of the month.
  - Due to size of caseload, TJC eligible residents are being excluded if they are not motivated to work with the social worker.

Recommendations:

The same prioritizing mechanism from the TJC model should apply to all lists and resource issues. Focus first on those with the highest risk with longer lengths of stay followed by those with high risk and shorter lengths of stay, and then moderate risk/long length of stay. Increasing motivation to access services for this group is as important of an outcome as accessing the services.

With the addition of new HSPHD staff to the ACF, it is important to reinforce the needs-matching aspect of the TJC initiative.

Social workers should have access to the transition plan and/or the LS/CMI domain scores when meeting with a client in order to determine the services that are needed based on the highest criminogenic needs from the assessment.

Technical changes:

For evaluation purposes described in the previous section, it would be useful to capture the following in OMS:

- Date referred to the social worker
- Date met with the social worker
- Services referred to as a result

Community Case Manager

Standard:

In order to achieve continuity of care, the transition plan needs to be followed in the community with the assistance of the Community PO or a community case manager. The community case manager will collaborate with the ACF POs and Social Workers to build the transition plan. Ideally, Community POs or other community case managers will meet with the resident while still in the ACF to build rapport and to establish expectations of supervision. Building rapport and establishing clear expectations with the resident can increase compliance with the terms of probation post-release. The community case manager will also refer clients to additional services based on the transition plans and hold them accountable. A community case manager will provide intensive support and management for high risk/need individuals who need to follow strict treatment regimens.[10]

Observations:

The TJC initiative is not well-known by the community PO's. A successful pilot and evaluation will require full support from staff. There will be two different TJC populations being released from the ACF – those who will have an Adult Field Service PO and those who will not. Although it is clear who will follow through with the transition plan for those who are released to an AFS PO, the role needs to be further established. It is unclear how the transition plan will follow those who leave the ACF with no AFS PO.

Recommendations:

The transition plan needs to have clear follow-through in order for the TJC pilot to be successful, especially for those who will not be released to probation supervision. The community case manager, be it a PO or another community service provider, should meet with the resident while still in the ACF to build familiarity, establish a first meeting date post-release, and discuss expectations as related to supervision and the transition plan post-release.

Technical changes:

- Ability to track services referred and services attended post-release to evaluate the outcomes as described above.
- Ability to note meetings with the client while in the ACF in fields that are not text-based.

Community Service Providers

Standard:

Sharing responsibility across systems for the people we serve is one of the values in the Hennepin County TJC Principles. "Building and maintaining the collaborative partnerships necessary to plan and carry out a TJC initiative requires many different individuals and organizations to play different roles and assume different responsibilities."[11] The collaboration should be at both the executive level and at the implementation level. "In addition to shared goals and principles, joint ownership also involves identifying shared outcomes of interest and common performance measures to assess progress, inform adjustments to the strategy, and hold the local initiative accountable to its goals."

[10] Urban Institute Triage Matrix
[11] The Urban Institute – The TJC Model http://www.urban.org/projects/tjc/model.cfm

Observations:

There are many community service providers on board with the TJC initiative and willing to provide services and assistance. One key achievement is that Driver and Vehicle Services is coming to the ACF to make Minnesota ID cards for those who do not have driver's licenses. Something as simple as a government-issued photo ID can make a big impact upon release.

One of the barriers is that all providers who will be entering the facility need to have background checks and PREA evaluations prior to being granted permission to enter. This is time-consuming and may deter certain providers from offering resources. Another barrier is the access to residents in the facility. Outside service providers can only come into the facility at specific times. A final barrier is that some of the programs offered by the community service providers have very specific requirements for eligibility.

Recommendations:

- The Urban Institute recommends using community service providers to teach additional classes within the facility – specifically T4C.
    - This could provide PO time to focus on the key TJC element, the transition plan.
- Although it will not be exhaustive and will be a "living document," a list of service providers, their eligibility requirements, and any other information should be maintained and used by the POs for referrals while the pilot population is still in-custody and post-release.
- Communicate with POs (ACF and AFS) and Social Workers regarding outside service providers.
- Ensure that the ROI is signed to grant the ability to get data from community partners regarding resident progress post-release.
    - Without access to this data, the evaluation process will be minimal.
- Determine how community service providers will get information regarding the goals of the transition plan and how the POs or community case managers will get information back from community service providers regarding outcomes.

Technical changes:

In order to evaluate the referral to services and the success of the pilot, there is a need to track the following information in a way that is not scanned or text-based:

- Referrals to outside service providers
- Programs they are referred to
- Meetings with outside service providers (within the ACF or outside) and dates
- Whether there is successful completion of a program offered by an outside service provider

Conclusions

The ACF has gone to great lengths to ensure that the pilot TJC initiative is successful. New classification processes are in place, new assessments are being used, new programs are being run, and outside service providers are being brought in. This evaluation shows that many elements are established and others are forming, as would be expected for an initiative in this early stage of implementation.

A further step toward successful implementation is to ensure that the staff is on board with the TJC philosophy to fulfill the mission of "embedding TJC in Corrections." Providing greater clarity to staff related to the TJC philosophy will help ensure TJC doesn't becomes just another "program," another addition to an overwhelmed caseload. To ensure data integrity, it is imperative that the values of TJC are upheld and followed.

Finally, in order to fully evaluate the success of the pilot, technical changes need to be made to allow data to be entered into OMS fields rather than scanned and attached. When data is entered, it can be pulled, reports can be run, and the impact of TJC on the clients can be evaluated. To return to Principle 13, "in order to know if what we do works, we must measure what we do." This can only happen with changes to the technology.

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Notes

1. The DOCCR's role and reach, as Hennepin noted in its TJC application, is broad: the agency provides oversight and services to criminal justice-involved individuals at all stages of the legal process from pretrial risk assessment and bond evaluation to short-term incarceration and postrelease supervision and services through its Adult Field Services (AFS) unit. As such, the DOCCR works closely with the HCSO's pretrial detention staff, the judiciary, and local law enforcement.
2. In 2011, 58 percent of individuals committed to the ACF accessed public health care and 56 percent qualified for public assistance; 27 percent need chemical health services; 12 percent were homeless.
3. Hennepin County is involved in several national initiatives including the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI), a collaborative involving juvenile court judges, prosecutors, defenders, and community members that began in 2005 to divert juveniles from custody, and the Bureau of Justice Assistance's Criminal Justice Coordinating Council initiative.
4. In reality, this allocation supported co-coordinators, Connie Meyer and Brad Kaeter. Hennepin was strategic in its selection of staff for these positions. Ms. Meyers, for example, was the ACF's Manager for Programs and Services, but previously worked with HCSO for more than decade during which she served as the main coordinator to bring community-based services and programming into the ADC. Mr. Kaeter held prior positions with Hennepin County's CJCC as well as the HCSO.
5. By the end of the TJC TA period, this pilot arrangement had expanded to include two other social workers; a total of three HSPHD social workers worked out of the ACF to deliver prerelease case management and services coordination. These social workers continued to work with clients in the community after their release from the ACF.
6. Similar to the ADC, the DOCCR conducted initial screens on ACF residents at booking, but these screens identified medical and/or mental health needs, not the individual's risk to reoffend, and were used to determine housing security level, not risk of reoffense.
7. Vera identified four factors—**admission age** (those 20 and younger were more likely to be rebooked within a year), **current charge** (property and drug offenses increased likelihood of jail readmission), **number of prior jail** admissions, and **proximity of recent jail admissions** (those with a prior jail stay in the prior eight weeks were more likely to be readmitted within a year)—as predictive of jail returns (Wei and Parsons 2012). Hennepin found three additional factors were predictive for the ADC population: if the top charge was for a DWI or violent crime or involved a weapon.
8. As of August 2014, transition case plans had been completed for 180 clients.
9. Respondents were asked to rate the range, quality, and accessibility of services available to jail-involved clients, both while in the jail and upon return to the community, using a four-point scale in which 1 signified "unsatisfactory" and 4 signified "excellent." Scores were averaged to calculate an overall measure of intensity. A score of 2.50 was the midpoint.

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Statement of Independence

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