CENTER FOR APPLIED RESEARCH & ANALYSIS

Bernalillo County Behavioral Health Initiative (BHI) Resource Reentry Center (RRC) Process Evaluation

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Introduction

In February 2015, the Bernalillo County Commission (BCC) and voters approved a gross-receipts tax (GRT) expected to generate between $17 and $20 million each year to improve access to care and to develop a unified, coordinated behavioral health system in Bernalillo County (CPI, 2016). One of the approved service components of the GRT was the Resource Reentry Center (RRC) which provides services and referrals to individuals immediately upon being released from the Bernalillo County Metropolitan Detention Center (MDC). The goal of the RRC is to enhance linkages of individuals with community-based services to reduce recidivism and to improve public safety. Previous research suggests that in the first few days following release, individuals returning to the community are at high risk for drug use, homelessness, and other problems that may increase the risk of reoffending (Jannetta et al., 2011). However, to date no research has evaluated the programmatic operations of the RRC or whether the linkages to services offered by the RRC resulted in reduced recidivism. In 2021, 14,440 inmates were released from custody from the MDC, and in 2022 15,323 inmates were released.

The goal of this process evaluation was to determine how closely the RRC was following evidence-based practices for reentry and to determine how successful the RRC has been transitioning individuals from the jail to the community. This report will discuss the current process components of the RRC. To evaluate the effectiveness of the RRC, we (1) conducted a survey of county staff involved in the reentry process (n = 25) to better understand how staff perceive the reentry planning process and the RRC, (2) conducted observations of the intake and screening process at the MDC, and (3) reviewed client records for all inmates who passed through the RRC between 2018 and 2022.

This report presents the findings and limitations discovered in the RRC's currently used reentry and transition processes compared to best practices. We found that there were challenges associated with how the RRC screened, assessed, and targeted individuals for intervention related to a lack of standardization across process components (i.e., not all questions from validated instruments being asked, risk scores not being automatically generated), which can potentially impact recidivism reduction. Surveys collected from staff members provided insight into challenges related to reentry, such as the need for a single case plan to follow the individual through jail and into the community. Finally, analysis of the client-level data illustrated the services and needs of clients. While many individuals (n = 9,985) completed risk needs assessments (RNAs), the number of individuals that completed transition plans (TPs) is far less (n = 2,785). Due to the nature of the different challenges of the current process in place, determining the impact of the RRC on recidivism reduction remains complicated.

Literature Review

The criminal justice system has increasingly prioritized research on adult reentry programs, aiming to reduce recidivism through various programs and services. While there have been recent best practices established surrounding reentry planning for individuals with mental health conditions and substance use disorders involved in the criminal justice system developed by the Substance Abuse and Mental Health Services Administration (SAMHSA 2023), reentry in jails remains challenging since they are "designed as shorter-term holding facilities; therefore compared to prisons, there is less opportunity for long-term planning for reentry into the community and they often have smaller budgets for programming" (SAMHSA, 2023). Thus, it is especially important that the implementation of best practices in jails adopt organized collaboration among all involved in the reentry process.

Much research on adult reentry programs focuses on the risk and needs of inmates with psychological, behavioral, and substance use problems (Mitchell, et al., 2019, Fox et al., 2019, Wilson, et al., 2011). Previous research finds that 75% of those in jail have co-occurring substance use disorders (Fox, 2019). An important approach in reentry, therefore, should be to determine an inmate's risk and needs upon being placed into custody. While there are various reentry models that can be implemented, it is imperative that jails select one that can serve the needs of all inmates who enter the system.

One model that has been developed is the Assess, Plan, Identify, Coordinate (APIC) model. The APIC model components include assessing an inmate's clinical and social needs and risks, planning for treatment services related to an inmate's needs, identifying different post-release programs, and coordinating with an inmate to develop a transition plan (Osher et al. 2003). Osher et al. (2003) argue that if these elements are incorporated into a reentry plan, inmates' outcomes such as incidence of psychiatric symptoms, hospitalization rates, relapse to substance abuse, suicide, homelessness, and criminal justice system involvement will be improved. Although these reentry system components seem straightforward, the challenge is establishing and maintaining a process within an entire system from initial intake through release. Ensuring that a single case plan is used among all organizations interacting with a client and deciding upon which tools should be used for screening, assessment, and data collection prove to be challenging in jails.

Another reentry model is the Transition from Jail to Community Model (TJC) developed by the National Institute of Corrections and the Urban Institute. This model includes three major system components: inmate screening, assessment, and case management (TJC, 2012). While the goal of the TJC model is to improve outcomes for inmates, this model also emphasizes the necessity of collaboration between jail staff and community-based partners and provides real lessons learned as well as tools used by jails. Since the model provides a foundation and ways in which to implement tools, this model is especially useful in providing structured recommendations on

components that may be overwhelming for jails and staff to establish. Additionally, the TJC model recognizes the challenges with system-wide changes, so it provides jails a guide to roll out the model in phases, making it an appealing choice to ease the overwhelming nature of large-scale systematic changes. Research on the TJC model by Willison et al. (2014) evaluated the early implementation stages of a TJC-modelled reentry program using a quasi-experimental approach and found that the use of proper re-entry programming reduced an individual's risk of re-arrest by 24%. As part of this process evaluation, we evaluated whether the implementation practices of the RRC reflect those of the TJC model to determine if the RRC:

1. Follows best practices associated with jail reentry that include screening, assessment, and case management (TJC, 2012).
2. Reaches its intended target population by reviewing the number and types of individuals the RRC serves.
3. Influences the recidivism of clients served.

Screening and Assessment

To determine which inmates are at higher risk to recidivate, it is important that jails incorporate a valid instrument in the screening process to evaluate the risk and needs of every individual being booked into custody. The TJC model recommends implementing a two-stage screening and assessment process to effectively determine the risk and needs of each individual. Due to the potential fast turnover of inmates in jail, the TJC model recommends implementing a triage approach to effectively determine and prioritize resources for inmates that need them the most. The triage approach as defined by the TJC model is a way to "prioritize interventions based on where resources are most needed or are most likely to be successful" (Christensen, et al., 2012, p. 2). Ultimately the goal of the screening and assessment process according to the TJC model should be to categorize individuals and then determine the appropriate type of, and the intensity of, interventions. Since there are two elements present in this portion of the process, it is necessary to define the differences between screening and assessment and their relationship.

The screening principles established by the TJC model are:

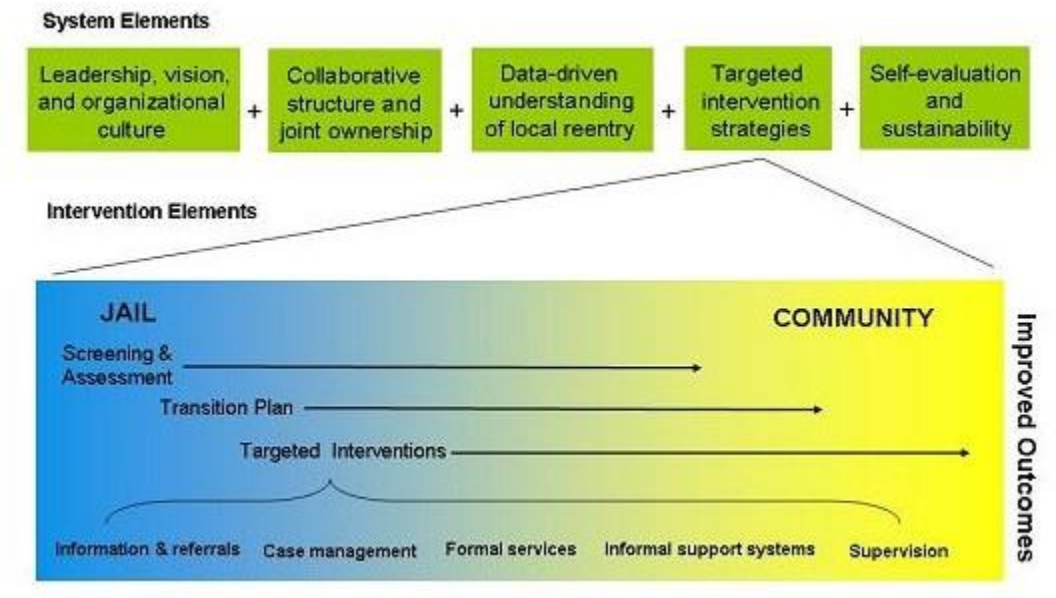
1. Risk screening should be done using a valid and reliable[1] tool designed to measure risk to reoffend in the community.
2. Screening should be conducted on the entire jail population and should occur as close to booking or initial entry as possible.
   Screening should be used to categorize the jail population by risk level with different intervention tracks for each level.

[1] Reliability is the extent to which a tool accurately measures results. Validity is the extent to which a tool measures what it is designed to measure.

Assessment in the TJC model entails evaluating an individual's criminogenic risk factors [e.g., having antisocial peers, antisocial thinking, antisocial personality, employment/vocational skills, family dysfunction, education level, substance/alcohol abuse, self-management/life skills, and use of leisure time]. These risk factors can be modifiable and are related to an inmate's likelihood to reoffend (Christensen, et al., 2012). Assessment is intended to develop targeted, specific goals for inmates within and outside of custody. While screening is intended to be a simple process, assessment aims to dive deeper into treatment targets for all individuals. The assessment principles of the TJC model are:

1. Assessment is provided for inmates who have been screened as medium or high risk for re-offense.
2. All assessment must be statistically valid and reliable.
3. Assessments of criminogenic need must guide case planning, case management, and targeted treatment.

Figure 1.
The TJC Model



Case Management

Case management in the TJC model plays a critical role in the reentry process. According to the model, case management should bridge the gap between the services an individual receives from entry into jail and upon release into the community. The TJC case management principles include:

1. Case management services are provided to clients who have been screened as medium to high risk to reoffend.

2. Clients receive a comprehensive case plan that builds upon needs assessment by specifying interventions that address the client's identified criminogenic needs.
3. A single case plan is used by all agencies interacting with the client, including the jail, probation, and community-based service providers, and the case plan follows the individual into the community upon release from jail.
4. Jail staff coordinate with staff from community-based organizations to ensure that clients are referred to appropriate programs and services.

To be effective, case management should begin during incarceration by a team. The case plan should:

1. Be created in jail to prepare an inmate for release.
2. Focus on immediate post-release interventions.
3. Focus on longer-term transitional periods while an inmate is in the community.

This component of the TJC model requires that the case plan be brief and transparent while highlighting an inmate's risk level and criminogenic needs.

This component can present challenges due to the amount of time inmates spend in jail. However, the TJC model provides strategies intended to guide jails and agencies in streamlining the process. Developed case plans should contain information regarding community supervision, such as probation or parole. Furthermore, case plans should be provided to the supervising officer upon an inmate's release from jail.

The TJC model also encourages inmates to be active participants in their case planning process and to work with their case managers to establish short-term and long-term post-release goals. The case plan goals should also be reviewed with inmates regularly. Partnering community-based organizations should be selected by case managers to address the criminogenic needs of inmates using evidence-based practices. Additionally, the reentry program should align service intensity with an individual's risk level. For example, if an inmate scores as high-risk with alcohol abuse, they should be referred to a program that has shown to be effective and is evidence-based in targeted treatment rather than simply referring an inmate to a 12-step program. While there may be several different community-based programs available for inmates, it is the responsibility of the case management team to inventory and establish programs that are evidence-based[2] and all organizations involved should work in tandem to treat individuals.

[2] Evidence-based is defined as a concept or strategy that is derived from or informed by objective evidence. https://www.edglossary.org/evidence-based/

The TJC model recognizes the challenges associated with the continuity of care due to variations in length of stay across the jail population and provides some strategies that have proven to be valuable. These are listed below with brief descriptions.

1. *Jail "In-Reach"*: this method consists of community-based service providers meeting with inmates in jail to help them with resources upon release. Beyond providing recommendations, this method helps build rapport and trust. Additionally, some community-based providers provide case management in jail and continue through a designated center when an inmate is released. The "in-reach" method has also been used to incorporate informational sessions on different resources available.
2. *Consistency in Programming and Services*: this is a key component in case management strategies according to TJC, and encourages consistent assessment, case planning, programming, and other services between the jail, community-based providers and supervising agencies (TJC, 2012).
   Information Sharing: Case plans and assessments should be automated and shared across jails and community-based resources to ensure easy access for all involved parties and should be kept up to date.

Current Process Description and Comparison to the TJC Model

This section will discuss the findings of the current process in place for inmates that are booked into MDC custody and released to the RRC and how it compares to the TJC model.

Receiving Screening

Prior to being booked into MDC custody, inmates must undergo a receiving-screening process completed by the jail medical contractor. The receiving screening process is designed to capture an inmate's medical information, substance and alcohol use, behavioral health history, and previous incarcerations. All information is captured in an electronic system, and once inmates complete the receiving-screening process, they must sign and consent to being booked into custody. Information captured in this process follows the individual into jail and can be used to determine placement, services, and resources for inmates.

Table 1 highlights the specific instruments that the MDC uses to evaluate inmates' medical history, substance and alcohol use, behavioral health history, and propensity to recidivate. While these tools have been integrated into the electronic system to screen inmates, there have been some challenges in how and what data is captured and stored. Staff indicated they are operating at about 50% capacity, and with the shortage in staff, screening is difficult to complete for the entire jail population. Additionally, staff members discussed the issues of incoherence (i.e., inability to answer questions, lack of clarity, inability to communicate effectively) , noncompliance (i.e., refusing to participate in the screening process, getting physically and/or verbally violent), and wanting to get the screening done so officers can be on their way as

hindrances in screening. These tools are used to help determine potential recidivism risk and, per best practices, should be scored automatically as close to intake as possible to begin reentry planning. The TJC model emphasizes the need for consistency and completeness in using a selected tool; however, the current process in place is not consistent, so completeness varies. To elaborate, while some staff spend time screening all inmates that come in for booking, others do not. Questions are skipped, some staff were unfamiliar with the tools, and risk scoring is not generated automatically. Screening is intended to guide assessments and case plans for each inmate after they are booked into custody.

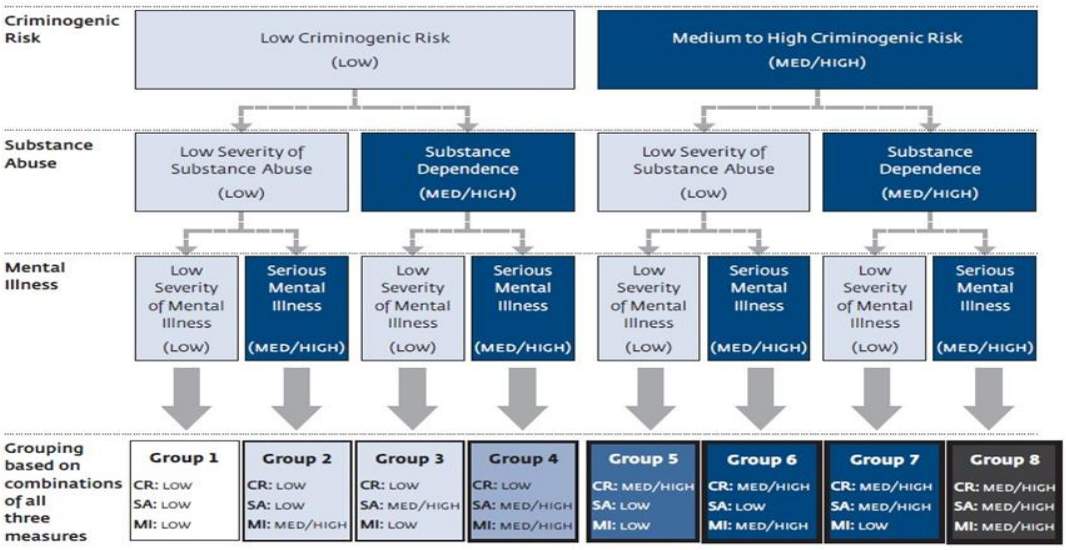
Table 1.
Incorporated Validated Instruments in MDC Receiving Screening

Tool	Number of Questions		Measures
Brief Jail Mental Health Screen (BJMHS)	8		Mental Health
Alcohol Use Disorders Identification Test Consumption (AUDIT-C)	3		Substance Use
Drug Abuse Screening Test (DAST-10)	10		Substance Use
Opioid Risk Tool	5		Substance Use
Proxy Risk to Recidivate	3		Criminogenic Risk
Total	29		--

Assessment

Assessments for the RRC should occur as close to booking as possible and should be used for inmates who score medium to high risk during the receiving screening process. The Risk Needs Assessment is the tool used by the RRC which was developed based on the framework that was established by Osher et al. (2012) that aims to target behavioral health and substance use needs of individuals under correctional supervision. Based on this framework, risk/needs responsivity (RNR) is crucial in preventing future reoffending in inmates with behavioral health needs. Assessments are completed by the transition plan staff and follow an individual through release to the RRC. Figure 2 highlights the Criminogenic Risk and Behavioral Health Needs Framework which groups individuals on their likelihood to recidivate.

Figure 2.
Criminogenic Risk and Behavioral Health Needs Framework, Osher et al. (2012)



While this model has proven to be effective as an assessment tool, screening and receiving data should capture baseline information so staff are aware of which individuals to target for assessment.

Because the current receiving screening process is inconsistent (i.e., not all questions from the screening tool being asked, there is not a standardized way in which questions are asked and the inability of the electronic tool to automatically generate scores), staff have challenges determining which individuals to target while at MDC. Transition planners have relied on high utilization of emergency room visits and CARE campus data to evaluate whether inmates are medium or high risk. Risk Needs Assessments are also completed by RRC staff once inmates are released through the center. Although this method serves as an interim solution, to effectively begin transitioning individuals into the community, the TJC model emphasizes the need for assessment to be done as close to booking as possible based on receiving screening data.

Case Management

Inmates that are assessed at MDC have a case plan developed, or transition plan, that follows them to the RRC, where they are provided with resources and assistance if needed. However, if no transition plan is developed while they are in custody, they can develop one while at the RRC once released. Transition plans are voluntary, regardless of whether an inmate scores at a medium to high risk to recidivate on the RNA.

Many inmates may score medium to high risk to recidivate but choose to not create a transition plan (n = 3,686), and once released may face challenges that can lead to reoffending and back in jail. The RRC also helps these individuals contact and request services if the individual agrees.

Inmates are usually contacted or attempted to be contacted within five days after leaving the RRC to follow-up with staff members and to verify they have been in contact with or have visited the community-based resource they were referred to.

While the transition plans developed for inmates are helpful in determining the types of services one may need, there are many areas of improvement in the current process. The TJC model recommends that the transition plan is developed while an inmate is still in custody. While this may not be possible for all inmates due to time constraints, it can aid in a smoother process once the inmate is released. Additionally, for case management to be effective, it would be helpful if the RRC worked with probation and parole to establish a single transition plan that could be shared across all involved organizations. Currently, data is maintained by the different units (i.e., MDC, RRC, probation and parole, community-based organizations) involved with inmates through separate electronic databases. While the timeframe for case management may be difficult to evaluate, individuals with a higher risk to recidivate may require a longer timeframe of case management.

Methods

To better understand how the RRC operates and to evaluate how the current process compares to the TJC model we surveyed RRC staff, conducted observations of the transition planning process at the RRC, and reviewed client records.

Staff Surveys

We administered surveys to RRC staff (i.e., reentry staff, transition planners, and supervising staff at the MDC) in order to evaluate how staff perceive reentry planning at the RRC. The survey included questions asking RRC staff to evaluate their beliefs about offenders, participation in the reentry process, reentry planning and collaboration, the RRC, job characteristics, perception of the program's implementation, and demographic characteristics.

We developed the survey in Opinio, and staff members were recruited through an email flyer with a link directly to the survey. The survey was sent to RRC and MDC staff in June 2022 with five different reminder emails over a span of two weeks. Since it was necessary to obtain IRB approval from UNM Health Sciences, transition planners were surveyed later as they are employed by UNM Hospitals. The survey was sent to transition planners in November 2022, and five reminders were sent out over a two-week period. The survey was sent to a total of 31 staff members.

A total of 69 questions were included in the survey and were adapted from various tools across literature. We identify sources of the adaptation in Table 2 below. The first portion of the survey after the demographics section focused on perceptions of offenders. The next section of the

survey explored staff job satisfaction, collaboration between staff members and different stakeholders. All data were analyzed using the softwares Jamovi, Excel, and Atlas TI.

Table 2.
Sources Used to Adapt Questions for Staff Survey

Source	Assesses
Transition from Jail to Community (TJC) Model, 2012.	If current process aligns with best practices
Castle, Tammy L. (2008). Satisfied in the jail? Exploring the predictors of job satisfaction among jail officers. *Criminal Justice Review, 33(1),* pp. 48-63.	Job satisfaction in corrections
Public Attitudes Towards Offenders with Mental Illness Scale (PATOMI): Establishing a Valid Tool to Measure Public Perceptions.	Perceptions
Perceptions of Interagency Collaboration: Relationships between Secondary Transition Roles, Communication, and Collaboration	Collaboration
Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. *American Journal of Evaluation, 27(3),* 383-392.	Collaboration

Observations

We conducted 18 hours of observations with different staff members in the Law Enforcement Area (LEA) at the MDC between July and August 2022. Observation times differed daily to observe different staff members and to ensure observations were occurring while bookings were happening. All observations were recorded on an approved observation form that captured the observer's name, the date, times of arrivals and departures, times of observation begin and end dates, location, number of staff present, a physical description of the setting, field notes, notes regarding the intake and assessment process as well as decisions and criteria needed from staff members, and finally questions/conversations that occurred with staff members. Analytical notes were completed within 24 hours following the end of each observation session. Each booking was timed, and an inventory of each question asked from the validated instruments incorporated was taken to compare the process across different staff members.

Client Record Review

Risk Needs Assessments (RNAs)

We reviewed client records to determine the types of services offered and the population served by the RRC. We received data from the RRC in September 2022 from SharePoint, RRCMS, and Care Manager. Table 3 describes the years each system was used and the number of variables in each RNA spreadsheet. We organized, merged, reformatted, and cleaned five spreadsheets using *R*. Once data were cleaned, we conducted analyses to evaluate inmate demographics, services

requested, and the number of clients served by the RRC across all RNAs. Since TPs are optional for individuals passing through the RRC, a separate process for data organization was required for these. All data were organized and analyzed in Excel and Stata.

Transition Plans (TPs)

TPs are voluntary which means that an inmate can complete an RNA and decline to complete a TP. Across all three data systems, short-term and long-term goals were captured for inmates who consented to completing a transition plan. While the data consisted of long and short-term goals, there was a lack of standardization in how the data were captured in all three systems. Some of the data was captured in an open-text format while other data was captured in a categorical format. This prolonged data analysis as data that was stored in open-text form fields had to be manually coded to match the categorical data.

We include all long-term goals in our subsequent analyses. However, because of the number of short-term goals that clients were required to establish in SharePoint, we limited short-term goal analysis due to time constraints. SharePoint captured one long-term goal and two short-term goals for clients, RRCMS captured one goal across all clients and CareManager also included one goal. We randomly sampled 10% of the short-term goals to include in analyses (n = 261 clients). We also qualitatively analyzed short-term TP goals to determine common themes. After goals were organized, they were linked back to the corresponding RNAs.

To evaluate the effects of the RRC on clients' recidivism rates, we used whether an inmate was transition-planned to evaluate before-and-after changes in recidivism rates. We note that attempting to evaluate the effects of the RRC on recidivism rates by relying on whether an inmate was transition-planned is a suboptimal method for evaluating RRC effectiveness given the (1) self-selection of participants into TPs which may bias results and (2) the fact that the TP is not the primary theorized intervention pathway through which RRCs are anticipated to have effects (i.e., case management and direct service linkages are the primary theoretical pathways through which RRC should exert an effect on recidivism outcomes; the TP occurs temporally prior to these connections but data on case management and service connections are unknown and thus the TP serves as a weak proxy for the provision of these services).

Results

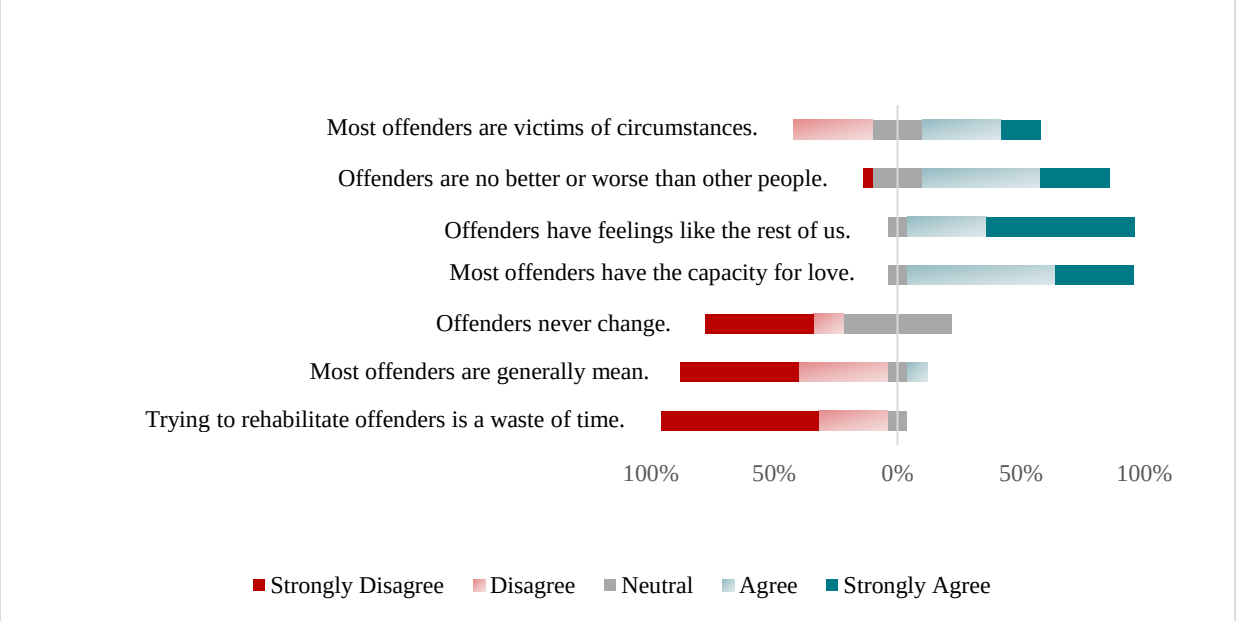
This section reviews findings from staff surveys, MDC observations, and our recidivism analysis.

Staff Surveys

Staff surveys had an 81% response rate (n = 25). The main purpose of this survey was to gather insight on how staff members perceive inmates and the reentry process in its entirety; we provide secondary information on staff demographic characteristics in Appendix A.

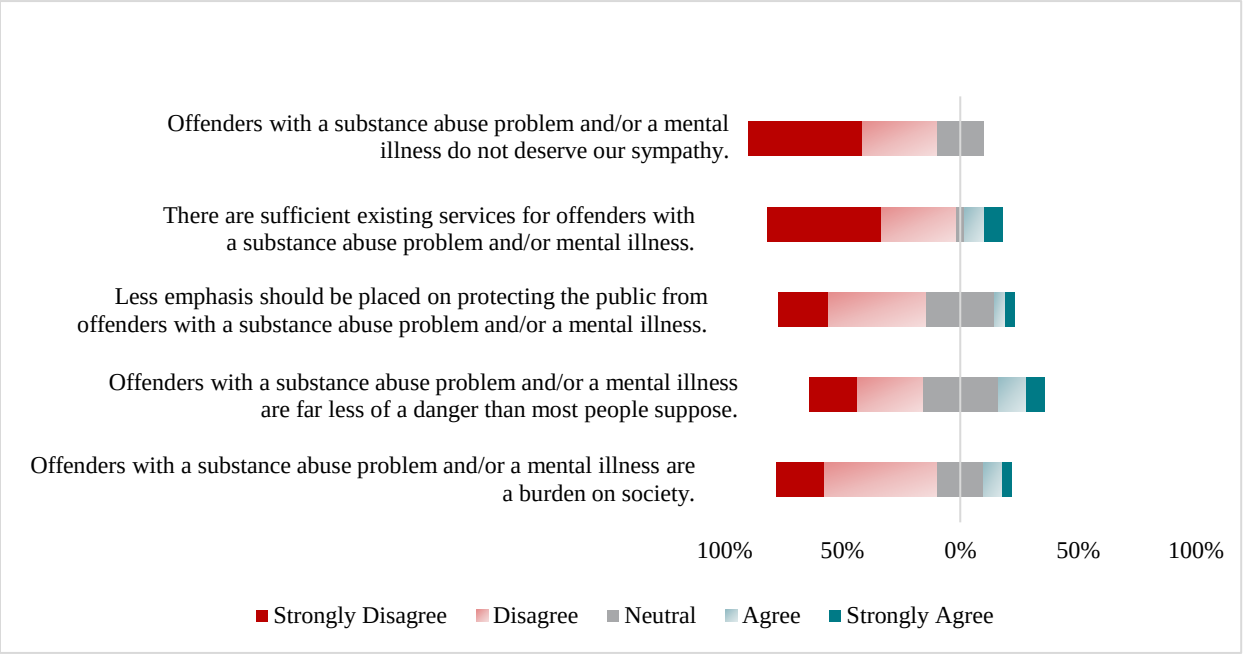
Figure 3 suggests that staff members generally agreed with the statement that rehabilitating offenders is not a waste of time (92%) and acknowledged that offenders have the capacity for love (92%), change (56%), and feelings like the rest of us (92%). While all staff may not perceive inmates the same, these findings are important and research in this area suggests that positive attitudes highlight the perspective that inmates are normal people capable of change (Kielsberg, et al., 2007).

Figure 3.
Survey Results: Staff Perceptions of Offenders



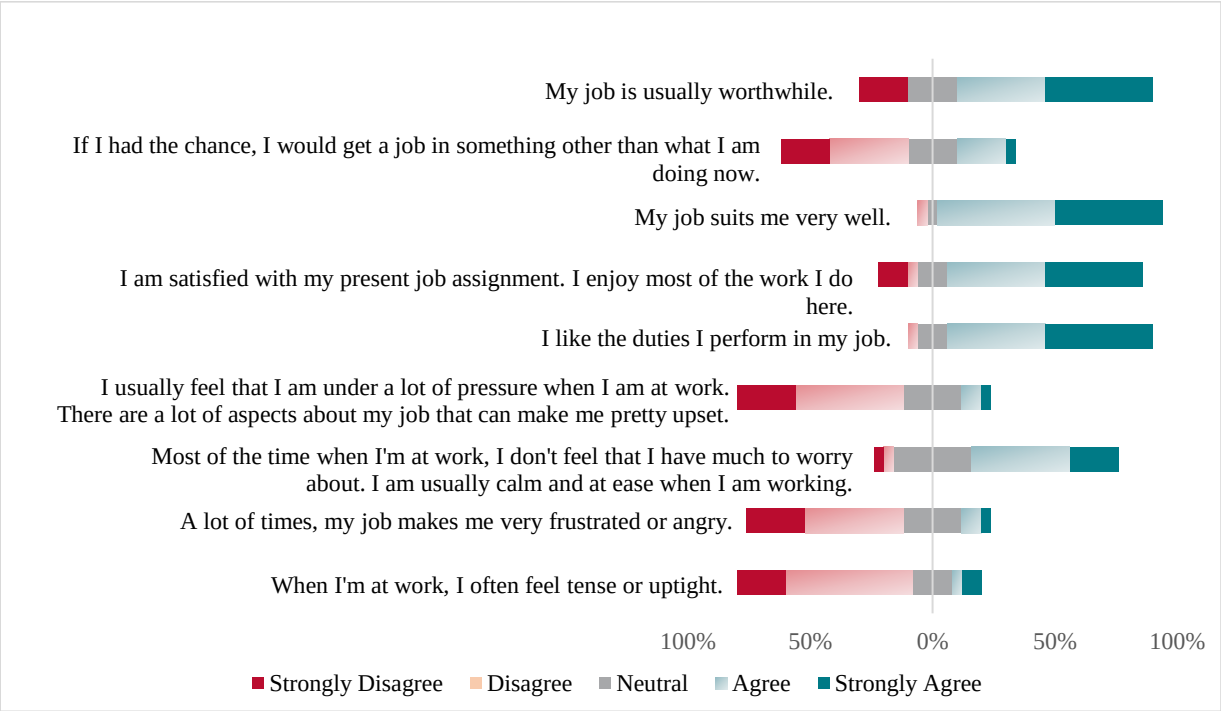
While staff members mostly disagreed that less emphasis should be placed on protecting the public from offenders with a substance abuse problem and/or a mental illness (63%), staff members agreed that there is a lack of sufficient services for individuals and that the jail should play more of a role in ensuring individuals have access to these services (80%), especially those with a substance abuse problem or mental illness (Figure 4).

Figure 4.
Survey Results: Staff Perceptions of Offenders with Substance Abuse and/or Mental Illness



In terms of employee satisfaction with their current jobs, most staff members indicated that they enjoy their current duties (84%) and that their jobs are usually worthwhile (80%). A little over half of respondents also indicated that if given the chance, they would not get a job in something other than what they are doing now (52%) (See Figure 5). This is important since job satisfaction can lead to lower turnover rates, increased productivity as well as an improved work culture (Lambert, et al., 2016; Yang, et al., 2011).

Figure 5.
Survey Results: Job Satisfaction



To evaluate staff understanding on best practices as established by the TJC model, staff were asked questions based on principles that should be present in the reentry process. Figures 6-9 highlight the findings from the staff survey. Though most staff members agree with the components that are deemed effective in the TJC model, there appears to be a lack of follow-up communication with community-based service providers and some discrepancies on how to best care for low-risk offenders.

Figure 6.

Survey Results: TJC Questions Gauging Perceptions - Best Practices

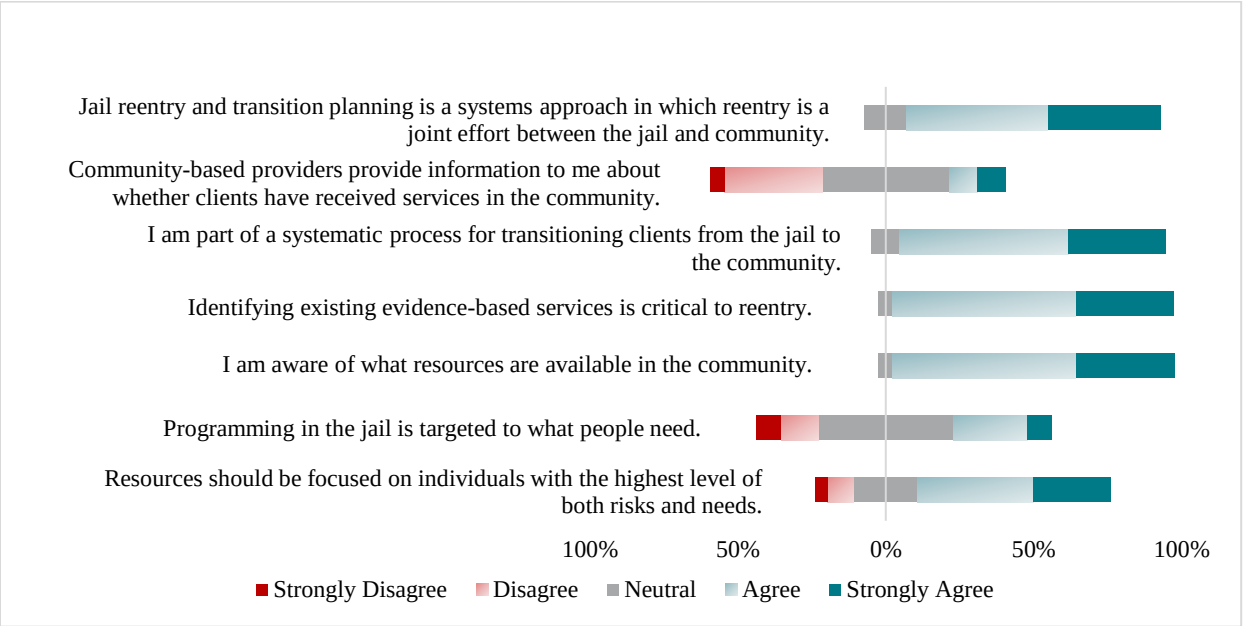
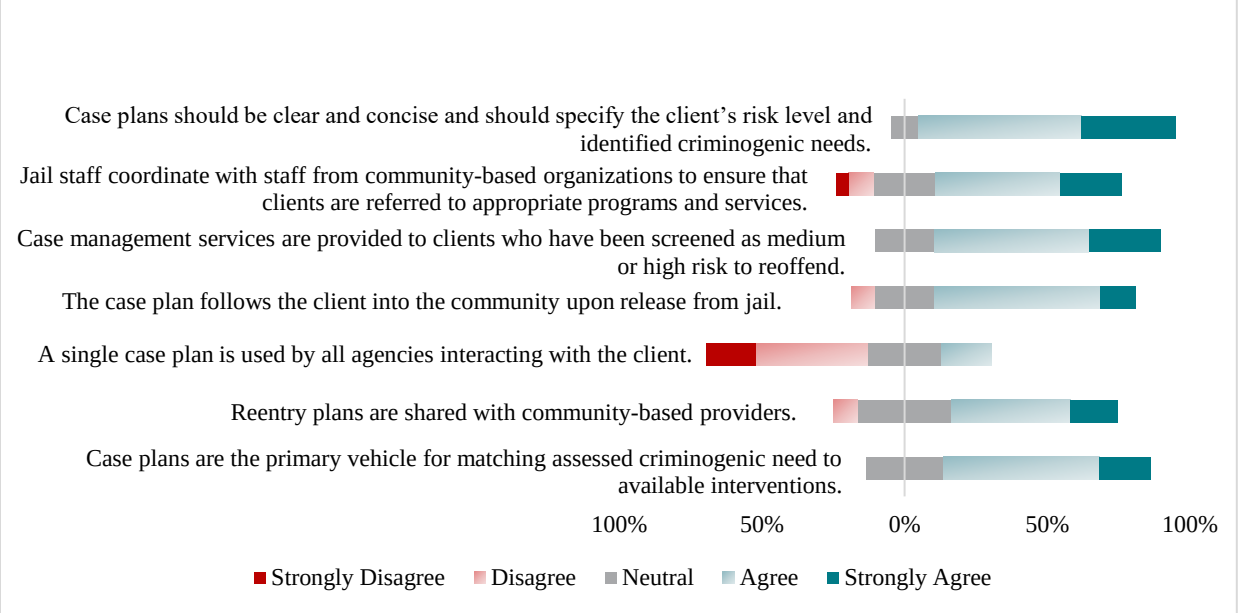


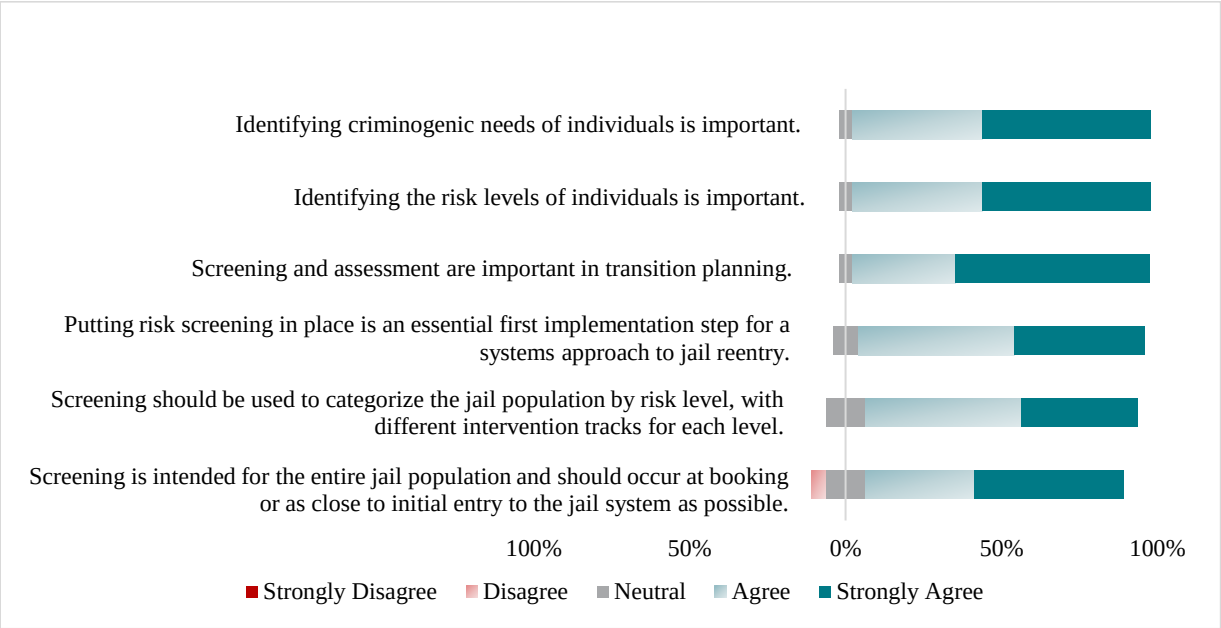
Figure 7.

Survey Results: TJC Questions Gauging Perceptions - Case Plans



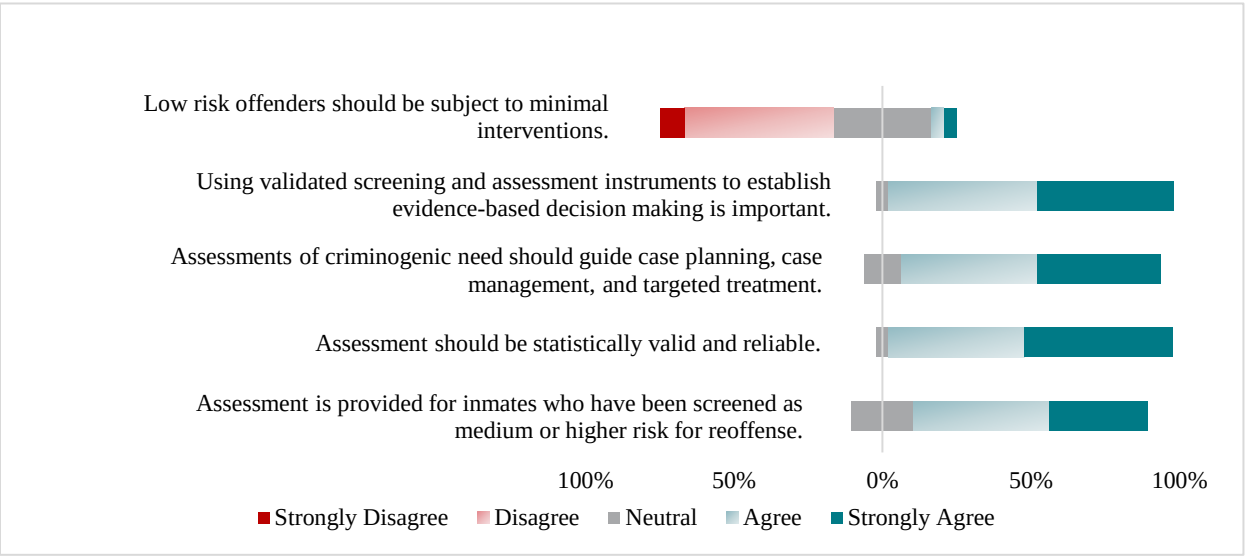
Additionally, staff indicated that there is a lack of programming in the jail targeting what individuals need (28%), and most staff agreed that a single case plan is not used by all agencies interacting with the individual (56%).

Figure 8.
Survey Results: TJC Questions Gauging Perceptions - The Importance of Screening



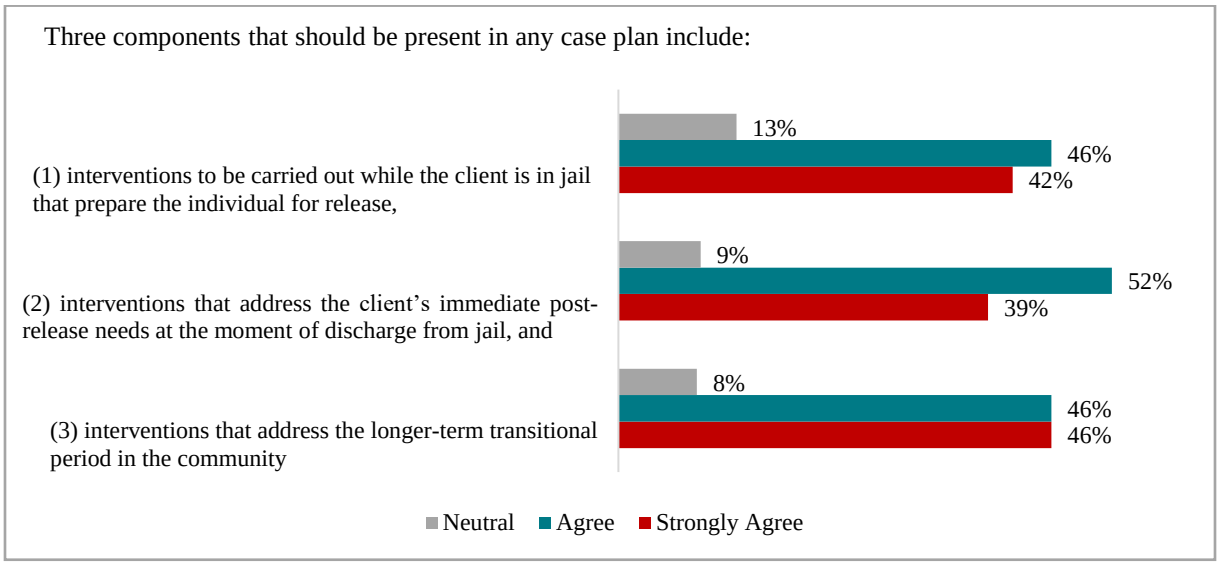
50% of surveyed staff believed that low risk offenders should not be subject to minimal interventions (Figure 9). Although this idea is appealing, it is not recommended by the TJC model as it requires more resources that can be used for medium to high-risk offenders.

Figure 9.
Survey Results: TJC Questions Gauging Perceptions - Assessment and Interventions



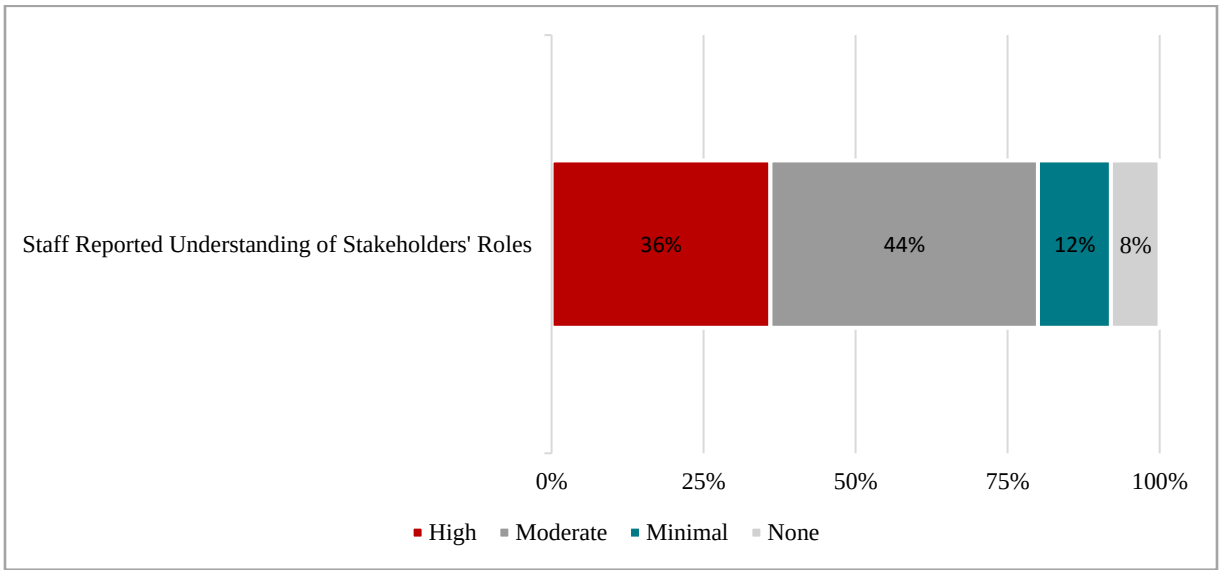
While staff members mostly agree on the components that should be present in a case plan (see Figure 10), it seems that the challenge lies in communication with the different agencies involved with inmates.

Figure 10.
Survey Results: Gauging Perceptions of Necessary Case Plan Components



Overall, staff reported a moderate understanding of the different stakeholders involved in the reentry process. These different stakeholders include Social Services Coordinators, Community-based Organizations, Transition Planners, Corizon staff, MDC security staff and Recovery Services of New Mexico. Most staff members reported having moderate communication with the various stakeholders.

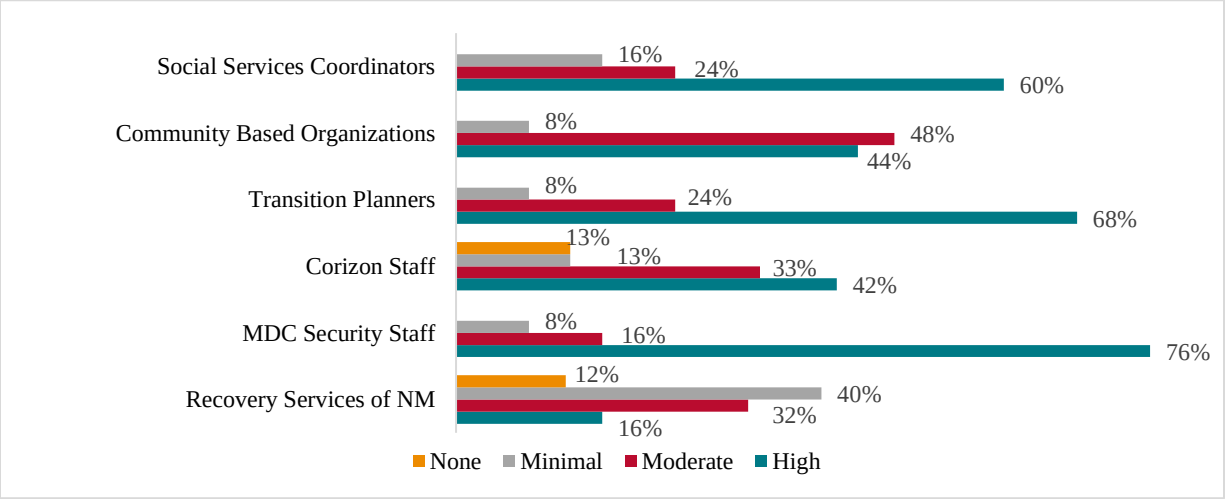
Figure 11.
Staff Reported Understanding of Stakeholders



In addition to staff members' level of understanding, we also assessed levels of communication with the various agencies involved in the reentry process. Although a majority of staff members reported a moderate to high level of communication with social services coordinators (84%), community-based organizations (92%), transition planners (92%), Corizon staff (75%) and MDC

security staff (92%), 52% of staff members reported having minimal to no communication with recovery services of New Mexico.

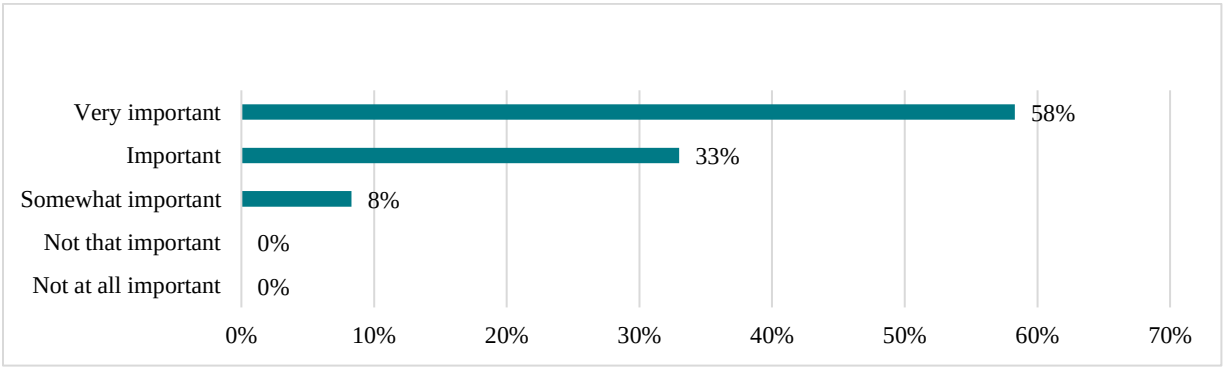
Figure 12.
Survey Results: Staff Reported Communication with Stakeholders



To conclude the staff survey, we were interested in understanding whether staff believe that the RRC program is important in impacting recidivism. Fifty-eight percent of staff agreed that the RRC was an important program for influencing recidivism rates (Figure 13).

Staff members provided the responses below when asked how important they believe the role of this program is in impacting recidivism rates for those clients who are involved with the criminal justice system.

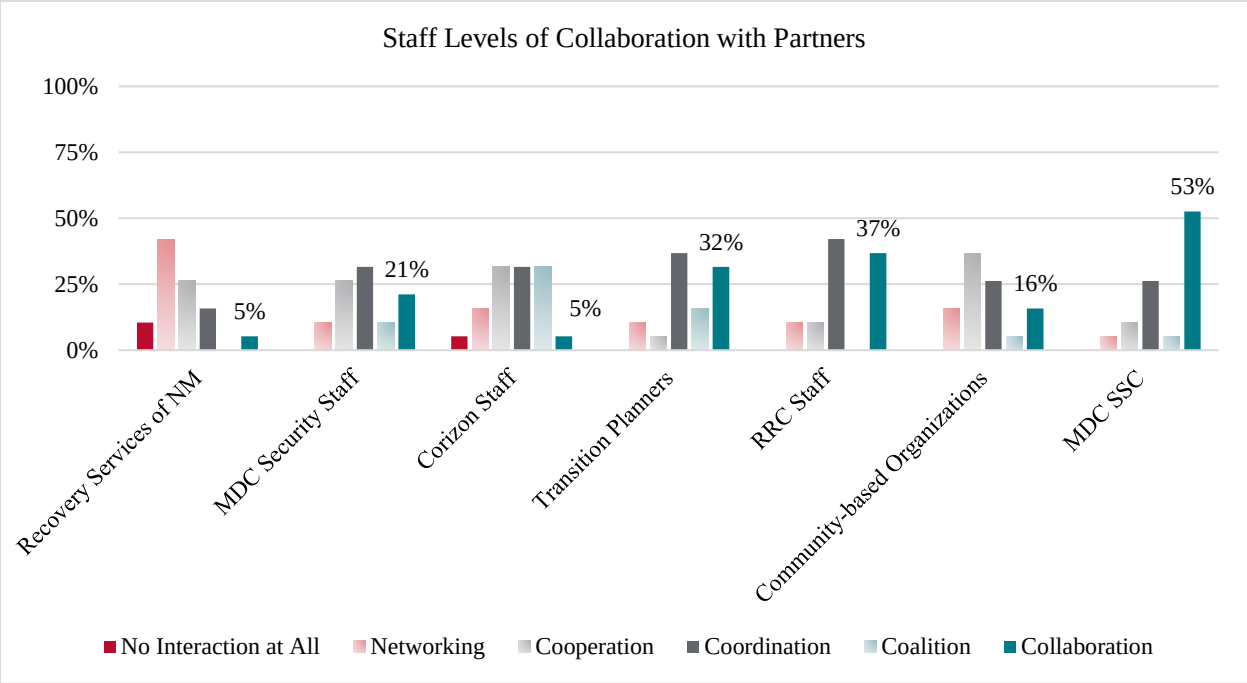
Figure 13.
Survey Results: Staff Perceptions - The Importance of Program on Impacting Recidivism



Results from the collaboration scale can be seen in Figure 14. For reference, collaboration among all partners is considered the highest standard, followed by coalition, coordination, cooperation, networking, and finally no interaction at all. While some collaboration is reported across all

partners, there is a need for more collaboration among all partners. As seen in Figure 14, the highest amount of collaboration reported is with MDC Social Service Coordinators (53%).

Figure 14.
Staff Levels of Collaboration with Partners



The final portion of the staff survey included open-ended questions to assess strengths, challenges, and recommendations related to the current reentry process. The following quotes are presented to shed light on staff perceptions and experiences with the reentry process.

Key Strengths of the Program

Collectively, staff assert that they provide inmates with a supportive environment and staff that can work together to assist individuals with services.

> *"We have staff who care and are willing to do the work."*
>
> *"We are front line with the inmates. We work together to get things done. We provide a lot of support for the inmates."*
>
> *"We are able to receive client[s] in a neutral environment. Where they can change their mindset from being in jail to returning to the community. Thus the client is able to request services the client might not in the jail and be offered services that are not offered in the jail."*

Challenges and Weaknesses of the Program

Some challenges and weaknesses discussed by employees include short staffing at MDC, and communication with other organizational staff. To effectively target individuals for assessment, staff must be able to meet with inmates as soon as possible.

> *"My organization weakness is communication within the team. The organization does not focus enough on bring[ing] all employees together."*

> *"Staffing MDC is low on security staff which makes it hard to get in the pods. The number of resources in the community make it hard to refer a person if everyone in the state is using the same places."*

> *"Short security staff makes it hard to get in to pods. Work loads are uneven. Inmates have unreliable access to tablets and kiosks to ask SSC questions when they are quarantined or on lockdown and a visit can not occur. There is not enough coordination of treatment/care with all the different departments. There is not one main system where we can see notes of what transition planner did, PSU counselor, doctor, ATP, discharge planner, community connections, Fasttrack, etc."*

Staff also mention the need for a better system as well as a single case plan for individuals, which is essential according to the TJC model.

> *"The challenges are limits in time with clients. It would be beneficial to afford Community Support Workers some time in the community for field work, as well as negotiating contracts with apartment complexes; and work programs. As of right now, we are barely scratching the surface of what we could be doing."*

> *"Care Manager System is not user friendly and it creates more work for the user. SSCs, Transition Planners, RRC case managers and Corizon are not on the same data base system. The systems should talk to each other. Corizon needs to conduct discharge planning in advance and not on the day of release. Corizon should conduct needs assessments and document actual goals and steps needed to accomplish these goals. Their discharge plans are not helpful and this puts pressure on RRC to figure out what to do with a client who has very high needs once the client goes through the RRC. There is often not enough time and the individual would benefit from planning ahead of release. RRC is not open 24/7 due to staffing. The automated risk framework group scores are not available at this time. Waiting on Corizon."*

Staff Recommendations

Staff recommendations include the need for a single case plan within a shared database and the ability to expand services to individuals once they leave the RRC.

> *"It would be beneficial for the RRC to extend further into the communities and have additional locations in the community for long term relationships with these clients. An active case load that worked with clients in the community would allow for more goals to*

be accomplished. This project is ambitious, but definitely needs to include more connections to resources in the community."

"A system where information can be shared between MDC departments and contractors at the jail can see notes on each inmate and services that have been provided, like what applications they have completed and services they are being set up with."

Additionally, staff members express the need for collaboration among those involved with inmates while in custody.

"Agencies that work with clients to provide vouchered housing and services for the homeless need to start the application process in custody because clients are lost once released with out housing options."

"More staff at MDC, or a four day work week would be beneficial for transitions planners."

Observations

Results from observing the receiving screening process highlight a lack of consistency in the ways in which individuals are screened. Table 4 displays questions from all instruments incorporated into the screening process.

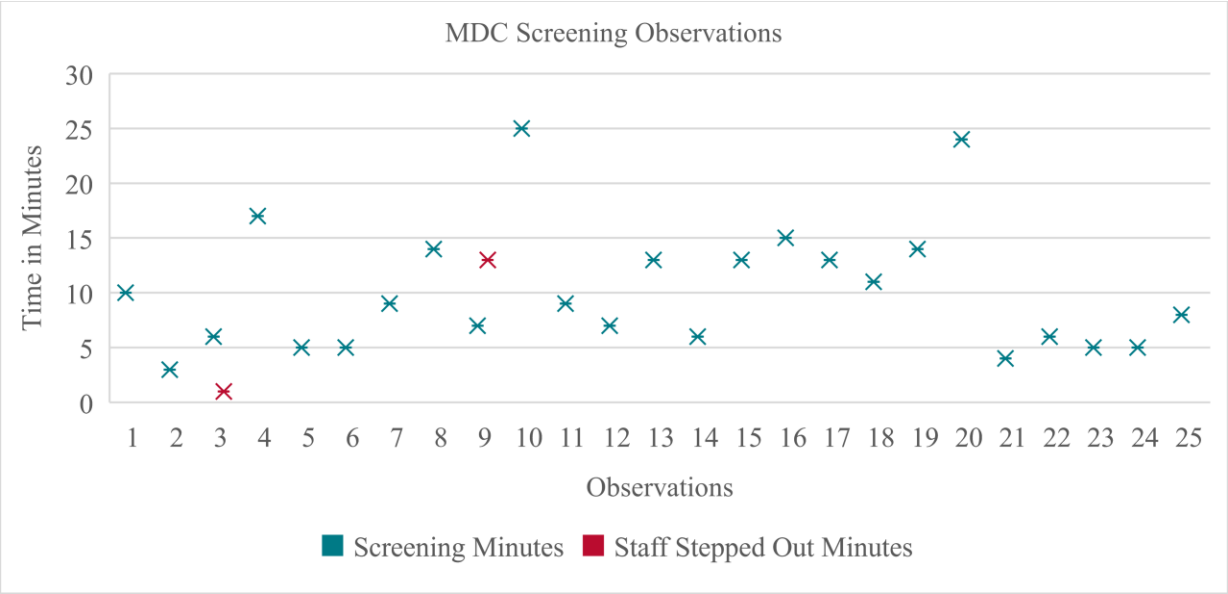
Table 4.
Observations of Incorporated Validated Instruments

Tool + Questions	Observed Questions Asked
Proxy Risk to Recidivate	
How old are you?	X
If arrested previously, how old were you at your first arrest?	X
How many times have you been arrested previously?	X
Brief Jail Mental Health Screen (BJMHS)	
Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?	
Do you currently feel that other people know your thoughts and can read your mind?	
Have you currently lost or gained as much as two pounds a week for several weeks without even trying?	X
Do you currently feel like you have to talk or move more slowly than you usually do?	
Have there currently been a few weeks when you felt like you were useless or sinful?	
Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems?	X
Have you ever been in a hospital for emotional or mental health problems?	X
The Alcohol Use Disorders Identification Test-Consumptions (AUDIT-C)	

How often did you have a drink containing alcohol in the past year?	X
How many drinks did you have on a typical day when you were drinking in the past year?	X
How often did you have 6 or more drinks on one occasion in the past year?	
Drug Abuse Screening Test (DAST-10)	
In the past 12 months…	
Have you used drugs other than those required for medical reasons?	X
Do you abuse more than one drug at a time?	X
Are you unable to stop abusing drugs when you want to?	
Have you ever had blackouts or flashbacks as a result of drug use?	X
Do you ever feel bad or guilty about your drug use?	X
Does your spouse (or parents) ever complain about your involvement in drugs?	
Have you neglected your family because of your use of drugs?	
Have you engaged in illegal activities in order to obtain drugs?	X
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	X
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding?)	
Opioid Risk Tool	
Family history of substance abuse	X
Personal history of substance use	X
Age between 16-45 years	
History of preadolescent sexual abuse	
Psychological disease	

Table 4 reveals that only 55% of questions embedded within the screening tools were observed being asked. One potential explanation for the fact that not all questions were asked was revealed through conversations with staff who indicated that they did not understand what these tools were. Many staff members did not realize that the questions built into their electronic system were selected from validated instruments and did not understand the importance of asking them; because of this, they chose to exclude some of the questions.

Figure 15.
MDC Screening Observations



During the observations, staffing was limited and that was made clear by all staff members observed. Most staff members were assigned to secondary tasks on top of screening individuals, such as making daily rounds for detoxing inmates, providing medications to inmates, responding to any emergency in any of the pods, and contacting other staff members for information such as psychiatric medications for inmates. Figure 15 summarizes time staff spent screening individuals and examples of when staff had to step away for different lengths of time to attend to other job-related responsibilities. In observation number 9, the red X indicates the staff member stepping out for roughly 13 minutes prior to completing the screening.

Additionally, staff members frequently stated their hurry in screening individuals was due to officers needing to get back out into the community. Since all individuals must undergo a medical screening as part of the receiving process, officers must wait for a screening to be completed prior to leaving in the instance that someone is not medically cleared to be booked into custody. This can happen for several reasons, such as medical injuries, illnesses, etc. When this does happen, officers must take the individual to a hospital, typically UNMH, so they can get treated prior to being admitted to MDC custody. Table 5 includes descriptive statistics for all observations that happened with staff. Overall, 75% of screenings took 13.5 minutes or less while 25% of screenings took 5.5 minutes or less. Additionally, the maximum amount of time screening an inmate was 25 minutes while the shortest screening took 3 minutes.

Table 5.
Observation Descriptive Statistics

N = 25		Percentiles	Time
Mean	10.16	10	4.6
Median	9.0	25	5.5
Mode	5.0	50	9.0
Min.	3.0	75	13.5
Max.	25.0	90	19.8

One final point regarding the observations with screening staff members is that many of them were not aware of the different screening tools incorporated into the electronic system nor did they know their importance. It was also determined that the tools were not being scored automatically by the electronic system, so inmates booked into custody did not have any scores associated with them. Since automated scores trigger the entire reentry process, the lack of this is problematic. Transition planners rely on these scores to assess individuals and to appropriately target individuals who need services most.

Client Record Review

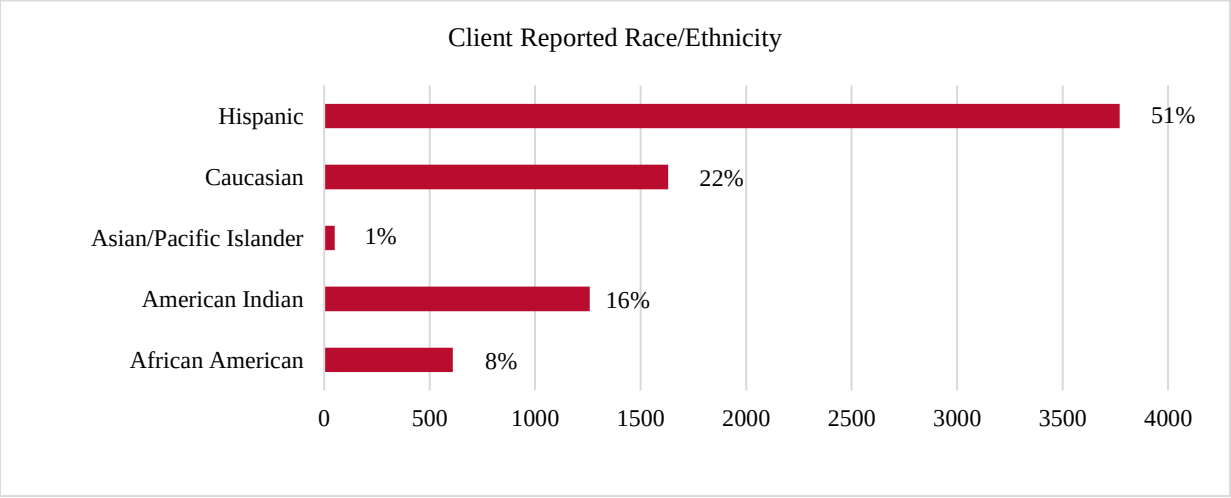
In what follows, we review client records from RNAs and TPs. As mentioned previously, clients can complete RNAs yet decline to complete a TP.

RNAs

Demographics

9,985 individuals were served by the RRC from 2018 to 2022 and most clients served were male (74%) and 51% of all clients identified as Hispanic.

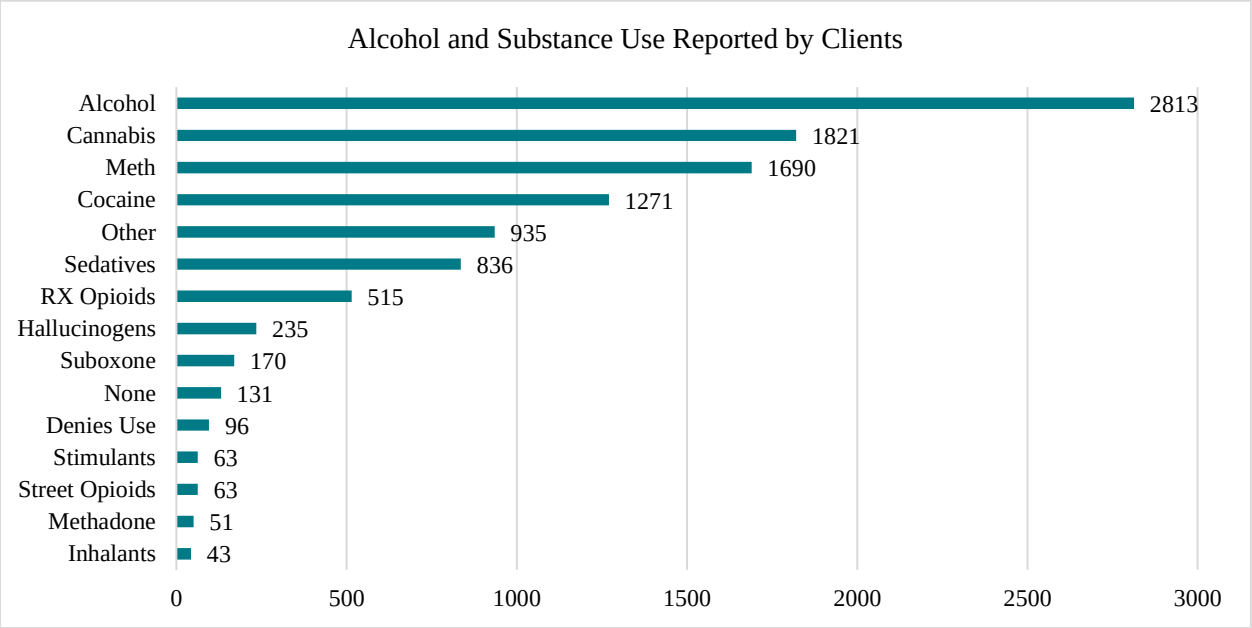
Figure 16.
Client Race/Ethnicity



During assessment, inmates provide information regarding alcohol use and substance abuse. Figure 17 provides a detailed inventory of inmates' non-exclusive alcohol and substance use at intake. Alcohol use is the highest reported across all individuals (*n* = 2,813).

Alcohol and Substance Use Reported at Intake

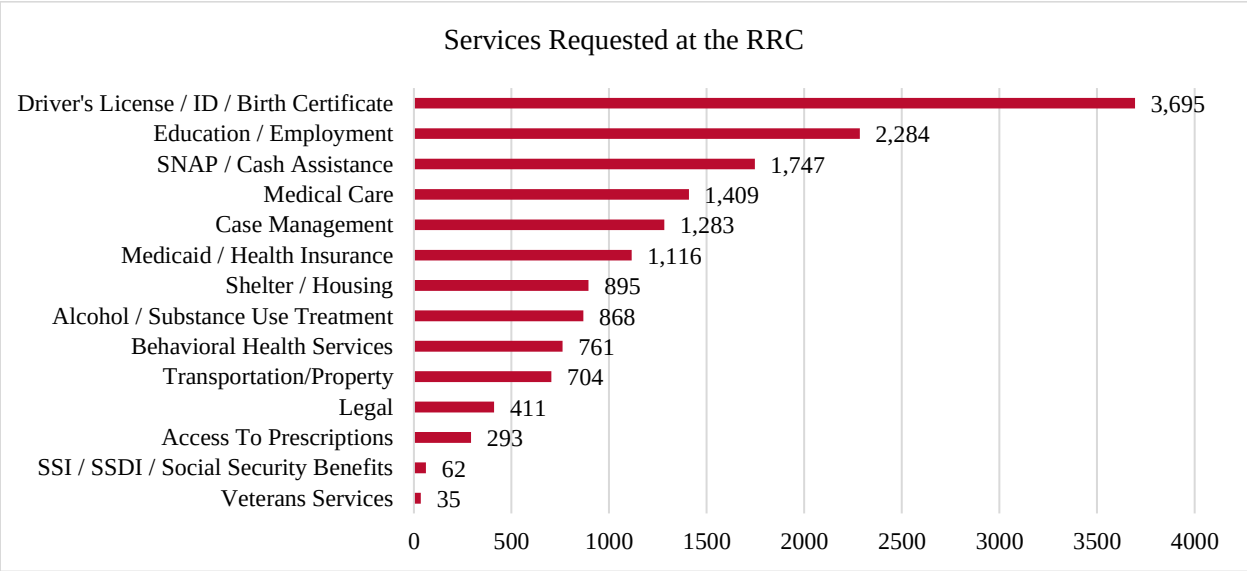
Figure 17.
Alcohol and Substance Use Reported by Clients



Client Needs

An inventory of services clients sought while at the RRC was analyzed to gather insight on the types of help individuals seek when released from MDC. Clients can choose more than one service while at the RRC. The following figure represents which services were requested most.

Figure 18.
Services Requested at the RRC



73% of individuals who completed RNAs at the RRC scored medium to high risk to reoffend yet only 34% of them completed TPs.

Client Risk Scores and Consent to Transition Plans (TPs)

Figure 19.
Client Medium to High-Risk Groups

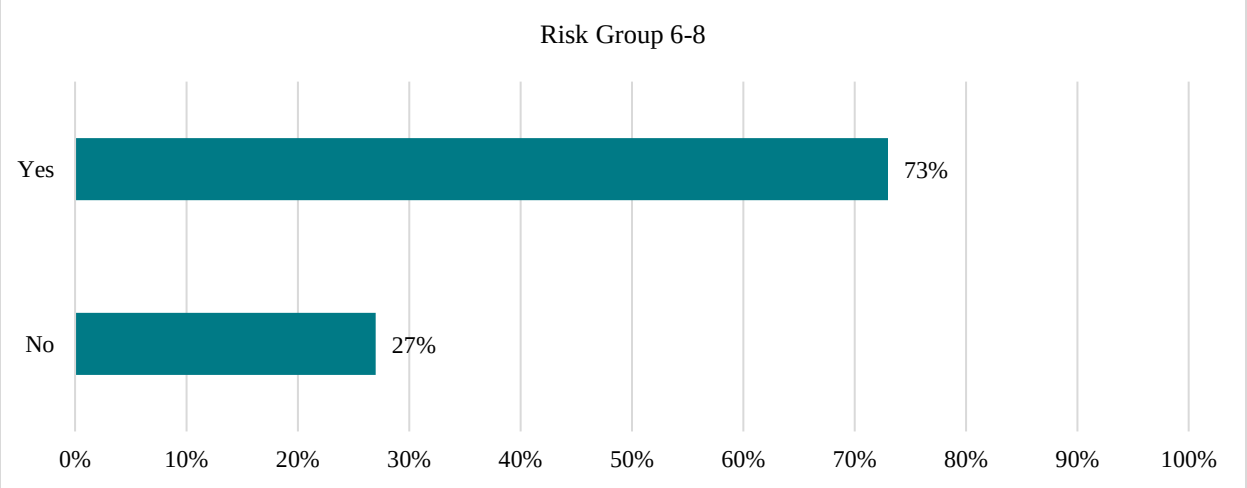
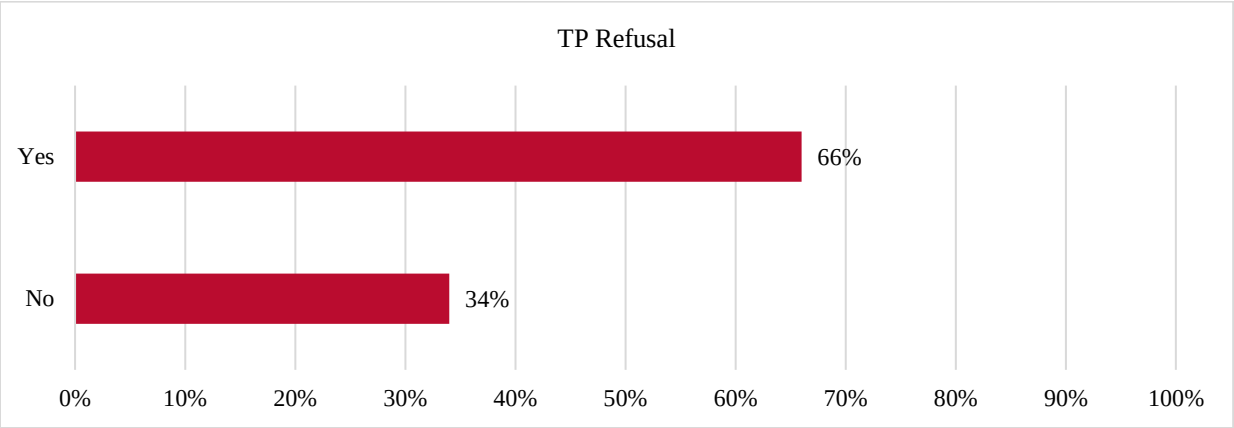


Figure 20.
TP Refusal Rates



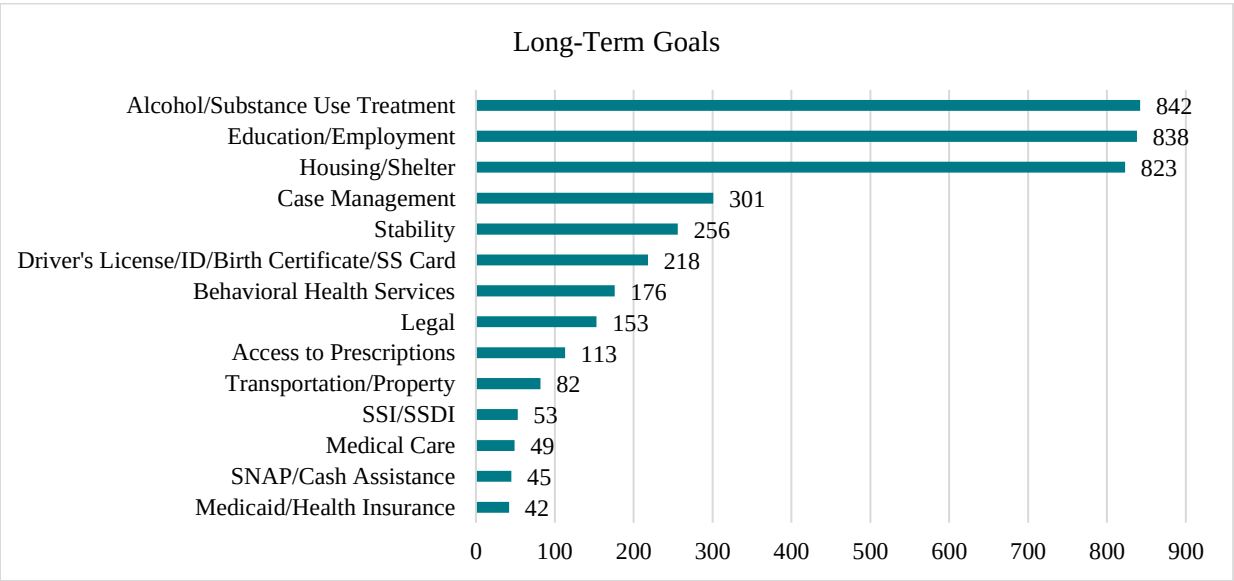
Transition Plans (TPs)

Of the 9,985 individuals that completed RNAs, 3,995 individuals initially agreed to complete a TP. 926 individuals consented to a TP but did not develop any short-term or long-term goals and 194 individuals initially consented to a TP but then later declined. The total amount of individuals included in analysis was 2,875, 29% of the individuals that completed RNAs.

The first phase of analyses included categorizing short and long-term goals established by clients. Long-term goals suggested that most individuals wanted to focus on sobriety, followed by education/employment and housing (see Figure 21).

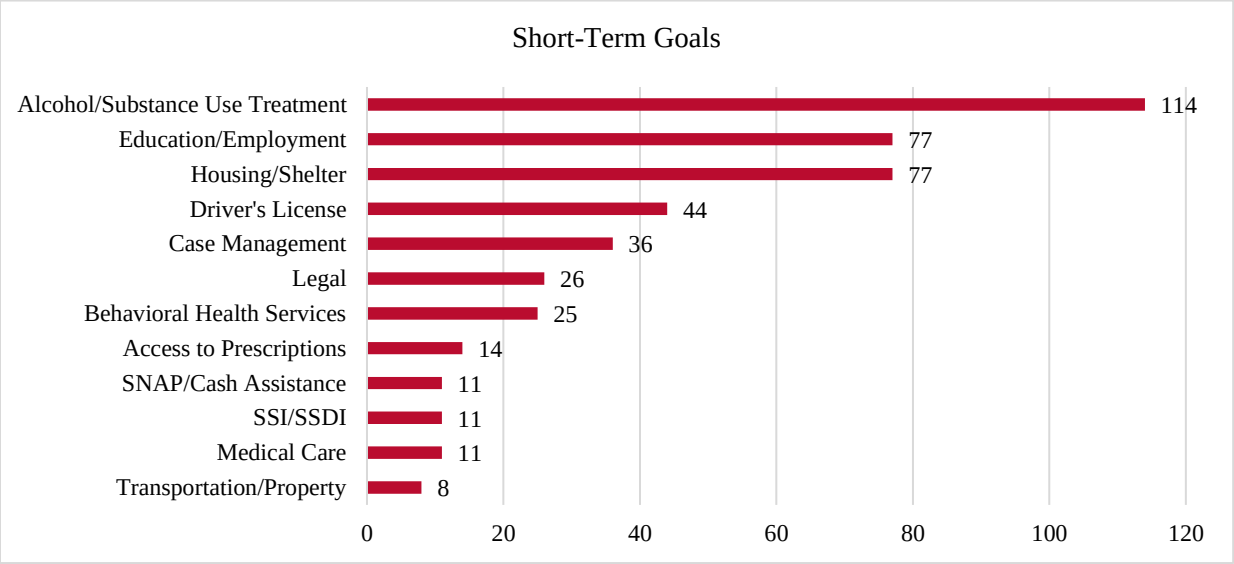
Transition Plan Goals by Risk Levels

Figure 21.
Long-Term Goal Categories



The 10% of short-term goals that were analyzed reflect similar findings. Most individuals established short-term goals that focused on sobriety, followed by education/employment and housing.

Figure 22.
Short-Term Goal Categories



Findings from the qualitative analysis of all short-term goals revealed the following themes. The bigger the words appear, the more frequently they were mentioned. Housing, job, and sober were mentioned the most in short-term goals across all records.

Figure 23.
Short-Term Goal Analysis

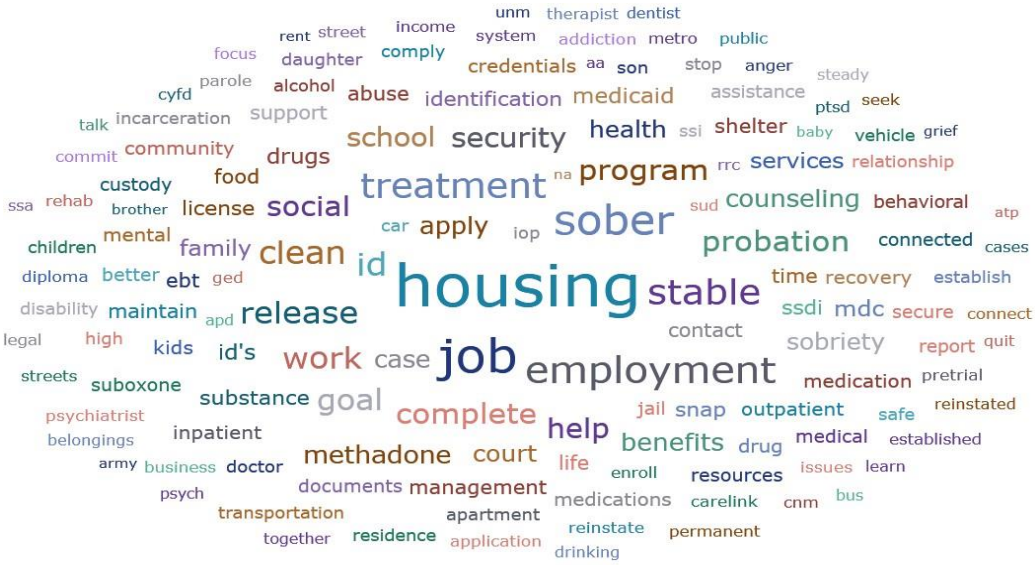
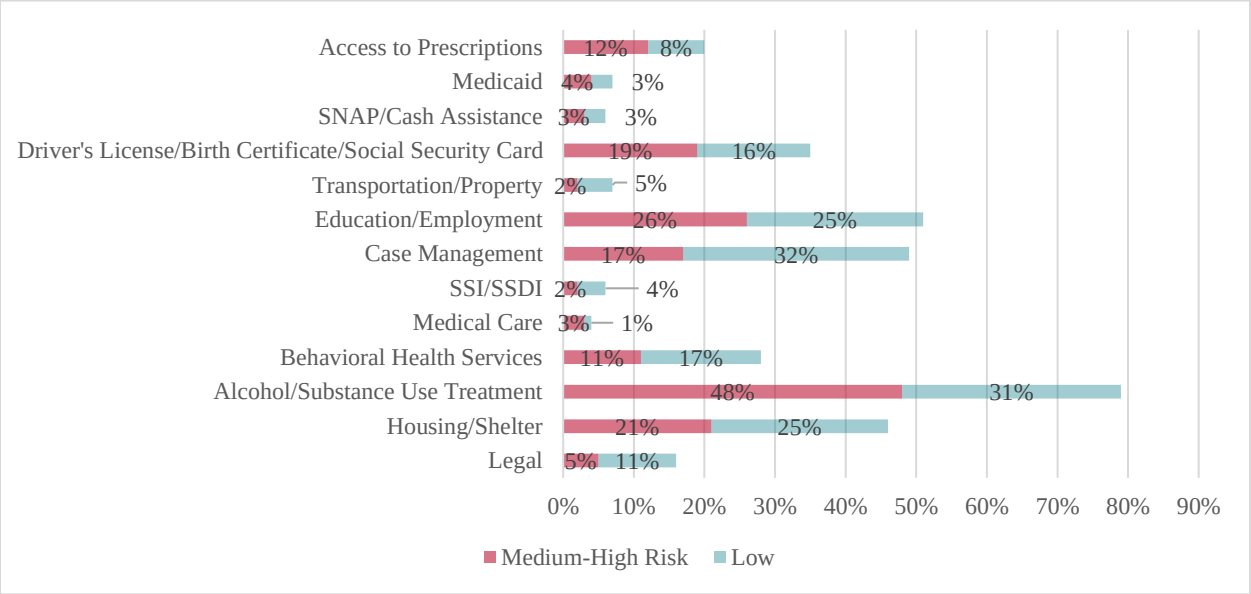


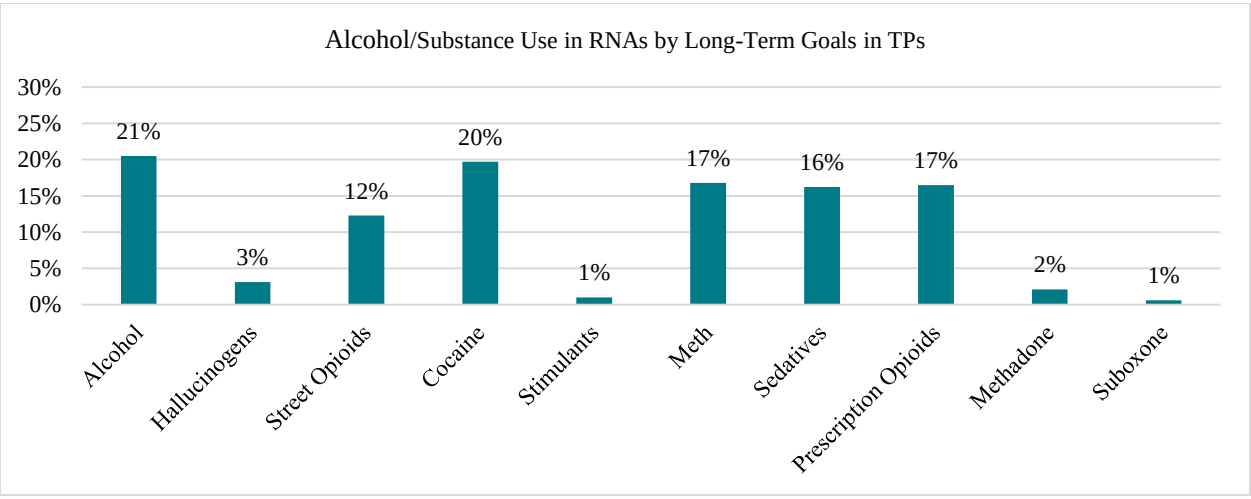
Figure 24 suggests that long term goals across low and medium to high-risk offenders share similar goals. Alcohol/substance use treatment is the number one goal established by individuals.

Figure 24.
Long-Term Goals by Risk Levels



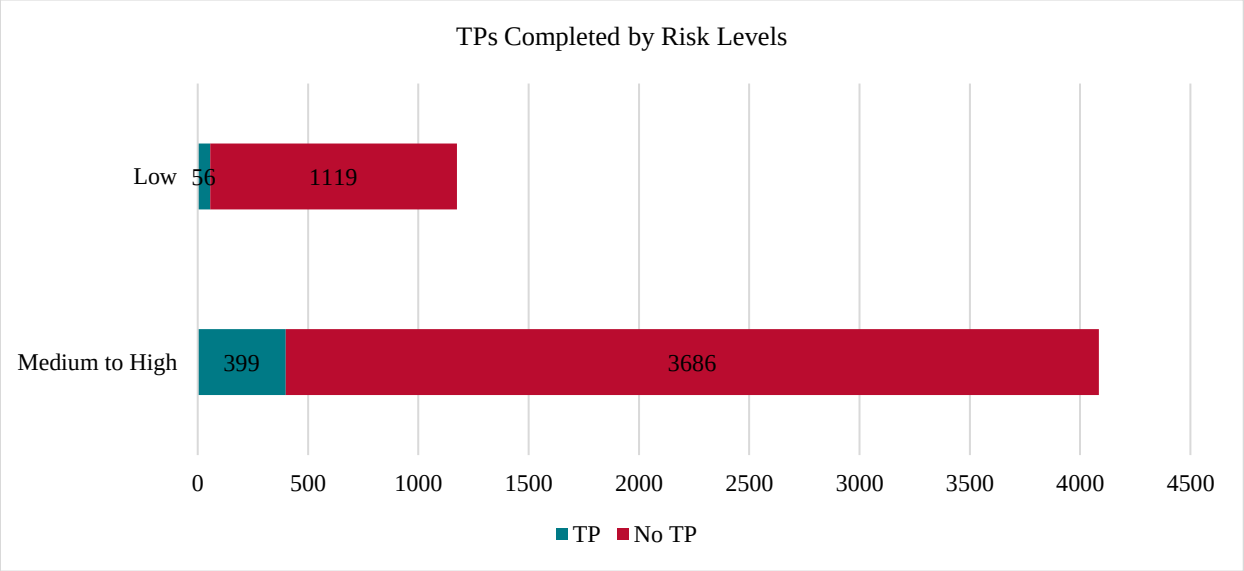
Since goals from TPs were similar across all risk levels, we wanted to determine the relationship between alcohol/substance use treatment from RNAs compared to long-term goals of sobriety. Out of all 2,875 TPs completed, 664 individuals selected alcohol/substance use treatment as a long-term goal. Of these individuals, 21% indicated in their RNAs that they use alcohol, 20% indicated they use cocaine, followed by 17% of individuals claiming use of meth and prescription opioids at 17%.

Figure 25.
Reported Alcohol/Substance Use in RNAs Compared to Alcohol/Substance Use Treatment in TPs



399 individuals who scored medium to high-risk completed a TP, while 3,686 individuals who had a score of medium to high-risk did not complete a TP.

Figure 26.
TPs by Risk Group



To assess the relationship between a client's risk level case management service provision, we conducted a chi-square test of independence to determine if there was a correlation between risk level and whether an individual had previously been receiving case management and between risk level and whether an individual received a referral for intensive case management (ICM). There was no significant difference between low-risk individuals and case management in comparison to medium to high-risk individuals and case management X^2 (2, N = 1,495) = 4.5, p = .106. Additionally, there was not a statistically significant difference in ICM referrals and risk level across all individuals X^2 (2, N = 1,495) = 1.01, p = .603 (see Figures 27-28). This finding does not align with TJC best practices since individuals who score as medium-to high-risk should be receiving more intense services.

Figure 27.
Case Manager Reported by Client

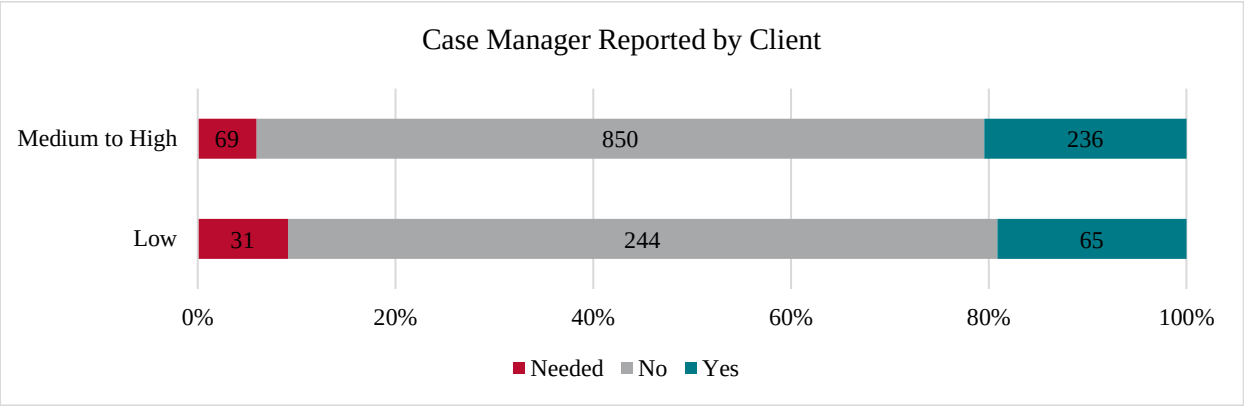
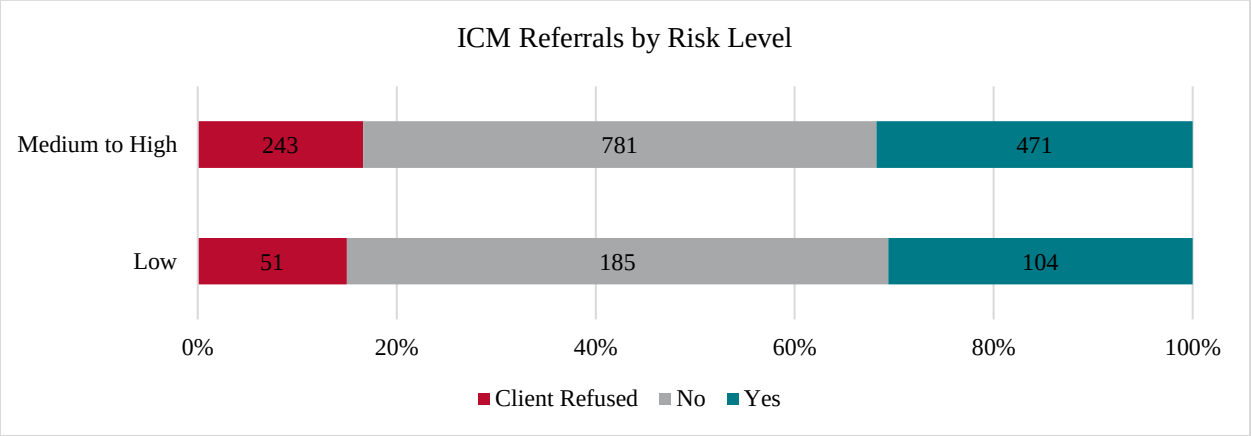
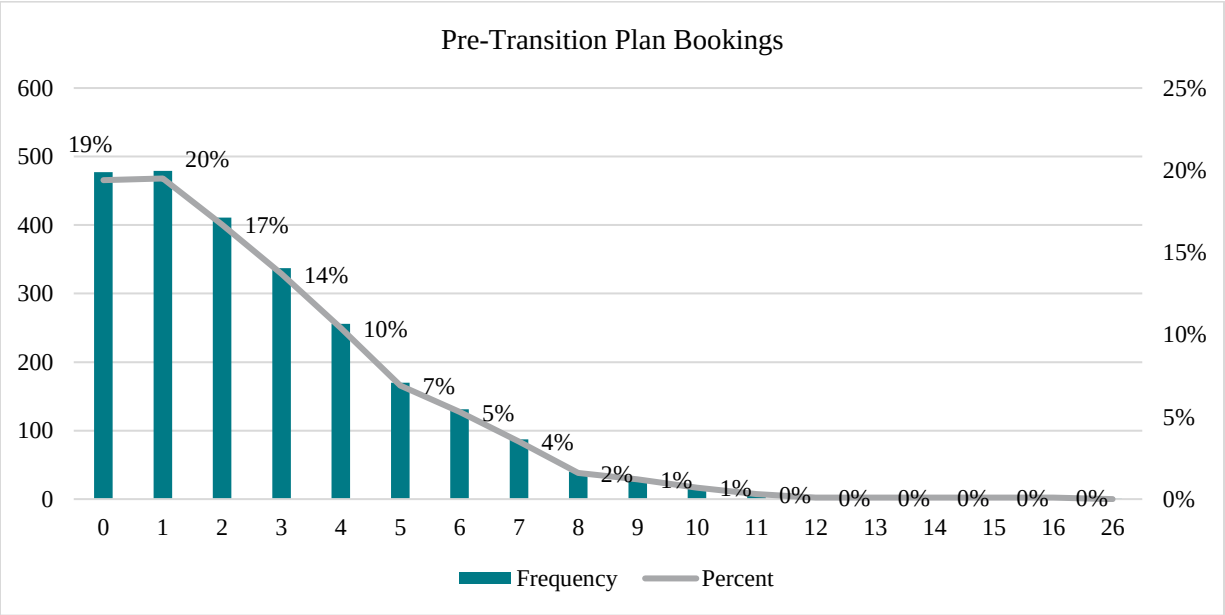


Figure 28.
Intensive Case Management Referrals Made by RRC



Finally, we want to explore whether there were differences in the number of bookings before and after an individual had a contact point with the RRC. After excluding cases where dates were mismatched and excluding cases where individuals were not transition planned, we had 2,455 cases to use for recidivism analysis. We analyzed the count of bookings two years prior to RRC contact and two years following RRC contact. Figure 29 presents the distribution of the number of pre-transition plan bookings. 477 (19%) of individuals had no bookings prior to their transition plan, and 1,978 (81%) had one or more bookings.

Figure 29.
Pre-Transition Plan Bookings



There were 15 individuals that were still in custody as of August 31, 2023 so they were excluded from the post-transition plan data, and an additional 561 individuals had not yet completed the two-year period, or could have been released to other agencies. To determine how many bookings individuals had in the post-bookings sample (n = 1,879), a paired sample t-test was performed for all individuals who were included in the post-two-year term bookings. The paired sample t-test revealed a significant reduction in bookings between pre-transition plan bookings (M = 2.87, SD = 2.52) and post-transition plan bookings (M = 1.77, SD = 2.01), t(1,1879), p = < .001. The effect size, as measured by Cohen's d was d = 2.69, indicating a very large effect of transition plans on rearrests. This suggests that the average amount of bookings an individual has prior to completing a transition plan is 1.1 times greater than individuals who complete a transition plan.

Table 5.
Pre- and Post-Transition Plan Bookings

	Mean	N	Std. Deviation	Std. Error Mean
Pre-Transition Plan Bookings	2.87	1879	2.52	0.05813
Post-Transition Plan Bookings	1.77	1879	2.01	0.04638

Although these results are significant, using TPs as a proxy for recidivism is not ideal for several different reasons. First, there is the issue of selection bias, or differences in the population that completed transition plans, such as more intrinsic motivation in the selected sample which would lead individuals to want to change behaviors. Additionally, individuals who have lower levels of risk may be more likely to complete transition plans which could explain the change observed.

Finally, it could be that individuals who participate in case management outside of the RRC account for the changes observed.

Discussion

The purpose of this process evaluation was to evaluate how the RRC operates in comparison to best practices as established by the TJC model. To effectively transition inmates out of jail and into the community, it is important to first screen individuals as close to booking as possible. While the RRC does include a screening process, our observations of the screening process indicate that the validated screening measures are not used across all inmates and staff in a consistent manner, with some scale questions being omitted. Additionally, although validated tools are incorporated into the screening process, staff report not understanding the purpose or function of the tools which leads to their incorrect administration. Without proper knowledge and training on the tools, staff members will not be able to properly screen individuals. Furthermore, the electronic database used should generate scores automatically based on screening information. This will provide transition planners with critical information needed to target medium to high-risk individuals as soon as possible. Without risk information, screening cannot be effective for any parties involved which ultimately impacts assessment and the capacity to narrowly target interventions to the specific risks and needs of an individual client.

We sent staff surveys to 31 staff members involved in the reentry process to gather insight on attitudes of the current practices in place. While this component is not part of the TJC model, it allows for a greater understanding of collaboration among the various staff members as well as strengths and weaknesses of the process. Additionally, these surveys allowed us to evaluate where improvement is needed in the process as established by the TJC model. In particular, staff survey results indicate there is a greater need for communication with community partners as well as a need to have a single case plan that follows the individual through the reentry process and after the individual is released into the community. Without a streamlined process, assessments cannot be administered regularly like the TJC model suggests. While this may be a complex circumstance to address, it is critical to recognize the evolving needs that individuals may face upon release and without agencies working together to help minimize the challenges associated with recidivism, it is likely that individuals will continue to reoffend.

Results from the staff survey also indicate that staff members agree that low-risk level offenders should be targeted for intervention in the same manner as medium to high-risk individuals. While it is important to deter low-risk level offenders from the criminal justice system, the TJC model emphasizes the need to focus energy and resources on medium to high-risk level offenders. Triaging individuals who require more from agencies and staff is an essential component of any reentry process. In analyses of the client records, we present evidence that there was not a significant difference in how low-risk offenders and medium to high-risk offenders are being case-managed. Although it may seem counterintuitive, this creates a

disadvantage for individuals who are medium to high-risk that require more intensive case management, especially in situations such as being short-staffed.

Limitations

There were several limitations that impacted this process evaluation. To better evaluate the effect of the RRC on clients' recidivism, it would be necessary to have a control group and an experimental group where each group would randomly be assigned to complete a transition plan. Because individuals can voluntary select into completing a transition plan, it is worth noting that individuals who self-selected into completing a transition plan might differ in some systematic way from individuals who do not complete a transition plan (e.g., because noncompliance was an explanator of the lower levels of completed transition plans, perhaps individuals who agree to complete transition plans score, on average, higher on a trait like agreeableness) and variation in this trait between the experimental and control group and not the transition planning per se (e.g., the fact that individuals who completed the transition plan, on balance, may be more agreeable on average, and agreeableness predicts lower criminal justice system involvement) may better explain the observed disparity in recidivism rates across the two groups. This is one limitation to exploring mean differences in bookings between the two groups as is: it is unclear whether the transition planning or some other confounding trait difference between the groups observes the direction of the effect observed. Similarly, our results do not statistically adjust for other factors that may influence the relationship between transition-planning and recidivism rates. We only evaluate recidivism among the subset of RRC clients who voluntarily consented to be transition planned; this excludes most clients who pass through the RRC. Moreover, knowing that a client received a transition plan does not tell one anything about (1) the intensity or scope of case management services they were linked to following reentry or (2) the scope of services they engaged with following reentry, which would be more precise and conceptually accurate measures of the effects of a program like RRC on recidivism.

A third limitation of our process evaluation was the lack of organization in data provided and a lack of standardization across all systems used. For instance, the use of open-ended text form fields instead of categorical form fields (e.g., drop down boxes) to identify client's short and long-term goals complicated our capacity to identify goals efficiently.

Case management should be centered around evidence-based practices. While transition planners currently work with individuals in a short-term capacity, long-term case management is ideal for higher-risk offenders. As the TJC model emphasizes, assessments should be given more than once since risks and needs often fluctuate. The RRC would benefit from establishing a more streamlined case management process. Additionally, a single case plan should be used by all agencies involved from intake and through release. Without a streamlined process, it is nearly impossible to effectively case manage anybody.

Future studies on the RRC should include a comparison group if an experimental group is not feasible. A comparison group consisting of individuals similar in demographics and bookings can provide more insight on the effectiveness of the RRC. Additionally, it is strongly

recommended that the RRC establish an effective form of case management. This component would be challenging to maintain, however the TJC model provides a plethora of resources available for all jails to use. Finally, the RRC, MDC and the contracted medical provider would all greatly benefit from developing standard operating procedures. Medical staff completing the screenings should be trained on the different tools utilized to determine risk levels, however, would also greatly benefit on understanding all the various factors associated with recidivism. Without providing baseline information to all staff, it is difficult to determine how or why an entire system may not be effective in impacting recidivism. The TJC model highlights the need for collaboration among all staff involved with inmates, including probation and parole agencies.

References

Christensen, G. E., Jannetta, J., & Willison, J. B. (2012). *The role of screening and assessment in jail reentry*. Urban Institute Justice Policy Center.

Fox, B., Verona, E., & Fournier, L. (2019). Psychological assessment of risk in a county jail: implications for reentry, recidivism and detention practices in the USA. *Journal of Criminal Psychology, 9(4),* 173-186.

Jannetta, J., Dodd, H., & Elderbroom, B. (2011). *The elected official's toolkit for jail reentry*. Urban Institute, Justice Policy Center.

Kjelsberg, E., Skoglund, T. H., & Rustad, A. B. (2007). Attitudes towards prisoners, as reported by prison inmates, prison employees and college students. *BMC public health*, *7*, 71.

Lambert, E. G., Minor, K. I., Wells, J. B., & Hogan, N. L. (2016). Social support's relationship to correctional staff job stress, job involvement, job satisfaction, and organizational commitment. *The Social Science Journal*, *53*(1), 22-32.

Miller, J. M., Miller, H. V., & Barnes, J. C. (2019). Treating co-occurring disorders in jails: outcome findings from a second chance act offender reentry program. *Crime & Delinquency, 65(5),* 583-605.

Osher, F. C., D'Amora, D. A., Plotkin, M. R., Jarrett, N., & Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. WS Hein.

Osher, F., Steadman, H. J., & Barr, H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: The APIC model. *Crime & Delinquency*, *49*(1), 79-96.

Phase 1 Preliminary Plan on Behavioral Health - City of Albuquerque, Dec. 2015, www.cabq.gov/health-housing-homelessness/documents/community-partners-phase-1-preliminary-plan-on-behavioral-health.pdf.

Solomon, P., & Draine, J. (1995). Jail recidivism in a forensic case management program. *Health & Social Work*, *20*(3), 167-173.

Substance Abuse and Mental Health Services Administration. (2023). Best practices for successful reentry from criminal justice settings for people living with mental health conditions and/or substance use disorders.

"The Transition from Jail to Community (TJC) Initiative." *Urban Institute*, www.urban.org/policy-centers/justice-policy-center/projects/transition-jail-community-tjc-initiative. Accessed 12 Oct. 2023.

Warwick, Kevin, et al. Transition from Jail to Community Initiative, 2012, *Case Management Strategies for Successful Jail Reentry*, https://www.urban.org/research/publication/case-management-strategies-successful-jail-reentry. Accessed 12 Oct. 2023.

Wilson, A. B., Draine, J., Hadley, T., Metrau S., & Evans, A. (2011). Examining the impact of mental illness and substance use on recidivism in a county jail. *International Journal of Law and Psychiatry*, *34*, 264-268.

Yang, S. B., Brown, G. C., & Moon, B. (2011). Factors leading to corrections officers' job satisfaction. *Public Personnel Management*, *40*(4), 359-369.

Appendix A

Staff Survey Demographics

The following tables reflect aggregated staff survey results.

Table A1.

Staff Ages

Staff Ages

	N	Min	Max	Mean	Std. Deviation
Age	23	26	62	41.43	11.29

Table A2.

Highest Level of Education Reported by Staff

Highest Level of Education	N	%
Completed degree, (i.e. B.A./B.S. degree)	15	60.0%
High school diploma or equivalent (GED)	2	8.0%
Master's degree (i.e. M.A./M.S./M.S.W degree)	4	16.0%
Some college	4	16.0%

Table A3.

Caseloads Reported by Staff

Staff Caseloads

Caseload	N	%
0 - 100	18	72.0%
100 - 250	5	20.0%
Total	23	100.0%