

**Final Report to the  
Nebraska Community Corrections Council:**

**METROPOLITAN COMMUNITY JUSTICE  
RECIDIVISM REDUCTION CENTER STUDY**

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## **Executive Summary**

### ***Recidivism***

Recidivism, or repeat criminal offending, is the bane of the criminal justice system. One of the main goals of the American justice system is to dissuade individuals from ongoing criminal activity through sanctions and/or rehabilitation. When contact with the justice system fails to deter future offending, society must endure a cascading financial burden of increasingly severe and correspondingly expensive interventions.

Attempts to eliminate or, in the alternative, reduce recidivism are ultimately attempts to extinguish or suppress undesirable behaviors. Towards this end, the criminal justice system targets behaviors which impact others in a negative way or which render normal community life insecure. Strategic interventions tend to take one of two dimensions: 1) stabilizing the offender's life through support and treatment, often characterized as rehabilitation or, 2) punishment and incapacitation.

Nebraska's justice system has always utilized both approaches; however, the prevailing tradition has leaned towards punishment, monitoring, and incapacitation. This can be seen most vividly in the public's pressure for the Legislature to enact "tough on crime" laws which heighten criminal penalties for crimes deemed especially intolerable at any given time. Since few behaviors are decriminalized and penalties are rarely lowered, this gradually leads to an ever-widening net being cast. One result of this approach has been a steadily expanding population of criminal offenders who require supervision or incarceration.

The need for more and more prison beds eventually became so large that the Legislature was compelled to consider whether less expensive alternatives could reduce repeat offending without compromising public safety. It was partially this realization which prompted the genesis of the Community Corrections Council in LB46. (Laws, 2003; Neb. Rev. Stat. §§ 47-619 to 47-633) The Council's mandates included:

- coordinating efforts to establish community correctional programs across the state to assure necessary supervision and services to adult felony offenders in the community,
- reducing Nebraska's reliance upon incarceration as a means of managing low risk offenders, and
- decreasing the probability of criminal behavior while maintaining public safety. (NCLEJ Website)

### ***Recidivism Reduction Center Study***

As part of its ongoing effort to fulfill its stated mission, the Council used research findings from the Methamphetamine Treatment Study to request legislative support for justice strategies aimed at enhancing community corrections. Among the different items submitted, the Council recommended funding for a "community justice recidivism reduction center to be located in the Omaha metropolitan area." (Statement of Intent, LB 1258; 99<sup>th</sup> Legislature, 2<sup>nd</sup> Session) The bill requested "\$3,000,000 from the General Fund for FY2006-07". (LB 1258)

During discussions of the Appropriations Committee, a draft document was considered which provided greater detail about the structure of the Recidivism Reduction Center ("Recidivism Center"). The draft noted the existence of "profound gaps and deficiencies related

to access to mainstream services for Justice clients” and generally observed that a lack of coordination between justice agencies and community service providers interfered with the effective delivery of services. The goal of the Recidivism Center was to provide a point of collaboration and coordination which would better meet the treatment and support needs of offenders. The Committee tabled the appropriations request and recommended, in the interim, that UNO’s College of Public Affairs and Community Service conduct a study to “coordinate and plan for the implementation” of such a Center. (Laws 2006, LB1060)

Upon the Governor’s and Legislature’s approval of \$45,000 for the study, the Community Corrections Council executed a contract with UNO-CPACS to complete the study. The contract specified that the study “shall be a review of community and justice resources available in [Douglas County] that may be utilized by the Center and a review of the substance abuse treatment needs of felony-level drug offenders in the metropolitan area.” The contract further specified that any plan should consider:

- “the overall need for mental health and substance abuse treatment services targeted at reducing recidivism among felony offenders”,
- how the Recidivism Center would be juxtaposed against comparable services such as Probation/Parole’s Day and Evening Reporting Center, the Specialized Substance Abuse Supervision Program, and community-based treatment services being developed as part of the behavioral health reform effort; and,
- “the central importance of collateral support services such as education, job-training, job counseling, housing assistance, drug and alcohol testing, family counseling and parenting classes”.

One of the main planning questions sought to be answered by the Study was which offenders should be “targeted to receive services through such a center.” Finally, the study was to yield some insight into the eventual costs of a Recidivism Center and consider “the means by which the [Center] can achieve sustainability.”

### ***Offenders targeted by the Recidivism Center***

Meaningful planning discussions are predicated upon knowing either: 1) the risks and needs of the targeted population, or 2) specifying the array of services which can be made available, then finding which offenders would most benefit. The review of the history behind the Study suggests that the Council places the identification of an offender population paramount to setting up a Center with a particular group of services. In other words, it is more important to identify which offenders need assistance and address their individualized needs than to implement a specific program.

Different labels have been used to identify the group of offenders intended to benefit from the Recidivism Center. They have been variously described as “Justice clients”, “felony-level drug offenders” (Draft Document, LB 1060, Study Contract), “felony offenders” (Study Contract), and “felony offenders with drug addiction problems” (Study Contract). At the same time, discussions about the possible mix of services the Center should deliver have indicated the population could be drawn from Probation, Parole, Douglas County Drug Court, and could even include “DWI 1<sup>st</sup> offenders”. (Draft Document)

In and of themselves, these labels do little to parse the Center's targeted population from the 20-23,000 different offenders arrested in Douglas County in a given year. If one considers these terms along with the aspirations expressed for the Recidivism Center, however, we can begin to home in on who would benefit from such a Center.

Foremost among the aims of the Center is to reduce the likelihood that an individual will eventually go to prison. This is the basis for the Council's very existence. Second, the Draft Document and Contract indicate the Center should fill gaps in existing services, integrate with ongoing community correction initiatives, but avoid duplication. Finally, the Contract states "the study should . . . anticipate the degree to which a center may impact non-governmental treatment providers and disrupt the existing market for these services.

To summarize, the guidelines for identifying the best population for the Center are:

1. Offenders who appear likely to go to prison in the future;
2. Offenders who are unlikely to obtain services from service systems already in place; and,
3. Offenders whose service needs can be met in a way which promotes community service capacity.

### **Why offenders go to prison**

Douglas County sent 561 offenders to the custody of the Nebraska Dept. of Correction Services (DCS) due to offenses committed in 2004. These inmates were convicted of 665 crimes. Fifty-four (10%) of the inmates were incarcerated for a single-drug related offense; 17 (3%) were convicted of an alcohol-related driving offense. This represents 11% of the total number of crimes for which inmates were convicted in 2004.

Among the more prominent expectations for the Recidivism Center was that it would improve offenders' access to substance abuse treatment services. It is anticipated that this treatment will diminish the likelihood that the offender will go to prison. However, the complete criminal histories of these 71 drug and alcohol offenders show that prior to the conviction which led to their imprisonment, they accounted for 1,928 crimes across 100 different offense categories including, Driving Under Suspension (281), assaults (156), thefts (81), weapon violations (65), robberies (15), sex assaults (6), and homicide (2). In other words, each of these "felony-level" drug and alcohol offenders had an average of 27 prior arrests or convictions. While substance abuse probably played a role in the incarceration of these offenders, their criminal histories had a more direct influence on that decision.

When we examine why drug and alcohol offenders end up in prison, we see that the main factor leading to incarceration is the one thing which no program can ever change: *prior criminal history*. There will always be a group of offenses for which people are imprisoned regardless of their past criminal history, such as murder, serious arsons, aggravated robberies, and serious sex offenses. With these relatively few exceptions, however, the relationship is straightforward and direct: the more offenses a person has, the more likely they will be sent to prison; the fewer offenses a person has, the less likely they will be sent to prison.

The real key to reducing the flow of offenders to prison turns on keeping individuals with few offenses from accumulating more. This means, by definition, the offenders who are most likely to avoid prison are those who receive support services and aggressive monitoring before they have been arrested and convicted for a larger number of crimes. This also implies that for the Recidivism Center to succeed, it must address the broad spectrum of recidivism risk factors.

An emphasis on substance abuse is unlikely to keep offenders from going to prison if the four remaining risk domains are inadequately attended to.

### Offenders not receiving services

For the Recidivism Center to avoid overlapping with other services means it must focus on offenders who are unlikely to receive services. The following figure from the Methamphetamine Treatment Study is helpful:

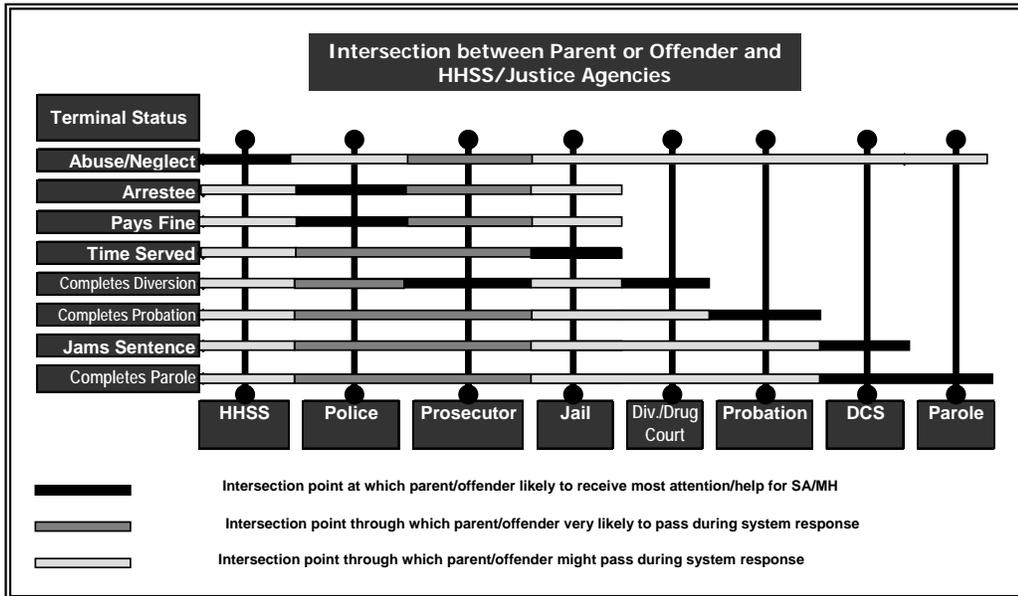


Figure 1. Terminal Status of Offenders in the Justice System. Methamphetamine Treatment Study (2006).

In those cases which terminate with Diversion, Probation, or Discharge from prison, offenders receive a number of services. Diversion includes Drug Court and its substance abuse treatment services and case-managed oversight. Probationers can receive risk assessments, mental health screens, substance abuse evaluations, Specialized Substance Abuse Supervision, and can be sent to the Work Ethic Camp for up to six months of treatment, counseling, education, and work skills. Parolees are provided, at a minimum, case-managed monitoring and many completed treatment programming while incarcerated.

Thanks largely to the Council's efforts during the last legislative session, this array of oversight and management, while not complete, has been amplified by additional support for the Fee-for-Service Voucher Program and the Probation/Parole Day and Evening Reporting Centers. The Council and agencies involved with these efforts continue to fine-tune implementation, but the point remains that offenders at this level of involvement with the justice system are being assessed, monitored, and many have access to treatment.

At the same time, there are pockets of offenders within the justice system who are not receiving any appreciable degree of rehabilitative attention beyond, possibly, the standard pre-sentence investigation conducted by probation. Some of these offenders may actually be under

the supervision of Probation as a result of a prior offense, but many are outside any connection to the revenue streams which are beginning to emerge for treatment services. The figure, above, illustrates that at least three groups of offenders leave the justice system without ever being subjected to oversight by Diversion, Probation, or the Nebraska Department of Corrections. Those offenders are the ones whose cases terminate with arrest (charges dismissed), with fines, and with county-jail time.

Offenders whose cases end with arrest are beyond the reach of the ordinary justice process. Arrestees who are booked into county jail pending trial, sentenced to jail as punishment, or who are sentenced to fines, however, are vulnerable to justice system leverage. Neb. Rev. Stat. § 28-105 delineates two classes of felonies (Class IIIA and IV) and four categories of misdemeanors (Class I, II, III, and IIIA) under which an offender can be sentenced to jail, but not necessarily placed on Probation. These six categories of crime apply to more than 870 different offenses under the Nebraska Revised Statutes. Granted the majority of these offenses may be related to crimes outside the typical purview of the offenders discussed here, but this fact does show that Douglas County probably has hundreds of offenders every year who are not subject to the intense assessment and case-managed monitoring on which real recidivism reduction depends.

Just how many offenders fall into this category is impossible to precisely calculate within the time and resource constraints of this study. However, this research has discovered much about which offenders end up in prison: as a general rule, those with long criminal histories. Given the number of Douglas County arrests suggesting a large number of offenders are on track for eventual incarceration and the scores of offense categories for which an offender can be convicted without mandated assessments or serious supervision, it is reasonable to estimate that at least 3-4,000 offenders per year could be identified as at risk of future incarceration.

The good news is that many of these offenders are probably strong candidates for the type of comprehensive programming envisioned by the original concept for a Recidivism Center. The bad news is that if the Recidivism Center does not serve several hundred offenders per year, it is unlikely to appreciably diminish the over-capacity problems of the Nebraska prison system. To meet the ultimate aim behind the Recidivism Center's proposal, it is not economically feasible to organize the program around a state or county-sponsored initiative providing direct services to this many offenders.

Instead, the Center must be organized in a way which 1) assesses the recidivism risk for these offenders, 2) actively links them with community service providers, and 3) provides some level of case-management to maximize the likelihood that offenders receive the services which have been deemed crucial to their rehabilitation.

## **Promoting Community Capacity**

At the time of this study, Douglas County had just over 120 different service providers handling offender referrals for mental health or substance abuse treatment, job-training, housing, or general counseling services. These referrals came from a variety of justice sources, including Drug Court, Adult Diversion, Douglas County Corrections, and Probation. Requests ranged from evaluation and direct treatment services to temporary housing and employment assistance and every other risk factor identified for recidivism.

Factoring in the number of offenders supervised by Drug Court, Probation, Parole, and Douglas County Corrections, one would predict that Douglas County service providers were

flush with business. In fact, just the opposite appears true. Service providers interviewed for this study complained that the only thing more unreliable than the number of offender referrals they could expect at any given time, was the amount of revenue they could expect to generate from taking offenders.

This dynamic exerts a pernicious impact on all service providers whether they are sole practitioners or for-profit/non-profit corporations. ***Success in reducing recidivism among Douglas County offenders depends on the ability of non-governmental providers to grow with the increasing demands of a community corrections oriented justice system.*** Direct services are critical to the success of justice agencies' attempts to slow the tide of offenders drifting towards prison. Yet, unpredictable referrals and reimbursements leave those service providers on which the system most relies, in a perpetual limbo where capacity-expansion plans are rife with risks of financial disaster.

The stress on service provider organizations increases as justice agencies speak ever more forcefully about moving towards evidence-based treatment practices. Most providers are organized to provide narrow categories of substantive services, but when their clients re-offend, the effectiveness of their treatment is tarnished by case-management issues over which the provider had no control. At least one major service provider from Douglas County reported that their agency provides limited case-management to offenders because they understand how critical it is to ultimate success, but they have to absorb the expense because none of the present re-imbursement streams pay for it. Ironically, this is just the opposite of the juvenile system where HHSS has long contracted for substantive services and case-management practices like tracker programs.

The unpredictable nature of the system compels service providers to take all referrals and shoe-horn them into programming regardless of how well they fit. This flies counter to one of the central tenets of best-evidence practices. There's no such thing as a universal program well-suited to every individual who passes through intake. Service providers worry, however, that if they refuse to take a client, justice agencies will consider them uncooperative and stop sending offenders their way. From this standpoint, providers are better off taking a chance that an offender will complete their program and that any negative outcomes following discharge will be chalked up as a garden-variety failure of the system rather than being attributed to the provider.

## **Conclusion**

These insights do not eliminate a Recidivism Center from consideration, *per se*, but provide critical guidance to how it should be conceptualized. The offenders who would most benefit from the Recidivism Center are those not receiving screening and comprehensive risk assessments during the ordinary justice processing of their case. It would be too expensive, and redundant, to simply create a program which paralleled the existing services found in Probation, Douglas County Corrections, Drug Court, or Parole. Service providers survive on business models which rely on steady, predictable referral streams to which governmental or private revenue sources are attached. Any hope of reducing the overall recidivism rate of Douglas County offenders depends on individualized assessments, successful connections with treatment and support services, and case-management.

The concept for a Douglas County Recidivism Center which best matches all these criteria is one which includes:

1. Mental health and substance abuse screening;

## Recidivism Reduction Treatment Center Study

2. Standardized risk assessment services;
3. Referral brokerage;
4. Case-management for select offenders; and,
5. Discharge planning.

In contrast to the other ways in which a Recidivism Center could be structured, a Center designed to assess 1,000 to 1,500 offenders per year and actively connect them to community service providers has the greatest chance of significantly reducing recidivism rates. Targeting those offenders who face relatively minor charges, at least from the justice system's standpoint, addresses the most "profound gap" which remains in building a comprehensive community corrections system response in Douglas County.

Using these assessment results to guide the referral of offenders to community service providers begins to erode the fragmented, silos identified in the community. By shouldering the expense of the assessment process and more effectively guiding offenders to services which best fit their risks and needs, the justice system stabilizes referral streams. This sets in place a dynamic collaboration between justice and service providers enabling the most effective providers to count on growing numbers of clients and the justice system being able to steer offenders from programs which prove incompetent or ill-prepared to meet the unique treatment and service needs of offenders.

Focused on assessment, referral brokerage, and limited case-management, the Center will operate at a cost per offender rate as much as 90% lower than a residential, long-term treatment, education, and employment facility.

The end-result fulfills the spirit behind the Recidivism Center. Large numbers of offenders receive the individualized help they require to break free from a life-style that promotes offending.

## Methodology

The first step to “coordinate and plan” for the Metropolitan Community Justice Recidivism Reduction Center (“Recidivism Center”) was to review the research literature to identify the risk factors associated with recidivism. Just as the Legislature and Council anticipated, five categories of risk factors were found to be strongly associated with recidivism: mental health, substance abuse, housing, education/employment, and family/social relationships. The research also exposed the underlying complexities associated with defining recidivism and identifying a target population for effective recidivism reduction strategies. Armed with this information, the research team developed a list of questions and focal concerns central to the successful implementation of the Recidivism Center for later discussion with stakeholders in the project.

In the second component of the project, an inventory was compiled of existing Douglas County programs and services available to assist offenders in overcoming factors that place them at risk for recidivism. The primary source for the list was the *Douglas County Corrections Pre-Release Program: Real Life Connections* which contained a comprehensive listing of organizations, programs, services and support groups that address each of the five major categories of risk factors for recidivism identified in the literature review.

In the third primary component of the study, the Research Team conducted a roundtable on October 6, 2006 with various stakeholders of the Recidivism Center project. Attendees included representatives from State, County, and City Government, the Court Community, the State and County Corrections Community, and the local Treatment Community. A list of attendees is included in *Appendix A*. Attendees were presented with the findings from the literature review and a summary of the inventory of programs and services. Stakeholders considered the list of research questions that emerged in the completion of the earlier phases of the project. For the list of questions discussed during the Roundtable, see *Appendix B*.

The Study’s fourth component included an analysis of DCS data. Although considerable input was gleaned during the stakeholder meeting, attendees were unable to specify who among Douglas County’s twenty-thousand annual offenders the Recidivism Center should target. The purpose of the data analysis was to determine whether inmates’ offense histories revealed a category of offenses which could guide offender selection for the Recidivism Center.

Finally, throughout the course of the Study, researchers maintained an ongoing dialogue with community service providers. Alegent Health, perhaps the main provider of crisis mental health services in Douglas County, was particularly helpful in enabling the research team to better understand these issues and the anticipated role that the Nebraska Recovery Center is expected to fill. Catholic Charities served a similar role in demonstrating the breadth of substance abuse treatment services available on an emergency, short-term, and long-term basis.

## **Clarifying the Concept of Recidivism**

One of the greatest challenges in developing a strategy for reducing recidivism is the difficulty associated with defining the concept of recidivism. It is generally accepted that recidivism is “the repetition of criminal behavior” (Rush, 1994; p. 289). While the definition seems straightforward, difficulties arise in our efforts to identify and measure behaviors that constitute recidivism. Moreover, it is necessary to determine the point in the criminal justice system at which recidivism reduction strategies should be targeted to have the greatest impact on the largest number of offenders.

### ***Complications Associated with Measuring Recidivism***

The task of measuring recidivism poses a logistical challenge. In fact, Beck (2001) refers to recidivism as “a fruit salad concept in the world of criminal justice” (p.1). The problem resides in the fact that there is no nationally-accepted standardized measure of recidivism. For the most part, attempts to measure recidivism tend to focus on repeated criminal behavior, measured as re-arrest, reconviction or re-incarceration, of those who have been released from a period of incarceration (see Langan and Levin, 2002). Some states, such as Colorado, include parole revocations for technical violations in their measures of recidivism; while in other states, such as Florida, only those who are returned to prison or receive a “new sentence to Community Supervision for a new offense” are included (Beck, 2001; p.1).

The Department of Correctional Services (2005) (DCS) in Nebraska defines recidivism as “criminal acts that result in conviction by a court when committed by legal offenders released from the Nebraska Prison System during a specified base time period who return to the Nebraska System within three (3) and (10) years of their release date” (p. 145).

## Offending and Recidivism

This section discusses recidivism on a national level and within the State of Nebraska. A profile of offenders from Douglas County who have been incarcerated in state facilities reveals whether Nebraska's use of incarceration in state prisons is *offense* or *offender* driven.

### ***Profile of Offender Population Entering Prison from Douglas County***

Criminal history data is available for 1,560 Douglas County offenders sent to prison for offenses committed during the 36 month period between December 2003 and October 2006. If the inmates are sorted according the total number of offenses contained in their complete recorded criminal history:

- 37 had one offense
- 102 had 2-3 offenses
- 419 had 4-10 offenses
- 416 had 11-20 offenses
- 220 had 21-30 offenses
- 195 had 31-50 offenses
- 48 had 51-75 offenses
- 7 had 76-100 offenses
- 2 had over 100 offenses.

Ninety percent of inmates had more than three prior, recorded arrests or convictions; nearly 75% had more than *ten*. Altogether, the 1,560 criminal histories for these offenders recorded 27,909 offenses, arrests, and violations. Since 2000, the offenders were responsible for 14,689 offenses. With regard to current offenses, 921 (59%) were sent to prison for a single charge.

### ***Recidivism Rates***

#### **National**

Based on a fifteen State study, the Bureau of Justice estimates that approximately 67 percent of offenders released from prison are rearrested within three years of their release (Langan and Levin, 2002). The *Consensus Project Report* estimates re-arrest rates among those with mental illness to be slightly higher indicating that, in some jurisdictions, over 70 percent of those with mental illness are rearrested (Council of State Governments, 2002; p.6). Langan and Levin (2002) indicate a reconviction rate within three years of release of nearly 47 percent. Even more startling, however is the fact that within three years of release, approximately half (51.7 percent) of the offenders released from prison will return to prison due to a conviction on a new offense or because of a technical violation of the conditions of their parole. Given the increasingly punitive sentencing policies and the high rates of re-incarceration among those released from state and federal prisons, we can expect the prison population and the associated cost to society to continue to swell in the coming decades.

## Nebraska

Nebraska has over 700 individuals on parole and another 4,200 in correctional facilities (Nebraska Dept. of Corrections, 2005). As mentioned previously, at the national-level, approximately two thirds of parolees are rearrested within three years of release, and approximately 52 percent are reincarcerated (Langan and Levin, 2002). While Nebraska recidivism rates are lower than average (approximately 23 percent), we can still expect that many of these individuals will commit new offenses when released into the community (Nebraska Dept. of Corrections, 2005).

Nebraska has recognized the need to aid offenders in either reintegrating back into the community in which they live or transitioning from correctional facilities to communities, and has begun to increase funding and awareness for community options in reducing recidivism. Both LB 46 and LB 538 have encouraged existing correctional services to tap into community resources in successfully reintegrating offenders and reducing the potential for re-offending. Such measures have resulted in groundbreaking projects such as Serious and Violent Offender Reentry Initiative, as well as an increase in new facilities such as the Day Reporting Centers (Nebraska Dept. of Corrections; Nebraska Legislature).

However, given the large numbers of offenders in Nebraska, many of the more intense and specific programs are only able to provide services to a small number of offenders, leaving the vast majority to “fall through the cracks” without knowledge of community programs or resources that might help them succeed. Because of this, there is a need in Nebraska to have programs that are designed to *complement*, rather than compete with programs already in existence such as the Serious and Violent Offender Reentry Initiative (Nebraska Dept. of Corrections) or the Day Reporting Center (Provision of LB 538, Nebraska Legislature). While the Reentry Initiative will attempt to identify offender risks and needs and to match offenders with services and supervision, it is designed to target a specific group of “approximately 60-90 high risk offenders, ages 18-35, within a targeted neighborhood of Omaha” (Nebraska Dept. of Corrections). Additionally, while Day Reporting Center(s), outlined as some of the community corrections specified in LB 538, are also intended to reduce recidivism, they are programs which are very much involved in offender plans because they are often court-ordered, requiring physical or telephone contact and participation in specific programs either at the center or through contracted services (Latessa and Allen, 2003). Douglas County seems to be in particular need of providing community information to the large number of offenders who will not have access to the more intense and specific programs slated for those with only the highest risk and most extensive needs.

## **Review of the Literature**

Recidivism reduction and prevention has been the subject of research in criminal justice, psychology, and even geography. Moreover, it has been the ever-elusive objective of countless criminal justice policy initiatives. Most previous research addressing recidivism reduction focuses primarily on a particular type of criminal behavior such as sex crimes (Levenson and Morenson, 2006), explicit populations of offenders such as juveniles (Pullman et al., 2006; Ryan and Yang, 2005) or specific factors thought to be associated with recidivism such as substance abuse (Belenko, 2006; Stuart, 2005) or mental health (Haggard-Grann and Gumpert, 2005; Phillips et al., 2005). Likewise, policy and program initiatives tend to target specific risk factors such as substance abuse or specific subpopulations of offenders such as felony drug offenders. Yet few studies have bridged the gap between individual and social offender needs and examined recidivism as an overarching phenomenon. What's more, even fewer programs have attempted to identify risk and needs for a general population of offenders. The purpose of the present study is to determine, based on the literature and the current state of service provision, the best approach to recidivism reduction for the greatest number of offenders.

### ***Risk Factors Associated with Recidivism***

As mentioned previously, most recidivism research has focused on specific populations of offenders, categorized by such things as seriousness/type of crime, age, gender or risk factors (see above for references). However, within these groups there are several broad categories of risk that seem to apply nearly universally as important factors for preventing recidivism. These categories include Employment, Housing, Family Contacts, Substance Abuse and Mental Health. "Prisoner 'needs' are related to risk in that there are individual treatment or rehabilitative attributes that are associated with reduced risk of further involvement in crime. These include education level, employment-related skills, mental illness, substance abuse, and family relationships. Recidivism can be reduced, it is hoped, by applying accurate risk models that determine which prisoners pose the greatest risk and have the greatest needs for treatment" (Austin and Hardyman, 2004; p. 14).

The purpose in breaking up risk factors into categories is to identify the category or categories in which individuals have the most need, and to better identify resources that would aid in preventing recidivism for the individual. It should be noted, however, that individual offenders often present with multiple risk factors (Council of State Governments, 2002; ). Plans for meeting the needs of offenders should address all of the risk factor present. Supporting evidence for these as important factors reducing recidivism is outlined below.

### **Employment**

Stable employment has consistently shown to be a strong predictor of whether an offender does or does not recidivate (Flavin, 2004; Holtfreter et al., 2004; Messina et al., 2006; Nilsson, 2003; Schram et al., 2006). Employment plays a role in recidivism for a few reasons. First, and perhaps most importantly, consistent and stable employment help to alleviate the potential for poverty, which, according to Flavin (2004) is "a better predictor of recidivism than [a] summary risk index" (p. 209). This may be particularly salient for women offenders, who, because of economic marginalization and situations such as single-parenthood, may be at greater risk for recidivism because of their poor economic conditions (Holtfreter et al., 2004).

Employment also reduces recidivism risk by providing an increase in “social capital” or the networks of shared norms and values that increase access to needed goods and services (Flavin, 2004). In this respect, increasing employment skills and opportunities may have considerable personal as well as economic benefits. Lack of employment, on the other hand, has been shown to be an important barrier for offenders to stay out of trouble, particularly for registered sex offenders (Tewksbury and Lees, 2006) and offenders with substance abuse issues (Messina et al., 2006). Stable employment can lead to higher likelihood of strong social networks, increased education and a stronger general adherence to social norms, all of which are strongly tied to a lower risk of repeat offending (Flavin, 2004; Messina et al., 2006; Vacca, 2004).

## **Housing**

Housing is another important factor in maintaining a low risk of recidivism and can be a unique challenge especially to parolees who do not have friends or family who might be able to provide living accommodations (Bahr et al., 2005). Housing is also important for recidivism risk for a number of reasons. First, and most obviously, housing is necessary in order to stabilize many other aspects of one’s life. Without adequate housing, employment, social networks and other factors important to a livelihood are much more difficult. Second, the particular housing situation can be an important factor in determining whether an individual successfully maintains law-abiding behavior. This may be especially true for those who find living arrangements in impoverished or drug-riddled communities. As one parole officer pointed out, “some get housing, but it is in a place that is unsuitable, living with another parolee or in a crack house,” (Bahr et al., 2005, p. 260). As with employment, housing difficulties seem to coincide highly for offenders with substance abuse issues (Nilsson, 2003).

Perhaps one of the most crucial factors regarding housing and recidivism is that of stability. A significant factor in predicting who would reoffend in Bahr et al.’s (2005) research included offenders who would be moving within a short period of time. This also can be linked to the notion of social capital and having some investment in a law-abiding lifestyle: “...avoiding recidivism is more important for those whose participation and investment in conventional lifestyle have given them access to higher levels of resources, since they have more to lose by continuing to commit offenses (Laub et al., 1998; p. 225).

In addition, those individuals who have assistance in obtaining adequate and stable housing seem to do much better at avoiding re-offending. Holtfreter et al.’s (2004) research indicated that women who were given state-based financial support to address short-term needs like housing were 83 percent less likely to re-offend than those who did not.

## **Family/Community Contact**

The importance of healthy family and/or community relationships is somewhat new to the idea of recidivism reduction, but has also been shown to be an important factor in encouraging social conformity and law-abiding behavior (Flavin, 2004; Bahr et al., 2005). Bahr and associates (2005) found that some of the most important factors associated with recidivism included the number of close relationships within the family network, and the quality of the parent-child relationship, among others. Austin and Hardyman (2004) also indicated that “healthy family relationships are consistent predictors of success after release” (p. 26).

Families can affect whether an offender recidivates by providing (or withholding) support, by socializing individuals in conforming behavior, and by creating and maintaining

important social contacts *outside* of the family structure. This need for support external to the family highlights the secondary need of strong community ties, which could aid in extended support, employment opportunities, and the like (Bahr, 2005). Family support has been shown to be a particularly strong factor in whether juveniles recidivate (Ryan and Yang, 2005).

Research also indicates that treating family relations and sometimes even involving family members in treatment has the potential to decrease risk of recidivism (Bayse et al., 1991). As Austin and Hardyman note, “there are very few such studies [on family relationships and recidivism], but those that we were able to locate suggested a positive relationship” (p. 18). They go on to discuss one study by Harer (unpublished) that indicated reduced recidivism with spousal support, and another that claimed that recidivism rates were associated with the number of family visits and contacts while the inmate was incarcerated (Hairston, 1990).

Thus, while there is not as much empirical support for the idea of family relationships and the reduction of recidivism, there is a good amount of evidence which suggests that positive/healthy family relationships will not only increase individual functioning, but may also increase the ability of offenders to succeed in other areas.

### **Substance Abuse**

Use of alcohol and illicit substances has been widely linked to arrestees generally, as more than 80 percent of state prison inmates have indications of serious drug or alcohol involvement (Belenko and Pugh, 2005). This is not limited to arrestees who are charged with drug crimes, or to those who live in urban areas where drug use is thought to be more prevalent. In Nebraska, between 30-45 percent of rural arrestees reported alcohol intoxication at the time of arrest, and 25-38 percent of rural arrestees tested positive for at least one drug at the time of arrest (Herz and Murray, 2003).

Substance abuse, like most of the other risk factors discussed here, has unique as well as subsidiary effects for arrestees. Continued substance abuse by released inmates greatly reduces the likelihood that they will be able to obtain and maintain steady employment, have stable family relations or comply with parole supervision requirements (Belenko, 2006). Because substance abuse is so prevalent among all arrestees, and because it is an extremely important factor in whether arrestees succeed after incarceration (Belenko, 2006; Stuart, 2005), obtaining access to help in battling substance abuse is a crucial component to recidivism reduction. Research indicates that substance abuse is a particularly important factor in violent recidivism, including domestic abuse (Stuart, 2005), and that incarcerated women are even more likely than incarcerated men to have severe substance abuse histories (Messina et al., 2006). What’s more, substance abuse counseling and treatment programs have been quite successful at effectively reducing recidivism among offenders (Hiller et al., 2006; Messina et al., 2005). Obtaining access to services that can help offenders to treat substance abuse and maintain a lifestyle of sobriety could greatly benefit a large number of offenders.

### **Mental Health**

Mental illness is another factor found to have a significant impact on recidivism (Haggard-Grann and Gumpert, 2005; Phillips et al., 2005). This particular risk factor is one that seems to affect a significant portion of the prison population; with the Bureau of Justice Statistics estimating that approximately 16 percent of the adult prison population has a mental disorder (BJS, 2005; Council of State Governments, 2002). Other estimates are even higher, but often include substance abuse as a particular type of mental disorder. For juveniles, mental illness

seems to be a much more likely confounding factor in criminal behavior, with one piece of research indicating that 67 percent of those in juvenile facilities met the diagnostic criteria for one or more psychiatric disorders (Wasserman, Ko and McReynolds, 2004). These figures are particularly significant when one considers the fact that it is estimated that only approximately “5 percent of the U.S. population has a serious mental illness” (Council of State Governments, 2002; p.4).

Mental illness is perhaps the most difficult risk factor to identify and to refer for appropriate services, for several reasons. First, the notion of “mental illness” covers such a vast array of problems, from substance abuse to depression to schizophrenia that identifying the specific areas in which problems might occur could be difficult. Second, mental illness often goes hand in hand with a variety of other disorders, including substance abuse, and so may be difficult to discern as an individual problem (Belenko, 2006). Third, mental illness often requires specialized treatment and seldom carries a particular timeline for appropriate treatment, so services may be ongoing and could take a substantial amount of resources to maintain. And fourth, while there is a public perception that mental illness goes hand in hand with violent behavior, individuals with mental illness are far more likely to be victimized themselves than to harm others, and it is often the manifestation of mental illness itself (bizarre language, strange gestures) rather than the commission of a serious crime, that results in the involvement of those with mental illness in the criminal justice system (Council of State Governments, 2002). It is precisely these difficulties in identifying and referring mental health issues that distinguishes this risk factor and one in which bridging the gap between the criminal justice system and professional services is crucial.

There are important indications of the promise and potential of mental health treatment options, including therapy that aims to help the dual diagnosis of mental illness and substance abuse (Broner et al., 2004; Wexler, 2003). While our criminal justice system is beginning to recognize the specific needs of offenders with mental illness with opportunities such as mental health jail diversion programs and mental health courts, a large portion of those released from incarceration could gain much more ground by utilizing a gatekeeper designed to direct these individuals to the appropriate services.

### ***Current State of Service Provision: The Focus on Niche Programs***

In general, available programs and services for addressing the risk factors associated with recidivism are described as a “fragmented” confederation of niche or “silo” programs. Specifically, existing programs and services tend to target either individual risk factors, or specific offender populations with little regard to the complex needs of a broad range of offenders. There are several compelling reasons why most programs and initiatives target only one or two specific risk factors of many offenders or, alternatively, multiple risk factors for only a specific subgroup of offenders. These include: specificity of treatment, lack of expertise and/or community resources, and information that is not easily integrated among service providers.

It is certainly understandable that many programs wish to minimize difficulties by focusing on recidivism reduction on a small scale. However, many of these same difficulties provide reasons that a program focusing on general recidivism reduction might be more beneficial to a community at large than piecemeal programs. While treatments for issues such as mental health or substance abuse may be specific, previous studies indicate that these factors are

often linked together, and that identifying multiple issues may be beneficial, if not crucial, to ultimately reducing future criminal behavior (Council of State Governments, 2002; Pullman et al., 2006). Integrating community-wide expertise and resources and improving communication between the criminal justice agencies and service providers provide a greater likelihood that offenders' risk(s) are identified and that resources are more efficiently mobilized to minimize those risks.

The impact of niche programming is further diminished by the lack of coordination among existing programs and services. With specific regard to mental health issues, the criminal justice system and its subsequent network of programs and services has been characterized by the Council of State Governments (2002) as a "wrong door" system. Specifically, when an offender with a mental illness comes in contact with the system, they are often referred from agency to agency. When they approach subsequent agencies to which they were referred they are often told that they need to seek services somewhere else. In essence they are shuffled from one "wrong door" to another and denied the services that they need, thus increasing the likelihood they will repeat the behaviors which brought them in contact with the system in the first place. The focus on niche programs and the subsequent lack of coordination and communication among existing programs are probably the greatest impediments to the effective reduction of recidivism.

### **Co-Occurrence of Risk Factors: Implications for Service Provision**

As previously mentioned, research indicates that the "network" of service for addressing recidivism is primarily comprised of niche programs that focus narrowly on either individual risk factors or specific offender populations. Unfortunately, research also indicates that a significant portion of the offender population exhibits multiple risk factors occurring simultaneously. The Consensus Report estimates that 75% of inmates with a mental health problem also suffer from a co-occurring substance abuse problem.

As discussed in the *Consensus Project Report*, Ditton (1999), a survey of jail and prison inmates, examined unemployment and homelessness among inmates who were mentally ill. Specifically, among inmates with mental illness, 38 percent of prison inmates and 47 percent of jail inmates were unemployed in the month prior to arrest (Council of State Governments, 2002; p. 12). It is estimated that while 5 percent of the general population with mental illness are homeless, approximately 30 percent of jail inmates and 20 percent of prison inmates with mental illness were homeless in the year prior to arrest.

### **The Deinstitutionalization of Mental Health Populations and Recidivism**

According to the Council of State Governments (2002), "few institutions have attempted so complete a change over the previous 35 years as has the nation's public mental health system" (p. 7). Where the system once relied almost exclusively on the provision of services within an institutional environment, mental health care today is primarily community-based.

In the State of Nebraska, the recent closure of the regional mental health facilities has resulted a rapidly growing number of people who must now rely on community mental health services. Regardless of how sound or humane the motivations may have been for this reform, the *Consensus Project* (2002) forecasts ominous consequences if aggressive safeguards are not systematically implemented.

With regard to recidivism in other states, the risk factor of mental health has been amplified by the deinstitutionalization of the mental health population and the grim notion that many mentally ill end up incarcerated simply because there is no where else for them to go (Rollin, 2006). The Council of State Government's *Criminal Justice/Mental Health Consensus Project* (2002) report highlights the dire need for a close working relationship between the criminal justice system and the mental health service providers.

The Consensus Report details the transfer of mental health patients to the criminal justice system. (Council of State Governments, 2002). Because many individuals are not violent or "serious" criminals, they tend to "fall through the cracks" when it comes to obtaining necessary treatment. At the same time, professionals in the mental health community are often overwhelmed by the difficulty in identifying, treating and sustaining therapy within the confines of the criminal justice arena. Prisons and jails tend to be environments that exacerbate the symptoms of mental illness, and inmates with mental illness are at particularly high risk of harming themselves or others. As a result, treatment in detention facilities or with incarcerated individuals can be especially difficult.

This difficulty often continues once those who have been incarcerated and who suffer from mental illness return to the community. If they are in a position to seek help for their mental illness (which is unlikely), offenders with mental illnesses who were previously incarcerated often find that providers are already overwhelmed with clientele and/or reluctant to treat someone with a criminal record (Council of State Governments, 2002). Consequently, the individuals who are in serious need of mental health treatment are those who often find it most difficult to receive.

As stated in the *Consensus Project Report*, "it is sometimes said that the mental health system has many doors—and all of them are closed" (Council of State Governments, 2002; p. 28). The report suggests that the most effective way of making mental health resources to offenders is to incorporate a "gatekeeper" who can provide a "point of entry" to care. It is this type of system, the report argues, that "encourages service integration, cuts down on conflicts and redundancies, and promotes more efficient use of resources," (Council of State Governments, 2002; p. 29).

### ***Summary: The Need for an Integrated Network of Service Provision***

While the risk factors discussed in the foregoing sections are not a comprehensive list for all offenders, they are the factors most commonly identified and most strongly linked with recidivism. They provide a solid foundation for considering how existing community resources can be delivered better to offenders.

The current state of service has been characterized as a "fragmented" and uncoordinated network of niche programs targeting individual risk factors or narrowly defined populations of offenders. It seems clear that, while some of these factors (such as mental health and substance abuse) may be more easily detected or severe, the most useful approach to reducing recidivism is to utilize a more comprehensive approach, and initiate a process by which any of these risk factors could be identified and appropriate support provided.

In short, large scale recidivism reduction is most effective when approached from an *offender* perspective rather than an *offense* perspective. Recognizing and dealing with a number of potential risk factors for a general population of offenders seems to be integral in recidivism reduction for Douglas County.

## Recidivism Reduction Treatment Center Study

With regard to offenders suffering mental illness, the Council of State Governments (2002) recommends coordinating services within a single agency acting as a “gatekeeper” or “single point of entry.” Given the complex mix of risk factors for any offender, the necessity of comprehensive assessments, and the fact that offenders clearly require assistance in accessing help, the recommendation appears to apply equally well to all offenders. This approach promotes a community-wide network of programs and services supporting large numbers of offenders rather than a select few.

The “no wrong door” strategy has much to recommend for the Douglas County Recidivism Center.

## Capacity: Programs and Services Available in Douglas County

In order to develop effective strategies for recidivism reduction in Douglas County it was necessary to compile a list of existing programs and services available to address the risks/needs of offenders. The list includes resources targeting each of the five categories of risk factors identified in the literature review: housing, employment, family/community contacts, substance abuse, and mental health. The primary source was the *Douglas County Corrections Pre-Release Program: Real Life Connections* inventory of programs and services. The Recidivism Center research team supplemented the list with regard to substance abuse and mental health services with the *Region 6 Behavioral Healthcare: Network of Care Providers Directory*.

The list is not exhaustive in scope, but illustrates the breadth of community-based programs that exist in Douglas County. To compile an exhaustive inventory of all programs and services, their eligibility requirements, referral and reimbursement streams, programming, and effectiveness involves database development and time characteristic of implementing a community provider index system and simply exceeds the resources of this project. Furthermore, in compiling a list of existing services it is important to note that lists become obsolete in a relatively short period of time due to attrition of existing programs and the creation of new ones. Thus, the list may contain some programs that no longer exist, while simultaneously excluding others that have been developed since the sources for our list were compiled. The Recidivism Center research team identified 155 programs, services, facilities and support groups utilized by the criminal justice system in Douglas County. The distribution of programs and services by recidivism risk factor is presented in *Table 1*, below. The complete list of programs and services is provided in *Appendix B*.

DISTRIBUTION OF SERVICES IN DOUGLAS COUNTY BY RECIDIVISM RISK FACTOR	
RISK FACTOR	PROGRAMS/SERVICES
Employment	28
Housing/Basic Needs	63
Family Contacts	15
Substance Abuse	29
Mental Health	20
<b>Total</b>	<b>155</b>

**Table 1. Distribution of Services in Douglas County (2006).**

### **Employment**

As indicated in the literature review, stable employment, or the lack thereof, has been found to be one of the strongest predictors of whether an offender will engage in repeat criminal behavior. Criminal justice professionals in Douglas County have at their disposal approximately 28 businesses, agencies and organizations that address offenders' employment needs. The services range from contract/temporary labor services, to job training/career counseling services, to educational services aimed at enhancing the career advancement potential of the participants.

The Recidivism Center research team also identified four life skills training programs that assist offender in debt and money management once they obtain employment.

### ***Housing/Basic Needs***

Another risk factor for recidivism identified in the literature was the lack of adequate housing. Adequate housing is related to stability and, therefore, to the likelihood that offenders will obtain employment and abstain from repeat offending. Douglas County has approximately 34 facilities that provide transitional housing to various populations of offenders. Facilities range from shelters established to help the homeless to therapeutic transitional housing for persons recovering from problems such as substance abuse.

Lack of adequate housing is often accompanied by an inability to meet other basic needs such as food and clothing. Within Douglas County there are at least 29 programs that address these needs. For example, there are a variety of organizations that provide food to persons who are in need. Other organizations provide clothing to the homeless and near homeless. There are also programs that provide career-appropriate clothing to those in need in order to secure employment.

### ***Family Contacts***

As the literature review indicates the least researched risk factor involves family contacts. There is some evidence which suggests that offenders who have positive family contacts will be less likely to engage in repeat offending. Unfortunately, much like the literature itself, services available to offenders to assist in the development of positive family contacts are scarce. The Recidivism Center research team was only able to identify one life skills training program that targeted the improvement of the parent/child relationship. The remainder of resources available to address family relations consists of 13 support groups that address family issues such as parenting, or coping with a family member who has a gambling addiction, problems with substance abuse, or problems associated with domestic violence.

### ***Substance Abuse***

As previously discussed, substance abuse, has unique as well as subsidiary effects for arrestees. Continued substance abuse by released inmates greatly reduces the likelihood that they will be able to obtain and maintain steady employment, have stable family relations or comply with parole supervision requirements. The result is often repeat criminal behavior and contact with the criminal justice system. Having already served a period of incarceration, the likelihood of a return to jail or prison is high.

There are approximately 25 substance abuse treatment centers identified by Douglas County Corrections and/or Region 6 that provide in patient and/or out patient treatment services to offenders who have problems with substance abuse. Additionally, as of August 28, 2006 there were approximately 110 individuals registered as substance abuse treatment service providers within Douglas County that conduct a combination of substance abuse evaluations, group and/or individual outpatient counseling. Many of the individuals registered provide services for one of the 25 substance abuse treatment centers/programs mentioned previously, others work in private

practices. In addition, the research team identified 4 support groups available to persons who suffer from addictions to alcohol or other illegal substances.

### ***Mental Health***

Mental illness as a risk factor for recidivism has received considerable attention in recent years. The shift toward deinstitutionalization over the past 30 years, and more specifically, the recent closing of regional mental health facilities in Nebraska, has left persons with mental illness with the task of seeking services within the community. Often, the failure to seek treatment or to follow a prescribed treatment plan results in the exacerbation of the symptoms of mental illness. Others within the community are left with no alternative other than to contact law enforcement. Because the capacity available to admit persons experiencing mental health crises is limited, there is often no alternative but to hold them in jail. The result nationwide has been the transfer of a significant portion of the population of persons with mental illness from hospital-like settings to jails and prisons, the “new asylums.”

The Recidivism Center research team identified 17 mental health treatment centers serving Douglas County. Of those, only two have the capacity to accommodate those in need of emergency protective custody (EPC). This is a significant finding since a lack of EPC capacity can lead to people being jailed by default; such confinement can exacerbate behavioral problems and lead to institutional offenses. The other service providers offer a range of services including community support, assessments, medication management, inpatient treatment services and outpatient treatment services. Additionally, according to the Nebraska Health and Human Services System (HHSS), there are approximately 761 Licensed Mental Health Practitioners (LMHP) in Douglas County. It should be noted, however, that it is not possible to determine the exact number of LMHP’s who provide services to persons who have come into contact with the criminal justice system.

Although it remains in the planning stage, some comment must be made regarding a new mental health facility which has not been officially named, but is publicly discussed as the “Nebraska Recovery Center”. On November, 12, 2006, the Omaha World Herald reported a coalition of philanthropists and at least two of Omaha’s major health care systems were working on a facility with 16 acute and 32 sub-acute treatment beds. The facility will be housed at the former Richard Young complex. According to the World Herald Report, Gov. Heineman “has agreed to provide \$5 million a year from cost savings at the Norfolk regional center.” While this has tremendous potential to ameliorate the mental health concerns expressed above, it remains to be seen how the facility’s programming will ultimately be structured. If everything goes as planned, the Recovery Center reportedly could open in “mid-2007”.

### ***Summary***

Douglas County has an extensive network of service providers attempting to address the five risk factors associated with recidivism as identified in the literature. At least 155 programs, services and support groups are available to assist offenders with their employment, housing, family contact, substance abuse and mental health needs. To what degree the existing services are sufficient to accommodate the vast range of needs for all offenders cannot be determined from the data. However, the present fragmentation and lack of coordination between service providers and the justice system handicaps the effective reach of what exists.

Although it is only one of the risk factors contributing to recidivism, mental illness deserves a final, separate comment. The Douglas County treatment community has made a heroic effort to develop the community-based mental health services demanded by Nebraska's Mental Health Reform initiative. At the same time, the findings from the Consensus Report show that in every state which has de-centralized mental health treatment, the mentally ill gradually transition into prisons. Douglas County has yet to demonstrate this problem, to the extent outlined in the Consensus Report, however, anecdotal evidence collected during this study suggest that it should be major concern. When a mentally ill man or woman is jailed for a minor offense, such as a public disorder violation, the nature of confinement can provoke assaults on county correction staff and other county jail inmates. Such assaults can quickly result in felony charges which lead to incarceration within the Nebraska DCS system. These inmates are a persistent challenge to institutional management.

The Douglas County Jail and Nebraska DCS facilities provide mental health services to all offenders to the best of their abilities, but jails and prisons cannot be confused for mental health treatment facilities. As the State and Douglas County work to reduce recidivism among the broad base of offenders, there is considerable merit in trying to divert the mentally ill from jail before they accumulate additional charges. The pilot mental health project currently operating in Douglas County Corrections under oversight from the Douglas County Attorney merits additional review and, to the extent that community service providers have the capacity to support it, should probably be expanded.

The complications associated with selecting offenders for the services of a Recidivism Center do not apply to the mentally ill confined in the Douglas County Jail. A simple screening for mental health issues, as implemented in the pilot project, can quickly alert the system to an offender's need for alternative placement and treatment services. **Whether the implementation of a full Recidivism Center is pursued or not, the justice system and community providers must continue to try to isolate offenders with severe mental illness from the rest of the Douglas County Jail population.** Only through these concerted efforts can Nebraska prove the exception to the findings of the Consensus Report.

## **Roundtable Discussion**

On October 6, 2006 the Recidivism Center Research Team conducted a roundtable session with stakeholders in the Recidivism Center project. The purpose of the roundtable was to clarify conceptual issues that emerged during the completion of the literature review and the compilation of the list of existing services in Douglas County. The Research Team divided the group into three smaller discussion groups and posed a set of discussion questions to the participants. The discussion questions are listed in Appendix B. Three primary issues emerged out of the roundtable discussion.

### ***Identifying the Target Population***

The first issue examined was whether the population identified in LB1060, “felony drug offenders”, would be the best served by a Recidivism Center. Many stakeholders argued that grouping individuals by a particular offense, or even level of offense did not move toward identifying the underlying issues that may have led to that offense. They asserted that an individual convicted of burglary was just as likely to have treatment needs as an individual convicted of a felony drug offense. Concentrating on offenses effectively deprived the system of the opportunity to identify and serve individuals who were not yet (but were on the road to becoming) felony drug offenders. Additional concern was expressed that focusing on such a narrow population would only serve a small portion of the population needing to tap into the community’s resources.

While a consensus was not reached regarding what specific population would be better served by such a center, many stakeholders indicated that targeting a population earlier in the system, when a lower-level crimes had been committed would effectively reach more individuals and better serve the community.

Some concern was expressed regarding the potential for “net-widening” if the target population were to include a broad range of offenses. However, broadening access to services is not the type of “net-widening” against which the justice system is ordinarily cautioned. In criminal justice terms, “net-widening” refers to the phenomenon when the number of offenders entering the system increases. Helping offenders, *who are already subject to criminal justice intervention* connect more easily to services does not increase the number of offenders in the system. In fact, it has the opposite effect: it pushes more offenders out of the justice system and keeps them from penetrating deeper into more expensive justice responses such as long-term probation and incarceration.

### ***Fragmentation of the Service Provider Network***

The second theme that emerged during the discussion focused on the type of program that this Recidivism Center should be. While some stakeholders believed there was value in a “stand alone” treatment facility that expanded community capacity to deal intensively with offenders, the majority felt that there were already a variety of programs that operated in this way and that a stand alone facility engaged in direct service provision would do little to reduce the community-wide incidence of recidivism. Several of the participants noted the fragmentation that exists in the service provider network. Participants indicated not only a need to coordinate programs and services to avoid duplication, but also the need for an assessment mechanism to ensure that the

programs that comprise the service provider network are effective. Currently, the prevailing measure of existing services' effectiveness rests in the fact that they receive referrals and reimbursements, and, therefore, are assumed to be effective.

One possible alternative to a standalone facility would involve a brokerage service, similar to Douglas County's Juvenile Assessment Center (JAC). A similar center for adults would act as a "gatekeeper" or single point of entry for services without directly providing or paying for them. The matter of size and sustainability were crucial factors for this issue. While standalone facilities would be able to offer more intensive treatment, the size of the population served would be relatively small and substantial resources would be consumed to maintain such a facility.

### **Administrative Concerns**

The third major theme that emerged during the roundtable focused on administrative concerns. Specifically, stakeholders expressed concerns regarding the appropriate agency for administering and maintaining the Recidivism Center. If the chosen course of action centers on establishing a standalone facility, administrative issues would center on the housing and maintenance of the facility itself, including staffing, referral, maintaining services, and working intensely with the correctional system and service providers. An overwhelming majority of the participants, however, felt that establishing a facility of this type would not be feasible. Consequently, the discussion focused on administrative issues as they applied to the establishment of an assessment and referral brokerage service.

With regard to the brokerage options, the discussion centered on whether a new organization/facility, such as an assessment center, would be formed or whether an existing agency within the justice system could oversee the administration of such services. As with a standalone facility, establishing a new agency did not receive as much support as the possibility of housing such services within an existing agency. There was some concern that probation already performs these functions and thus a brokerage service would be redundant. Others felt that probation would be the logical place to house the brokerage database. For others, determining which agency should administer the brokerage service turned on how the target population was defined and how early in the justice process such a center sought to address recidivism risks.

Specifically, most participants felt that the Recidivism Center would have the greatest impact if the target population included a broad range of offenders and included less serious offenses. Some felt that this could best be accomplished at a point as early as arrest or incarceration in the jail. Early progress documented with the Douglas County Attorney and Douglas County Corrections' Mental Health Diversion Program was held up as one example.

In sum, stakeholders were asked for feedback on a number of issues identified by the research team following the completion of the literature review and the compilation of the list of services available in Douglas County. For the most part, participants indicated that the Recidivism Center would have the greatest impact if it served a broad population of offenders and if it resembled a referral service or brokerage, similar to the recommendations in the *Consensus Project Report*, rather than a standalone facility serving a small group of offenders or offense types. While a consensus was not reached regarding the administration of the referral brokerage, many agreed that the earlier in the system the better. Housing a database with an agency early in the system, such as Jail, Diversion or Pretrial Services or with the County Attorney's Office was suggested as an alternative model.

## Recidivism Center Models

Given the findings from the data analysis, literature review, the compilation of the list of services available in Douglas County, and information obtained from stakeholders during the roundtable session, the research team conceptualized three potential models for the Recidivism Center:

1. A residential-oriented facility focused on intense treatment services for substance abuse/mental health, and collateral services related to
2. A “Brokerage” or Assessment Center
3. Service Brokerage Database

Each of these models provides certain benefits to offenders re-entering the community. When selecting a model, Nebraska must balance the cost associated with establishing and maintaining the Recidivism Center with the overall expected benefit. The analysis below highlights the benefits and drawbacks to the potential models.

### ***Finding the right criminals***

What type of programming reduces the number of offenders going to prison? This question is undoubtedly more complex than identifying an offender’s group within the justice system. The success of a recidivism reduction program, regardless of whether it is residential or community-based, depends on whether the programming matches the *individualized* risk and needs profile of the offender.

The initial concept for the Recidivism Reduction Center envisioned that it would target the substance abuse treatment needs of felony drug offenders. The obvious assumption in this vision was that such offenders are most at risk of ending up in prison because of chemical dependency problems. Our research has indicated several flaws in this assumption.

First, felony drug offenders are the product of criminal charging decisions which often vary. While an offender may have been involved in using or even selling drugs, plea bargaining and other prosecutorial decisions do not ensure that an individual will be charged with a felony drug crime. Douglas County sent 561 offenders to the custody of the Nebraska Dept. of Correction Services (DCS) as a result of offenses committed in 2004. These inmates were convicted of 665 crimes. Only 54 (10%) of the inmates were incarcerated for just a drug offense; 17 (3%) were convicted of an alcohol-related driving offense. This represents only 11% of the total number of crimes for which inmates were convicted in 2004, although other statistics indicate that the number of offenders using and abusing substances is much higher.

Second, by the time felony drug offenders become officially identified as “felony drug offenders” they are often far advanced in, and committed to, a criminal lifestyle, lessening the impact that treatment aimed at recidivism reduction might have. The complete criminal histories of 71 of these offenders shows that prior to the conviction which led to their imprisonment, they accounted for 1,928 crimes across 100 different offense categories including, Driving Under Suspension (281), assaults (156), thefts (81), weapon violations (65), robberies (15), sex assaults (6), and homicide (2). In other words, each of these “felony-level” drug and alcohol offenders had an average of 27 prior arrests or convictions. While substance abuse probably played a role in the eventual incarceration of these offenders, their criminal histories had a more direct influence on that decision. With criminal records such as these, it is difficult to see how any residential treatment program, no matter how comprehensive, could reasonably be expected to overcome a life-long commitment to sustained criminal activity. Moreover, what

would the acceptable success rate be, from an evaluation standpoint, of any program attempting such a task? --75%? --50%? --25%?

Third, this small offender population does not share an identical need for services, even in terms of drug treatment. Just like addicts in the general population, felony drug offenders vary in their drugs of choice, the degree to which substance abuse contributes to their overall behavior, and the constellation of risk factors contributing to the likelihood that they will recidivate as addicts or as criminals. It is improbable that a residential facility for this population would have the resources and infrastructure necessary to meet the vast and varying needs of felony drug offenders with high level of offenses.

### **Residential-oriented Recidivism Center**

Given the level of offenses and programming needs demonstrated by the offenders discussed above, it appears that a residential center for this population would have little success without a secure facility staffed and programmed similar to Nebraska's Work Ethic Camp. It may be useful, then, to consider the WEC as a model to help identify what components would be necessary in order to put a residential treatment facility in place for felony drug offenders.

The Work Ethic Camp's location in McCook is undoubtedly helpful. Placing such a center in Douglas County would likely require a higher level of security than is currently in place at the Work Ethic Camp. Due to its location in McCook, offenders are far removed from the social connections and general temptations associated with life in their home community. The 285 miles between McCook and Douglas County may not be insurmountable, but they are a formidable obstacle to anyone attempting to escape. By contrast, a Recidivism Center housing Douglas County offenders, located in Douglas County, would require more than a chain-link fence to dissuade residents from leaving.

It is also important to remember that the Work Ethic Camp has historically run at 75-80% capacity. This translates to approximately 25 open beds at any given time. With recent legislative changes expanding the commitment criteria for offenders being sent to WEC, the least expensive option for the state to address the recidivism risk needs of cases like the 71 offenders convicted of drug crimes may be to simply send them to McCook.

Furthermore, the success rate of Recidivism Center residents will depend on the level of after-care support services and re-entry case-management that offenders receive upon discharge. The absence of such oversight and services is the main systems-related factor contributing to recidivism among Work Ethic Camp releases, parolees, county jail discharges, and offenders leaving Douglas County's Day Reporting Center. No matter how comprehensive the residential program may be in the Recidivism Center, unless post-release strategies and oversight are aggressively pursued, the criminogenic milieu to which an offender returns exerts a persistent counter-influence against the progress they made while living in the Center. This translates, eventually, into a return to behaviors which are likely to result in arrest.

Consider the consequences which would follow from that next arrest. The county attorney and courts would be faced with an individual who has an extensive criminal history, has been subjected to all types of different sanctions, and, now, has completed a \$34,000 program (the average annual cost per admission at the WEC) which failed to stop their criminal behavior. If this person faces even a single felony charge, they would inevitably be on their way to prison. Given the prototype of felony drug users discussed above, this scenario is far more plausible than not. When one factors in the enormous infrastructure required for a new program along these

lines, a residential-oriented recidivism center for felony drug offenders appears impractical at best, and redundant with an underutilized facility, at worst.

### ***Important Factors for Recidivism***

The purpose of the current study was, ostensibly, to determine what mix of services needed to be included in a residential program aimed at reducing the flow of Douglas County offenders to prison. One of the important problems in completing this task is that there are several risk factors for recidivism which cannot be addressed through residential treatment. In fact, of the five main categories of recidivism risk factors, substance abuse and mental illness are the only two which a residential treatment program could possibly influence. The other three (occupation, housing and family relationships) cannot be attended to in a facility. Prior research shows us that offenders have better success when they have the opportunity to be in “real life” situations with a high level of support.

This speaks again to the extensive after care that would be necessary with a residential treatment facility in order to adequately reduce risk of recidivism. In fact, it is important to note that a *majority* of the factors leading to recidivism would need to be attended to and supported after residential treatment dealing with mental health and/or substance abuse was completed.

### ***Helping the Right People in the Right Way***

Even if we assume that residential treatment is necessary for substance abuse (a poor assumption to make), there were only nine people out of 1560 recent DCS inmates from Douglas County who had no prior history and were incarcerated for a drug-related offense: five women and four men. Of these, only one man and none of the women were incarcerated for a drug arrest which occurred in 2006. The Douglas County courts simply are not sending people to prison for drug use alone; offenders are being sent to prison because they have long criminal histories which often include arrests for drug use.

The data shows that the main factor which leads to incarceration is the one thing which no program can ever change: ***prior criminal history***. There will always be a group of offenses for which people are imprisoned regardless of their past criminal history, such as murder, serious arsons, aggravated robberies, and serious sex offenses. With these relatively few exceptions, however, the relationship is straightforward and direct: the more offenses a person has, the more likely they will be sent to prison; the fewer offenses a person has, the less likely they will be sent to prison regardless of the instant offense for which they presently face sentencing.

The real key to reducing the flow of offenders to prison, then, turns on keeping individuals with few offenses from accumulating more. This means, by definition, the offenders who are most likely to avoid prison are those who receive support services and aggressive monitoring before they have been arrested and convicted for a larger number of crimes.

The primary obstacle to implementing a program of treatment, counseling and education services is determining which candidates from the offender population are most likely to avoid future prison terms if they receive these support services. We can identify which people need substance abuse treatment, mental health services or lack adequate education/job skills. What we largely cannot do, is predict which of these people are headed for prison based on the current offense which now has them embroiled in the justice system. Instead, we must measure an individual's overall risk of re-offense.

This insight does not eliminate a Recidivism Reduction Center from further consideration, *per se*, but suggests that a different conceptualization of the Center may be more effective in reducing Douglas County's overall recidivism rates.

### **Assessment and Referral Brokerage**

In 2004, Douglas County recorded more than 27,103 total offenses. As discussed above, 561 men and women over the age of 18 committed 665 (2%) of these offenses and were incarcerated. This means 98% of all Douglas County offenses resulted in a justice system response less severe than prison. If we assume that inmates' ratio of crimes per person holds for the rest of Douglas County's offenses, approximately 23,000 people were arrested.

While some portion of these offenders were probably first-time, low-risk individuals whose single contact with law enforcement cured them of ever returning, the data shows that many were also in the midst of amassing the string of misdemeanors, minor felonies and violations on which future incarceration decisions will be based.

As explained in the review of recidivism research, there are five domains of risk factors which justice agencies need community service providers to address: housing, employment, family/community supports, substance abuse, and mental health. Every offender who has a legitimate risk of future incarceration struggles with some combination of these risk factors. The justice system's best hope of preventing these offenders from continuing to commit offenses rests on a strategy which identifies the particular constellation of risk factors for a given offender and connects them with community supports which reduce or eliminate those factors. This is, in a nutshell, the key to re-conceptualizing the role of a Recidivism Reduction Center in Douglas County.

If the State's ultimate aim is to significantly reduce the number of individuals going to prison from Douglas County, then the offenders against whom it should target additional resources are those still in the early stages of their criminal career. Since an "offense" predicts very weakly who will eventually go to prison and who will not, Douglas County must identify which offenders can be helped through a broad assessment of their overall risk profile. Individualized risk assessments reveal two critical pieces of information: 1) the overall risk of continued recidivism, and 2) which risk factors contribute most to that person's ongoing criminal offending.

Overall risk scores indicate the severity of the offender's situation. Some offenders' overall risk scores will be so low, that the expense of extraordinary measures is unwarranted because those people will likely desist from offending simply as a result of their current brush with the justice system. At the other extreme, some offenders' overall risk scores will be so high (like the felony drug offenders discussed above) that society really has no other option than to commit them to highly structured conditions of supervision essentially aimed at incapacitation. In the middle, are offenders who require interventions leveraged against the threat of more severe punishment, but who are expected to respond reasonably well to case-managed support services and monitoring.

The constellation of individual risk scores, on the other hand, enables the system to determine what specific issues contribute to the offender's law-breaking. Many offenders, especially those in their late teens and early twenties, are arrested for drug/alcohol or public disorder or driving offenses, have a prior history of misdemeanor or juvenile arrests, incomplete

educations, and little legitimate work history. Some may need intense substance abuse treatment, others will be at greater risk as a result of their inability to obtain meaningful employment, and evaluations of others will indicate serious mental illness.

The primary consideration in conceptualizing a Recidivism Center aimed at reducing future offenses, then, is designing some sort of assessment process that reveals which offenders are at the highest risk of future incarceration, but also whose risk factors are particularly vulnerable to targeted support services and monitoring.

In those cases which terminate with Diversion, Probation, or Discharge from prison, offenders receive a number of services. Diversion includes Drug Court and its substance abuse treatment services and case-managed oversight. Probationers can receive risk assessments, mental health screens, substance abuse evaluations, Specialized Substance Abuse Supervision, and can be sent to the Work Ethic Camp for up to six months of treatment, counseling, education, and work skills. Parolees are provided, at a minimum, case-managed monitoring and many completed treatment programming while incarcerated.

Thanks largely to the Council's efforts during the last legislative session, this array of oversight and management, while not complete, has been amplified by additional support for the Fee-for-Service Voucher Program and the Probation/Parole Day and Evening Reporting Centers. The Council and agencies involved with these efforts continue to fine-tune implementation, but the point remains that offenders at this level of involvement with the justice system are being assessed, monitored, and many have access to treatment.

At the same time, pockets of offenders within the justice system who do not receive any appreciable degree of rehabilitative attention beyond, possibly, the standard pre-sentence investigation conducted by probation. Some of these offenders may actually be under the supervision of Probation as a result of a prior offense, but many are outside any connection to the revenue streams which are beginning to emerge for treatment services. At least three groups of offenders leave the justice system without ever being subjected to oversight by Diversion, Probation, or the Nebraska Department of Corrections. Those offenders are the ones whose cases terminate with arrest (charges dismissed), with fines, and with county-jail time.

Offenders whose cases end with arrest are beyond the reach of the ordinary justice process. Arrestees who are booked into county jail pending trial, sentenced to jail as punishment, or who are sentenced to fines, however, are vulnerable to justice system leverage. Neb. Rev. Stat. § 28-105 delineates two classes of felonies (Class IIIA and IV) and four categories of misdemeanors (Class I, II, III, and IIIA) under which an offender can be sentenced to jail, but not necessarily placed on Probation. These six categories of crime apply to more than 800 different offenses under the Nebraska Revised Statutes. Granted the majority of these offenses may be related to crimes outside the typical purview of the offenders discussed here, but this fact does show that Douglas County probably has hundreds of offenders every year who are not subject to the intense assessment and case-managed monitoring on which real recidivism reduction depends.

Just how many offenders fall into this category is impossible to precisely calculate within the time and resource constraints of this study. However, this research has discovered much about which offenders end up in prison: as a general rule, those with long criminal histories. Given the number of Douglas County arrests suggesting a large number of offenders are on track for eventual incarceration and the scores of offense categories for which an offender can be convicted without mandated assessments or serious supervision, it is reasonable to estimate that at least 3-4,000 offenders per year could be identified as at risk of future incarceration.

## Recidivism Reduction Treatment Center Study

The good news is that many of these offenders are probably strong candidates for the type of comprehensive programming envisioned by the original concept for a Recidivism Center. The bad news is that if the Recidivism Center does not serve several hundred offenders per year, it is unlikely to appreciably diminish the over-capacity problems of the Nebraska prison system. To meet the ultimate aim behind the Recidivism Center's proposal, it is not economically feasible to organize the program around a state or county-sponsored initiative providing direct services to this many offenders.

Instead, the Center must be organized in a way which 1) assesses the recidivism risk for these offenders, 2) actively links them with community service providers, and 3) provides some level of case-management to maximize the likelihood that offenders receive the services which have been deemed crucial to their rehabilitation.

## **Cost Comparisons of the Different Models**

### ***Residential-oriented Recidivism Facility***

The first model for the Recidivism Center involves a residential facility serving felony-level drug offenders in the metropolitan area. This model would operate as a stand-alone direct service provider and operate in much the same way as existing treatment centers with the exception that it is serving a target population. To adequately address the recidivism needs for this population, it would be necessary to incorporate treatment in the five identified known to contribute to recidivism: housing, employment, family/community contacts, substance abuse and mental health.

The strategy behind this type of facility would be to stabilize an offender with respect to his or her substance abuse treatment needs. During this process, offenders would work on their education, job skills, and develop discharge plans which capitalized on relationships in the external community that inhibited offending.

Due to the relatively small number of beds available, in comparison to all offenders who would fit admission criteria, selection decisions would be crucial. Just under 100 offenders were sent to prison for drug or alcohol-related arrests in 2004. This suggests the Center would have little impact on prison admissions unless the justice system diverted at least this many offenders to the program.

For the reasons discussed in the Rationale section, above, the primary offenders targeted for this level of intervention would be at a high-risk for being sent to prison. In accordance with DCS data, this means that offenders with multiple convictions and arrests would be the target population. To house this type of offender, the facility would require a secure infrastructure at least comparable to that at the WEC. Programming would parallel what is currently offered at the WEC. Given these similarities, the start-up and annual cost of operations for the WEC provide reasonable guidance in estimating the expense of Recidivism Center.

The WEC cost \$6.4 million to build. Considering the security measures that would have to be built into this type of Recidivism Center, the likelihood of locating a facility which could be affordably retro-fitted is remote.

The WEC's most recent annual operating costs averaged just over \$34,000 per bed. This actually breaks down to approximately \$17,000 per admission because the maximum time an offender can be sent to the WEC is 180 days. Assuming the Recidivism Center follows a similar programming cycle, an estimated 200 offenders per year could rotate through the center. At these rates, annual operating costs would be approximately \$3.4 million per year.

While such admission numbers exceed the current surplus capacity of the WEC, it is difficult to see how the expense of this Recidivism Model could be justified. Considering the charge the Legislature and Community Corrections Council issued for the study, this type of model clearly runs afoul of the admonition to avoid duplication and overlap with services which exist in the current system. Worse, it commits significant funding to very small number of offenders. Finally, offenders who completed this type of program run a razor-thin margin of error. A single arrest for behavior which could be characterized as a felony would almost certainly result in incarceration.

In summary, this type of program attempts to reduce recidivism among 200 of perhaps the most difficult group of offenders to keep from going to prison, duplicates existing levels of service, and will require sustained funding of approximately \$3.4 million per year.

## **Assessment Center and Referral Brokerage**

The second model proposed is designed to screen and assess approximately 2,000 offenders per year, actively link them with community services, and provide a limited degree of case-managed monitoring when such oversight aids an offender struggling with simultaneous, multiple risk domains. Under this model, the target population would not be limited to felony drug offenders, or felony offenders for that matter, but could accept referrals from all justice agencies who have identified an individual whose instant charge is unlikely to result in assessment or significant supervision. One way to move more in the direction of the Legislature's original vision would be for justice agencies to refer offenders with a relatively minor, current charge, but who have a prior felony offense for which they are no longer under supervision or monitoring.

This Recidivism Center model would conduct a comprehensive screening of offenders to identify their risks/needs and which services within the community best fit their particular needs. The assessment results would provide the system crucial insight into the constellation of services the offender required. Positive screens for mental health or substance abuse issues would lead the Center to refer such offenders for an evaluation. Overall scores from the standardized risk assessments could be used to determine whether case-management was needed to ensure the offender was adequately connected with all the services he or she needed. Specific risk factor scores would guide the Center in helping the offender to identify community service programs best suited to address their recidivism risk factors.

The strategy behind this model of the Recidivism Center would be to provide assessments and services to offenders whose prior criminal history signifies potential incarceration in the future, but who have not yet accumulated the string of violations and arrests which would all but guarantee it. The Center's targeted population would not be grounded in a particular group of offenses, but instead aimed at the large group of offenders passing through the system with a terminal discharge status of fines, county-jail time without Probation or the Douglas County Day Reporting Center services, and timed served.

There are several ways such a Center could be administered. Based on the research, feedback from the Stakeholders' Roundtable, and discussions with community service providers, it appears that a new program established outside Probation, Parole, or Drug Court would be the best implementation strategy. Even though it was external to these agencies administratively, economies of scale suggest that it could be physically housed in the same physical location as Probation/Parole's Day and Evening Reporting Center. Otherwise, a non-secure facility arranged and decorated like a typical business office setting would be all that was required.

Comparable assessment centers intended to serve the same estimated number of offenders, 2,000 or so per year, have cost approximately \$700-800,000 to set up. This cost will vary, of course, depending on whether existing office space owned by the State or County can be utilized, the degree to which remodeling is required to install adequate information and communication systems, etc. Annual operating costs for a Center of this nature are expected to average approximately the same amount as traditional probation. The most recent analysis showed an average daily cost of \$2.10 per offender or \$767.00 per year. Assuming the Recidivism Center operates at full capacity, this translates into an annual budget of \$1.5 million.

While the supervision costs of Traditional Probation are useful benchmarks for estimating costs, assessment specialists and referral brokers at the Recidivism Center are primarily expected to assess individual risks and needs, facilitate offenders' connection with service providers, encourage their ongoing participation in appropriate programming, and

document how offenders progress. This work load will vary from client to client, but should consistently represent less overall time with an offender than Traditional Probation ordinarily spends supervising offenders and monitoring their compliance with court-ordered conditions.

Another variation on this model would look to the existing service provider community for these services. Once the specs for such a Center were developed in greater detail, a competitive bidding process might reveal a service provider whose facilities are already well-designed for such a program. Special considerations would have to be taken to ensure that referrals were not disproportionately assigned to the parent agency. It is noteworthy, however, that several providers around Douglas County already enjoy the confidence of the justice system and would likely be strong candidates for such a Center.

In summary, this model of a Recidivism Center would address the recidivism factors of offenders who appear headed for prison, but are before the justice system on a relatively minor, instant charge. Since these offenders are unlikely to receive assessments or monitoring from the typical agencies such as Probation, Parole, Drug Courts or the Douglas County Department of Corrections, the Center fills a large gap in the continuum of interventions for offenders. Extremely cost-effective, this type of service is not expected to exceed the average cost rate of Traditional Probation, approximately \$2.10 per day.

### ***Service Brokerage Database***

A third possibility would not involve establishing a center, but would instead concentrate on identifying and categorizing existing services in the metro area in a database, then on training personnel in either the Pretrial Release Program, the Prosecutor's office, or Probation. Personnel would be trained in estimating offender needs and cross-referencing services.

This model would be of minimal cost. As a similar model, Maricopa County Probation office developed a program called Reach Out, which was established to help probation effectively screen, refer and sometimes offset the cost of substance abuse treatment for probationers. The total direct cost for this program was just over \$200,000 (Maricopa County Research Report, 1999). While this pilot program only identified substance abuse providers and treatment, it allows for a starting point of potential cost, including potential increased personnel for probation.

This type of model would serve a wider population than a residential treatment facility for felony drug offenders, because it would not be limited by offense. The impact of the program would depend on the agency with which the database is housed. If housed with Probation, it would potentially reach fewer individuals than the 2<sup>nd</sup> model, because it would only service those who come in contact with probation. If the database is housed within an agency that has contact with offenders earlier in the system, the potential population of offenders who would be served would be larger.

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## **Appendices**

**Appendix A: Attendance List for Recidivism Center Stakeholder's Roundtable Discussion, October 6, 2006**

John Synowiecki	Legislature
Ray Fidone	United States Attorney's Office
Mary Ann Borgeson	Douglas County Commissioner
Mark Foxall	Douglas County Corrections
Deb Minardi	State Probation
Joe Jeanette	United States Attorney's Office
Doug Johnson	District Court
Steve Spelic	Alegent
Kathy Kelley	Douglas County
Linda Leonard	Department of Corrections
Janee Pannkak	Department of Corrections
Linda Krutz	Community Corrections Council
Kristen Lynch	Douglas County
Carl Braun	Mayor's Office

**Appendix B. List of Programs and Services Addressing Recidivism Risk Factors in Douglas County**

DOUGLAS COUNTY PROGRAMS AND SERVICES BY RECIDIVISM RISK FACTOR*	
PROGRAM NAME	PHONE/ADDRESS

**RISK FACTOR: EMPLOYMENT**

**CONTRACT EMPLOYMENT/TEMPORARY SERVICES**

Manpower	397-5455 827 N. 98th St. Omaha, NE
Olsten Staffing Services	351-8367 33rd and Dodge St Omaha, NE
Owens Temporary	455-6337 7417 N. 30th St. Omaha, Ne
Heartland Temporaries	733-8663 4232 L Street Omaha, NE
Mid-America Placement Service	341-3338 1941 S. 42nd St. Omaha, NE
Best Temps	731-1466 5012 L Street Omaha, NE
Midwest Temporaries Inc.	390-2500 335 N. 76th St Omaha, NE
Labor Ready	345-1212 3023 Farnam ST Omaha, NE

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CBC Temporaries	571-8140 6653 Sorensen Parkway Omaha, NE
Work USA Inc.	734-8888 4534 S. 24th St. Omaha, NE
Labor Ready	738-9200 5102 S. 24th St. Omaha, NE
Labor Works	345-9675 3003 Leavenworth Omaha, NE
Industrial Temps	731-1466 5012 L Street Omaha, NE
Goodwill Industries	341-4609 1111 S. 41st St. Omaha, NE
Job Training Center of Greater Omaha	444-4700 2421 N. 24th St Omaha, NE
La Raza Job Training	734-1321 4923 S. 24th St Ste 101 Omaha, NE
Omaha OIC	457-4222 2724 N. 24th St. Omaha, NE
Metropolitan Community College	457-2400 main switchboard 204 W. Dodge Rd Elkhorn, NE
Worknet--Career Design	399-8181 9802 Nicholas Ste 375 Omaha, NE
YWCA--Women in Transition	345-6555 222 S. 29th St Omaha, NE 68131

**EDUCATION/CAREER ADVANCEMENT**

Adult Learning Center--Bellevue	293-5029 2221 Main St Bellevue, NE
Metropolitan Community College	457-2400 (main switchboard) 204 W. Dodge Road Omaha, NE
Adult Education Office--Omaha Public Schools	557-2620 3230 Burt St Omaha, NE 68131
University of Nebraska at Omaha	554-2727 6001 Dodge St Omaha NE 68182

**LIFE SKILLS: MONEY MANAGEMENT/BUDGETING**

Budgeting Seminar/Family Service Council Bluffs office	309-0016 515 E. Broadway Council Bluffs, IA
African American Family Ministries	345-6849 2221 N 24th St Omaha, NE 68110
Consumer Credit Counseling	597-2318 10843 Old Mill Rd Omaha, NE 68154
Debtors Anonymous	397-4059 681 S. 85th St Omaha, NE 68114

**RISK FACTOR: HOUSING/BASIC NEEDS**

**HOUSING**

Beacon House	551-6792 4615 Capital Ave. Omaha, NE
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New Creations Transitional Housing Program	898-5975 4460 Redman Ave Omaha, NE
Stephans Center Transitional Housing	731-0238 2723 Q Street Omaha, NE
Williams Prepared Place	991-3948 3525 Evans St. Omaha, NE
Compassion in Action/"All the Way" Transitional Home	451-4500 6119 Florence Blvd Omaha, NE
Salvation Army/37th Street Residential Living	3612 Cuming Street Omaha, NE
Restored Hope	345-7306 2316 Howard St Omaha, NE
Omaha Housing Authority/Home Transitional Housing Voucher Program	444-4200 ext.256 3005 Emmet St Omaha, NE
Douglas County Housing Authority	444-6203 5405 N 107 Plz Omaha, NE
Family Housing Advisory Service, Inc	934-7921 2505 N. 24th St Omaha, NE
Dorothy B. Halfway House/A Men's Therapeutic Halfway House	451-1008 P.O. Box 19473 Omaha, NE
Oxford House	551-9540 4970 Burt St. Omaha, NE
Oxford House	553-4283 5140 Pacific St. Omaha, NE

## Recidivism Reduction Treatment Center Study

Oxford House	738-9912 E street House Omaha, NE
Oxford House	934-2018 Benson Gardens 2538 N. 75th St Omaha, NE
Oxford House	933-8671 3817 Farnam St. Omaha, NE
Oxford House	884-0107 Pacific Heights 16718 Pierce Cr. Omaha, NE
Oxford House	453-2166 Cooper 6920 N. 31st St. Omaha, NE
Oxford House	934-7412 Stockman 4532 S. 41st ST. Omaha, NE
Oxford House	614-5716 Bluejay 3416 Burt St. Omaha, NE
Oxford House	614-1809 Castelar 2315 S. 14th St. Omaha, NE
Oxford House	502-9632 White Lion 3507 Harney ST Omaha, NE
Fresh Start 3/4 House	346-1356 1322 S. 25th St. Omaha, NE
Jacob's Place/operated by Omaha Home for Boys	558-0366 928 N. 47th Ave Omaha, NE

## Recidivism Reduction Treatment Center Study

Mercy Services Corporation/run by Mercy Housing Midwest	393-2096 7262 Mercy Rd Omaha, NE
New Creations Transitional Housing	451-6241 4460 Redman Ave. Omaha, NE
New Creations Veteran Transitional Services	453-1408 2406 Fowler Omaha, NE
Siena House	341-1821 1702 Nicholas Omaha, NE
Stephen's Center	731-0238 2723 Q Street Omaha, NE
Micah House	323-4416 231 S. 7th ST Council Bluffs, IA
Vincent House	342-3759 613 N. 17th ST Omaha, NE
Open Door Mission	422-1111 2706 N. 21st St. Omaha, NE
37th Readiness Program	898-7521 3612 Cuming Omaha, NE
Lydia House	345-9342 3030 N. 21st St. Omaha, NE

Recidivism Reduction Treatment Center Study

**BASIC NEEDS: FOOD/CLOTHING**

African American Ministries	345-6849 2221 N. 24th St Omaha, NE
GOCA	453-5656 2406 Fowler St Omaha, NE
Social Settlement	731-6988 4860 Q Street Omaha, NE
First Lutheran Church	345-7506 542 S. 31st St Omaha, NE
YWCA/Women in Transition	345-6555 222 S. 29th St Omaha, NE 68131
Salem Lutheran South	734-6957 4440 S. 25th St. Omaha, NE
Baptist Church	346-6429 3451 N. 9th St. Carter Lake, IA
American Red Cross	343-7700 2912 S. 80th Ave. Omaha, NE
Holy Family Door Ministry	341-6561 1715 Izard St. Omaha, NE
Lutheran Metro Ministries	N/A 4205 Boyd St. Omaha, NE
Together, Inc.	345-8047 1616 Cass St. Omaha, NE
Holy Name Church	451-6622 3014 N. 45th St. Omaha, NE

## Recidivism Reduction Treatment Center Study

Salem Outreach Center	455-1000 24th and Grant Omaha, NE
Our Saviors Lutheran Church	322-6655 313 Story St. Council Bluffs, IA
South Side Assembly of God	733-6583 4815 Harrison St. Omaha, NE
Chicano Awareness	733-2720 5825 S. 24th St. Omaha, NE
Project Hope	453-7649 4140 N, 42nd St. Omaha, NE
Urban League	453-9730 3022 N. 24th St. Omaha, NE
Juan Diego Center	731-5413 5211 S. 31st St. Omaha, NE
St. Benedict The Moore	348-0631 2423 Grant St. Omaha, NE
Salvation Army	328-2088 28 N. 7th St. Council Bluffs, IA
St. Martin de Porres Center	341-4004 2417 Burdette St. Omaha, NE
Family Service/Bellevue Multi Service Center	291-6065 116 Mission Ave. Bellevue, NE
Salvation Army	554-5860 3612 Cuming St. Omaha, NE

## Recidivism Reduction Treatment Center Study

Pearl Methodist	453-7440 2319 Ogden St. Omaha, NE
St. Cecelia's Cathedral	551-2313 701 N. 40th St. Omaha, NE
Urban Family League	451-1066 3040 Lake St. Omaha, NE
Westside Food Pantry	496-7833 15050 West Dodge Road Omaha, NE
Food Bank	331-1213 6824 J Street Omaha, NE

### **RISK FACTOR: FAMILY RELATIONSHIPS**

Father Flanagan's Boys home/Common Sense Parenting	498-1289 13603 Flanagan Blvd. Boys Town, NE 68010
Postive Parenting Support Group	333-6464
Parents United/Sexual Abuse Survivors	342-7007
PFLAG/Parent & Family of Lesbians & Gays	291-6781
Domestic Abuse Group/women	291-6065
Domestic Abuse Group/men	339-2544
Women Against Violence/YWCA	345-7273 222 S. 29th Street Omaha, NE
Choosing Non-Violence/Men's Therapy Group	553-3000
Domestic Abuse/Emotions	333-0217
Adult Children of Alcoholics	571-1344
Al-Anon Information Service	553-5033

## Recidivism Reduction Treatment Center Study

Al-A-Teen	553-5033
Co-Dependents Anonymous/Information	449-1716
Gam-Anon	527-5052
How to Cope/Lutheran Family Service of NE	342-7007 120 S. 24th Street Ste. 100 Omaha, NE

### **RISK FACTOR: SUBSTANCE ABUSE**

#### **SUBSTANCE ABUSE TREATMENT CENTERS**

Chicano Awareness Center	733-2720 4821 S. 24th St. Omaha, NE
Lydia House	345-9342 3030 N. 21st St. Omaha, NE
Sienna House	341-1821 1702 Nicholas St. Omaha, NE
Ponca Tribe of Nebraska	734-5275 2602 J Street Omaha, NE
GOCA	453-5656 2406 Fowler Omaha, NE
NOVA Therapeutic Community, Inc.	455-8303 3483 Larimore Ave. Omaha, NE
NOVA Therapeutic Community, Inc.	344-2583 1941 S. 42nd. St. Omaha, NE
Stephen's Center	731-0238 2723 Q Street Omaha, NE

## Recidivism Reduction Treatment Center Study

Alegent Behavioral Health Services/Immanuel Medical Center	572-2121 6901 N. 72nd St Omaha, NE
Campus for Hope/Catholic Charities	827-0570 1490 N. 16th St Omaha, NE
Sheehan Center/Catholic Charities	554-0520 3300 N. 60th St. Omaha, NE
ARCH	346-8898 604 S. 37th St. Omaha, NE
ARCH	346-1129 1502 N. 58th St. Omaha, NE
Lutheran Family Services	342-7007 124 S. 24th St Omaha, NE
Lutheran Family Services	894-4796 4980 S. 118th St Omaha, NE
Lutheran Family Services	455-9757 2401 Lake St. Ste 110 Omaha, NE
Santa Monica	558-7088 130 N. 39th St. Omaha, NE
Heartland Family Services	451-6244 6714 N 30th St Omaha, NE
Heartland Family Services	553-3000 2101 S. 42nd St Omaha, NE
Heartland Family Services	963-9699 11212 Davenport St. Omaha, NE

## Recidivism Reduction Treatment Center Study

Open Door Mission	422-1111 2706 N. 21st St. Omaha, NE
Nebraska Urban Indian Health Coalition	346-0902 2240 Landon Ct. Omaha, NE 68108
Adult Rehabilitation Center/Salvation Army	342-4135 2551 Dodge St Omaha, NE 68131
Veterans Affairs-Substance Abuse Treatment Center	449-0679 4101 Woolworth Ave. Omaha, NE 68105
University Drug and Alcohol Program	595-1703 1941 S. 42nd St. Ste 210 Omaha, NE

## **SUBSTANCE ABUSE SUPPORT GROUPS**

Cocaine Anonymous	978-8881
Narcotics Anonymous	978-3105
AA Central Office	556-1880 4901 Dodge St Omaha, NE
Bridging the Gap/AA Service Help	556-1879

## **RISK FACTOR: MENTAL HEALTH\*\***

Alegant Health Behavioral Services/Immanuel Medical Center	572-2121 6901 N 72nd St. Omaha, NE
Sheehan Center/Catholic Charities	554-0520 3300 N. 60th St. Omaha, NE
Omaha Campus for Hope/Catholic Charities	827-0570 1490 N. 16th St Omaha, NE

## Recidivism Reduction Treatment Center Study

Community Alliance	341-5128 4001 Leavenworth Omaha, NE
Douglas County Community Mental Health Center	444-7930 4102 Woolworth Ave Omaha, NE
Friendship Program, Inc.	393-6911 7315 Maple St. Omaha, NE
Heartland Family Services	553-3000 2101 S. 42nd St. Omaha, NE
Heartland Family Services	451-6244 6714 N. 30th St Omaha, NE
Heartland Family Services	963-9699 11212 Davenport St. Omaha, NE
Lutheran Family Services	342-70007 124 S. 24th St Omaha, NE
Lutheran Family Services	894-4796 4980 S. 118th St. Omaha, NE
Lutheran Family Services	455-9757 2401 Lake St. Omaha, NE
Salvation Army	898-5900 3612 Cuming St Omaha, NE
Region 6 Behavior Healthcare	444-6573 3801 Harney St Omaha, NE
The Spring Center/Region 6 Behavioral Healthcare	546-0770 3047 S. 72nd St. Omaha, NE

## Recidivism Reduction Treatment Center Study

Immanuel Medical Center/Center for Mental Health	572-2993 6901 N. 72 St. Omaha, NE
Telecare Corporation/Region 6 Recovery Center	342-4411 819 Dorcas St. Omaha, NE

## **MENTAL HEALTH SUPPORT GROUPS**

Panic Anxiety Support Group	455-9260
Depressive/Manic Depressive Association	551-3275
Emotions Anonymous	333-0217

**\*Information provided was obtained from the Douglas County Corrections Pre-Release Program  
*Real Life Connections***

**\*\*Information on Substance Abuse and Mental Health service providers was supplemented with  
*Region 6 Behavioral Healthcare: Network of Care Providers***

***Appendix C: Discussion Questions from the Roundtable***

1. Should the objective of the initiative/Recidivism Reduction Center be to reduce recidivism in the community or to reduce the County/State's reliance on incarceration?
2. Based on the objective identified in Question 1, what should the served population be?
3. Given your understanding of Douglas County's infrastructure:
  - should this initiative be administered by a contracted private agency?
  - Should administration be split equally between contracted private and public agencies?
  - or should this initiative be administered by an existing government agency?
4. If you believe the initiative should be split between private and public agencies or that it should be administered by public agency only:
  - should the initiative create a screening and referral service to meet the needs of the broadest population?
  - Or should the initiative create a program that serves as a direct service provider to specific population?

**Appendix D: Mental Health Screen Instruments**

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**Correctional Mental Health Screen for Men (CMHS-M)**

<b>Name</b> _____	<b>Detainee #</b> _____	<b>Date</b> ___/___/____	<b>Time</b> ___:___
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QUESTIONS	NO	YES	COMMENTS
1. Have you ever had worries that you just can't get rid of?			
2. Some people find their mood changes frequently – as if they spend everyday on an emotional roller coaster. Does this sound like you?			
3. Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems?			
4. Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings?			
5. Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments?			
6. Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?			
7. Do you tend to hold grudges or give people the silent treatment for days at a time?			
8. Have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed?			
9. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
10. Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed?			
11. Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			
12. Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled?			

<b>TOTAL # YES:</b> _____	<b>General Comments:</b>
<p><b>Refer for further Mental Health Evaluation if the Detainee answered Yes to 6 or more items OR</b> If you are concerned for any other reason</p> <ul style="list-style-type: none"> <li>o <b>URGENT Referral</b> on ___/___/____ to _____</li> <li>o <b>ROUTINE Referral</b> on ___/___/____ to _____</li> <li>o <b>Not Referred</b></li> </ul>	
<p><b>Person Completing Screen:</b> _____</p>	

**INSTRUCTIONS FOR COMPLETING THE CMHS-M**

**General Information:**

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Men (CMHS-M) with a grant funded by the National Institute of Justice.

**Instructions for administration of the CMHS-M:**

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial  
Detainee#: Detainee's facility identification number  
Date: Today's month, date, year  
Time: Current time (24hr or AM/PM)

**Questions #1-12** may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in his answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says he does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

**Total # YES:** total number of YES responses

**General Comments:** Staff may include information here to describe overall concerns about the responses (for example: Intoxicated, impaired, or uncooperative)

**Referral Instructions:**

**Urgent Referral:** A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

**Routine Referral:** A detainee answering "**YES**" to **6 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

**\*\*** If at any point during administration of the CMHS-M the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) he should be referred for immediate mental health evaluation.

**Referral:** Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

**Person completing screen:** Enter the staff member's name

**Correctional Mental Health Screen for Women (CMHS-W)**

<b>Name</b> _____ Last, First, MI	<b>Detainee #</b> _____	<b>Date</b> ___/___/____ mm/dd/year	<b>Time</b> ___:___
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Questions	No	Yes	Comments
1. Do you get annoyed when friends and family complain about their problems? Or do people complain you are not sympathetic to their problems?			
2. Have you ever tried to avoid reminders of, or to not think about, something terrible that you experienced or witnessed?			
3. Some people find their mood changes frequently-as if they spend everyday on an emotional rollercoaster. For example, switching from feeling angry to depressed to anxious many times a day. Does this sound like you?			
4. Have there ever been a few weeks when you felt you were useless, sinful, or guilty?			
5. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
6. Do you find that most people will take advantage of you if you let them know too much about you?			
7. Have you been troubled by repeated thoughts, feelings, or nightmares about something terrible that you experienced or witnessed?			
8. Have you ever been in the hospital for non-medical reasons, such as a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			

<b>TOTAL # YES:</b> _____	<b>General Comments:</b>
<p><b>Refer for further Mental Health Evaluation if the Detainee answered Yes to 5 or more items OR If you are concerned for any other reason</b></p> <p><input type="radio"/> <b>URGENT Referral</b> on ___/___/____ to _____</p> <p><input type="radio"/> <b>ROUTINE Referral</b> on ___/___/____ to _____</p> <p><input type="radio"/> <b>Not Referred</b></p>	
<p><b>Person Completing Screen:</b> _____</p>	

**INSTRUCTIONS FOR COMPLETING THE CMHS-W**

**General Information:**

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Women (CMHS-W), with a grant funded by the National Institute of Justice.

**Instructions for administration of the CMHS-W:**

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial  
Detainee#: Detainee's facility identification number  
Date: Today's month, date, year  
Time: Current time (24hr or AM/PM)

**Questions #1-8** may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in her answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says she does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

**Total # YES:** total number of YES responses

**General Comments:** Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

**Referral Instructions:**

**Urgent Referral:** A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

**Routine Referral:** A detainee answering "**YES**" to **5 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

**\*\* If at any point during administration of the CMHS-W the detainee experiences more than mild and temporary emotional distress (such as severe anxiety, grief, anger or disorientation) she should be referred for immediate mental health evaluation.**

**Referral:** Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

**Person completing screen:** Enter the staff member's name

## BRIEF JAIL MENTAL HEALTH SCREEN

**Section 1**

Name: _____ <small>First MI Last</small>	Detainee #: _____	Date: ___/___/_____	Time: _____ AM PM
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**Section 2**

Questions	No	Yes	General Comments
1. Do you <i>currently</i> believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you <i>currently</i> feel that other people know your thoughts and can read your mind?			
3. Have you <i>currently</i> lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are <i>currently</i> much more active than you usually are?			
5. Do you <i>currently</i> feel like you have to talk or move more slowly than you usually do?			
6. Have there <i>currently</i> been a few weeks when you felt like you were useless or sinful?			
7. Are you <i>currently</i> taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you <i>ever</i> been in a hospital for emotional or mental health problems?			

**Section 3 (Optional)**

**Officer's Comments/Impressions (check *all* that apply):**

Language barrier     
  Under the influence of drugs/alcohol     
  Non-cooperative  
 Difficulty understanding questions     
  Other, specify: \_\_\_\_\_

**Referral Instructions:** This detainee should be referred for further mental health evaluation if he/she answered:

- YES to item 7; OR
- YES to item 8; OR
- YES to at least 2 of items 1 through 6; OR
- If you feel it is necessary for any other reason

Not Referred  
 Referred on \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_\_\_  
 Person completing screen: \_\_\_\_\_

INSTRUCTIONS ON REVERSE

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**INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN**

**GENERAL INFORMATION:**

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

**INSTRUCTIONS FOR SECTION 1:**

NAME: Enter detainees name — first, middle initial, and last  
DETAINEE#: Enter detainee number.  
DATE: Enter today's month, day, and year.  
TIME: Enter the current time and circle AM or PM.

**INSTRUCTIONS FOR SECTION 2:**

**ITEMS 1-6:**

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

**ITEMS 7-8:**

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

**General Comments Column:**

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

- (1) Information about the detainee that the officer feels relevant and important
- (2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

**INSTRUCTIONS FOR SECTION 3:**

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

**REFERRAL INSTRUCTIONS:**

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.