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District of Columbia Criminal Justice Coordinating Council

FINAL REPORT

District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services

Justice Research and Statistics Association
Shawn M. Flower, Ph.D.

The Moss Group, Inc.

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Table of Contents

Table of Tables

Table of Figures

EXECUTIVE SUMMARY

The District of Columbia Custodial Population Study was commissioned by the District of Columbia Criminal Justice Coordinating Council (CJCC) pursuant to a request from the DC Council. The purpose of this project is to gain a better understanding of how justice involved individuals flow into and out of District of Columbia correctional facilities. Critical to this study is our ability to comprehensively describe the population of both District of Columbia Department of Corrections (DOC) and Federal Bureau of Prison (FBOP) inmates returning to the District of Columbia. Our goal is to understand their challenges, and to anticipate how best to serve these individuals to successfully return to the community. The study overall incorporates analysis of administrative data as well as discussions with key stakeholders – including public safety leadership, staff, and custodial service providers, as well as inmates and their families, in order to inform a comprehensive strategy to generate long-term successful outcomes.

This report combines the efforts of the Justice Research and Statistics Association (JRSA) and The Moss Group, Inc. (TMG) to describe the custodial population including demographics, current offense, past offense history, and length of stay in the facility. JRSA conducted the quantitative analysis for this project, using data provided by the DOC, Pretrial Services Agency (PSA) and the Department of Behavioral Health (DBH). The study sample consisted of 8,840 individuals in custody or admitted to custody DOC from October 1, 2014 to September 30, 2015 (FY2015). We also conducted an analysis of a release cohort from the FBOP). The FBOP data consisted of 2,108 individuals with a release address to the District of Columbia in FY2015.

The quantitative analysis is detailed in the first two chapters of this report. **Chapter I Stock and Flow** focuses on the custodial population analysis – or stock and flow – which comprehensively describes the flow of criminal justice involved individuals into and out of DOC in order to explain variations in custody populations. In addition to the Stock and Flow analysis, JRSA analyzed data provided by DBH to look at the circumstances and needs of individuals housed in DOC (**Chapter II Services Analysis**). The qualitative portion of the report was conducted by The Moss Group, Inc. TMG conducted focus groups and stakeholder interviews among inmates, DOC and other agency staff and community stakeholders; their findings are provided in **Chapter III Service and Programs Interviews**. Recommendations based on the overall findings of this study and informed by the literature review conclude this report.

Summary of Quantitative Findings

Description of the DOC Population - Overall

The DOC custodial population can best be described as diverse. Men (88%) and women (12%) are primarily African American/Black and were on average 35 years old, ranging from 15 to 82 years old. Among those in custody, 2,210 (or 25%) were from the ages of 18 to 24 – the population referred to as "Young Adult Offenders" (YAO) and another 1,685 (or 19%) were from 25 to 30 years old. The vast majority (77%) reported living in the District of Columbia, while 18% live in Maryland, 3% in Virginia, and the rest in other locations. More than half of those in custody are parents (57%) and have 2 children on average (ranging from 1 and 18

children). Additional information on the custodial population using the DBH Treatment Assignment Protocol (TAP) data provides a more detailed snapshot of those in custody at the DOC in FY2015.[1] For example, among those who completed the TAP, the majority were single (76%), 15% owned their own home, and 44% declared a religious affiliation. Based on DOC data, we know that many in custody are lacking a GED (38%) and are unemployed (60%). TAP data indicates that among those declaring a primary source of income, 31% received wages, 29% were supported by TANF/Public Assistance, and 29% were on disability.

Individuals committed to DOC had varied criminal justice histories, with criminal careers ranging from 1 day to 60 years, but on average had been justice involved for over 14 years. These individuals had an average of 12 arrests (ranging from 1 to 129), 6 prior convictions and an average conviction rate of 49% overall.

The data provided by DOC included 18,053 charges, representing 8,840 unique individuals and 10,680 booking or commitment stays in the study period. Individuals were committed to the facility as pretrial detainees, sentenced inmates, held on a writ, in transit, or due to a parole or probation violation. Overall, approximately 27% of the population consists of sentenced inmates, while 51% are detained pretrial. Within the study period, 8,840 unique persons had from 1 to 6 booking events (or stays), with most (7,340 or 83%) having only a single stay. The remaining 1,500 had 2 to 6 stays, with an average of a little over 2 stays in the period. The average length of stay was 93 days, within a range of 1 and 2,785 days (or 7.5 years). The most serious charge was frequently for a person offense (26%), followed by violations (22%) and property crimes (16%). Most individuals were classified as medium security. While more than half of the population was released within 30 days, those held pretrial remained in the facility between 31 and 57 days; those sentenced stayed between 58 and 198 days on average. Those held in transit, on a writ, or a hold stayed for the longest period – on average 217 days. While more than half of all DOC inmates were released outright at the end of their stay, slightly less than half left the facility in transit to another jurisdiction or justice agency (e.g., FBOP).

Based on DOC intake data, among those in custody, 31% experience an active medical condition, 11% have a mental illness diagnosis, and 5% have a substance abuse condition. TAP data provides a more detailed snapshot of the mental and physical conditions and substance needs among those in custody.[2] Those who completed the TAP assessment have both physical and mental health conditions -- 29% have one or more chronic medical diagnoses, and 41% are on medications for a physical problem. TAP respondents report having from 1 to 7 illnesses over their lifetime, with on average 1.5 conditions per person. Among those with 1 or more reported physical health conditions, most have between 1 and 3 problems – with 13 individuals reporting 4 or more. Lung and breathing problems are most often reported by 125 (or 10%); followed by sexually transmitted diseases and either Hepatitis A, B, and/or C (both 6%).

[1] The TAP is not universally conducted in DOC. We compared those who completed the TAP to those who did not and there were significant differences across numerous areas. For this reason, while we suggest caution be exercised in inferring these findings to the broader population, the finds are particularly relevant to certain older offenders.

[2] TAP data reported here are focused on *lifetime* measures; DOC intake data report *active* diagnosis.

Mental health conditions are more prevalent. Over 40% of those who completed the TAP assessment report they have been prescribed medications for psychological or emotional problems in the past. In addition, 46% report they have a psychiatric problem in addition to an alcohol and/or drug problem. While these measures are based on self-report and not a medical diagnosis, and those completing the TAP are doing so to receive mental health and/or substance abuse services, nonetheless, TAP respondents have very high rates of anxiety (46%) and depression (53%). In the general non-criminal justice involved population, anxiety disorders impact 18% of individuals and depression approximately 7%, annually. Similarly, those who completed the TAP have high rates of hallucinations (22%), as well cognitive issues (i.e., trouble understanding and concentrating) at 30%; and 20% have trouble controlling violent behavior. Many also report having attempted suicide – 13% -- also disproportionate to suicide statistics in the general public. The number of reported mental health conditions average of 3.14, ranging from 1 to 6 mental health problems.

The TAP Assessment also provides measures of substance abuse and treatment experiences, and the drug of choice varied widely. Alcohol was the most frequent primary drug of choice with (26%), followed by heroin or other opiates (21%) and cocaine/crack (18%). TAP completers are also heavy tobacco users -- 78% use some form of tobacco and the majority (82%) report smoking between less than ½ a pack to 1 pack a day. In terms of prior treatment experiences, more than 70% have had either detoxification or substance abuse treatment prior to completing the TAP. On average, these individuals have attended treatment 2.8 times, ranging from 1 to 30 times. In addition, 58% report they have attended 12 step or self-help group meetings.

DOC Population by Sub-Group

To differentiate the needs of specific offender populations, we looked at these demographic, offense, incarceration experiences, and release status within the cross-sections of gender and comparing young adult offenders (those age 18 to 24) to older adult offenders. We also explored these factors by those detained pretrial versus sentenced population. Unless otherwise indicated, differences discussed in the text were statistically significant.[3]

Description of the DOC Population – by Gender

Among those in custody of DOC during the study period, 12% are women and 88% are men. While generally racially equivalent across the groups, there are more White women than men (6% vs. 3%), and more Hispanic men than women (5% vs. 2%, respectively). Women also tend to be older (36 years old versus 34.7 for men); with fewer women falling into the Young Adult Offender age category (20% vs. 26% of men). A higher percentage of women have children (68% vs. 56% of men), with women having closer to 3 children on average (ranging from 1 to 13 children) and men having closer to 2 children, but reporting between 1 and 18 children. Women are more likely to be unemployed – 83% vs 59% and are less educated (43% of women are without a GED compared to 37% of men). Interestingly, while more women had active medical conditions while in the facility (34% vs. 30% of men); fewer women than men had indicators of

[3] Differences that are statistically significant if the "p-level" indicator is $p<.05$ or below. This notation means that the findings are highly unlikely (e.g., for $p<.001$ - less than a 1 out of 100 chance or $p<.05$ less than 5 out of 100 chances) to be the result of chance or coincidence.

mental illness (8% vs. 12%) or substance use conditions (2% vs. 6%). Based on the TAP assessment data, women are significantly younger than men (39 years old vs. 41 years old), are less likely to be married (6% vs. 10% of men), are more likely to be parents of minor children (55% vs. 40%) and are less likely to own their own home – 10% vs. 16% of men.
In terms of physical and mental health status, there were a few statistical differences by gender. Women were more likely to report a chronic medical problem (36% vs. 28% of men); were more likely to be on medications for a physical condition (53% vs. 38%) and were more likely to suffer from both arthritis (10% vs. 5%) and lung or breathing problems (18% vs. 8%).

Among TAP respondents, 64% of women (compared to 42% of men) report a co-occurring disorder – where one experiences both mental health concerns as well as substance abuse condition. A very high percentage of women also report depression in their lifetime (69% vs. 50% of men); anxiety (59% vs. 43%), cognitive difficulties (40% vs. 28%), at least one suicide attempt (26% of women vs. 11% of men) and are significantly more likely to be taking medications for psychological problems (59% of women compared to 38% of men). Not only were more women reporting these various issues, but on average had a greater variety of concerns than men (3.36 compared to 3.08). Women and men also vary in their primary drug of choice – with fewer women choosing alcohol, heroin, and marijuana than men. Specifically, 15% of women select alcohol as their primary drug of choice vs. 26% of men; 14% select heroin (vs. 20% of men); and 7% of women vs. 17% of men select marijuana. However, women are more likely to engage in cocaine/crack (27% vs. 14% of men) and PCP (21% vs. 13%). Treatment experiences were statistically equivalent between men and women.

A higher percentage of women are committed to the facility pretrial than men -- 66% of women are on pretrial vs. 49% of men. Within the pretrial status, a higher number of women are committed to the facility on a misdemeanor (33% of women vs.18% of men) and women have shorter booking stays in the facility – on average 49 days vs. 99 days for men. Generally speaking, women in the DOC facility are less serious offenders, and are more often held for misdemeanor offenses. At release, fewer women were transferred to U.S. Marshal or the Federal Bureau of Prisons -- 7% of women compared to 22% of men.

Description of the DOC Population – by Age

Justice involved individuals who are between the ages of 18 to 24 are referred to as a "Young Adult Offender" (YAO). Among the DOC population, 25% of those held during the study period fell into this category. On average, this population was 21 years old and there are more male YAOs than female YAOs. YAOs are also more likely to be Black (93% vs. 90%) than older adults. Given YAOs are in earlier stages of life, a smaller percentage have children (43% compared to 62% of older adults); and of those that do, they have 1.5 children (ranging 1 to 10 children). YAOs are also less likely to have a high school diploma or GED (56% vs. 32%) and 68% (vs. 58% of older adults) were unemployed when committed to the facility. YAOs were also less likely to have active medical conditions, but were equally likely to have an active mental illness and substance abuse condition compared to other adults.

Comparing criminal histories by YAO vs. older adults, it is not surprising to see that YAOs have shorter criminal careers because they have not had the same amount of time to engage in criminal activity. Across the board, YAOs have fewer arrests and charges. However, YAOs and older offenders do not vary with respect to their prior conviction rate in either arrests or charges. YAOs are convicted on an arrest 50% of the time; adult offenders are convicted in 49% of arrests.

YAO are most frequently committed to the facility on a pretrial felony – 44%; followed by sentenced felony (20%). In contrast, older adults are equally committed on pretrial cases (26% pretrial felony; 21% pretrial misdemeanor); and a violation (17%). A higher percentage of older adult offenders are also held in transit or on a writ (9% vs. 5% of YAOs). In terms of the current most serious charge, YAOs are far more likely to be committed on a person crime (47% vs. 33% of other adults) and less likely on drug charges (4% vs. 9%) and violations (8% vs. 18%). YAOs also committed more serious crimes based on charge severity which averaged 7.10 for YAOs and 9.3 for older adults – with the lower the number, the more severe the crime). A higher percentage of YAOs were identified as gang affiliated (10% vs. 4%). Undoubtedly related to the higher percentage of bookings on person offenses, severity of charges and gang affiliation, 22% of YAOs are classified as maximum security compared to 12% of other adult offenders.

Overall, the characteristics of YAOs in DOC are consistent with the literature. While YAOs have had less time to accrue an extensive criminal record, they are nonetheless generally serious offenders often charged with more severe person offenses. There are also higher levels of gang affiliation among this population. The majority of YAOs are also unemployed and without a high school degree or GED. This is a challenging population that will require interventions targeted to meet these needs.

Description of the DOC Population – by Detainment Status

The final sub-group profile developed on the DOC population is the comparison between those in custody pretrial versus sentenced population. Note that anyone held on a writ, in transit, or on hold are omitted from this sub-group population, parole violators are cataloged as either sentenced or pretrial, based on the status of their case. There were 7,611 unique individuals included in this sub-group examination – 58% held pretrial and 42% sentenced.

The pretrial population has more women (15% of those held pretrial are women vs. 9% of sentenced population, they are younger by one year, 34 vs. 35 years old and are less likely to be parents (55% vs. 58%). The Pretrial population is also less likely to have active medical condition (26% compared to 34% of the sentenced population), mental health (5% vs. 17%) active substance abuse condition (2% vs. 9%). However, in terms of race, number of children, attainment of a high school diploma/GED and employment status, the groups are equivalent. There were few differences in the TAP data between pretrial and sentenced – except for age (on average 42 years old for those on pretrial vs. 40 years old for sentenced) and that the pretrial population is more likely to visual issues (8% vs. 4% in the sentenced population) there were no other differences.

However, the pretrial population varies significantly from the sentenced population across all criminal history measures. Fewer crimes were committed in DC (71% vs. 77% of those serving a sentence) and pretrial had a shorter criminal career by 2 years. That 2-year difference may help explain why those held pretrial have fewer arrests (11.7 vs. 12.6), fewer charges (21.7 vs, 24.6), and lower arrest (44% vs. 55%) and charge (32% vs. 39%) conviction rates. With respect to the types of charges in the offense histories of those held pretrial versus sentenced, those in pretrial have fewer person, drug, public order, violations and traffic charges than those sentenced. There was no difference in the number of property crimes or warrants.
The pretrial population stayed significantly fewer days on average than the sentenced population (50 vs. 130 days). Looking to the current most serious charge those in pretrial were also much more likely to be committed on a warrant (23% vs. less than 1% of the sentenced population). However, the pretrial population is less likely to be committed on a person crime (34% vs. 43%) or a violation (10% vs. 19%) than the sentenced population.

While both populations are released to self-custody similarly, only 7% of the pretrial population is released to the U.S. Marshal or FBOP, compared to 36% of the sentenced population. A greater proportion of the pretrial population (20%) is transferred to Metropolitan Police Department or on a fugitive warrant than the sentenced population (4%). While 88% of the pretrial population is released on court order, only 3% of the sentenced population are released by this mechanism. Sentenced are most often released for time served and 97% are directly released from CDF/CTF. While those on pretrial are also released from CDF/CTF, they are also released from D.C. Superior Court (17%) and DOC hold (17%).

In many ways, the differences between pretrial and sentenced population reflect the pending nature of pretrial status more than a difference in offenders per se. While those on pretrial were less likely to have an active medical, mental health or substance abuse condition than the sentenced individual, in terms of other demographics and education and employment status, the groups are equivalent.

The differences in these sub-groups – women vs. men; young adult offenders vs. older adult offenders; and pretrial vs. sentenced populations -- highlight the diverse nature of the DOC population. This in turn provides a sense of the inherent challenges in effectively and efficiently addressing the varied needs of this population in an environment where the inmates are processed in and out of the facility within relatively brief time periods.

DOC Halfway House Participants

There are three halfway houses (HWH) where the DOC maintains custody of inmates and detainees. Of the 295 unique individuals whose last jail location was a halfway house, 129 (44%) were housed in Hope Village; 111 (38%) in Extended House, and 41 (14%) were in Fairview. With few exceptions, those in HWH are similar to those housed in the DOC facility. DOC custodial populations housed in halfway houses are more often on pretrial status, and are of lower security classification than those in DOC, yet overall, there are few differences between those in halfway houses versus and those secured in DOC.[4] Those in HWH are less racially

[4] The differences are driven by how individuals are placed into HWH facilities. Pretrial HWH commitments are court ordered, and sentenced commitments are voluntary, among those who meet HWH criteria.

diverse (94% are Black), and are less likely to have an active medical or mental health diagnosis. Those who participated in HWH also have fewer prior drug convictions and commit a higher proportion of their crimes in the District (78% vs. 74%) than others in the DOC population. Most of the individuals in the HWH were released as self-custody (94%) on a court order (83%) or time served (17%).

FBOP Returning Citizens vs. DOC Sentenced Population

The majority of 2,108 Federal prisoners returning to the District of Columbia in FY2015 were African American (92%) and male (92%). They were on average 38 years old, ranging from 17 to 79 years old and 13% were YAOs (between the ages of 18 and 24 years old). Among those returning, 42% did not have a GED.

In terms of physical health, 66% had no significant physical health issues while a third (32%) had a recently resolved issue. Similarly, the vast majority of the had no significant mental health, while 9% with a mental illness engage in routine services and/or receive intensive services when in a crisis (e.g., placed on suicide watch). We also looked at the intersection of the number of individuals with both physical and mental health need designations (N=1,587) and we see that most (64%) had neither a physical or mental health issue upon release. Another 26% had a level 2 physical health issue, but no mental health concerns identified. The remaining 11% had physical and/for mental health needs that will likely require assistance upon returning to the community.

The majority of those serving time in FBOP and returning to live in DC post release were sentenced in either DC Superior or District Court (1,806 of 2,108 or 86%), while another 10% were sentenced from Maryland or the Virginia Eastern District Courts. On average, prisoners returning to DC had sentences ranging from 3.5 to 75 years served a little over 2 years at FBOP (ranging from 9 days to 29 years); with an average sentence served for their offenses of 2.5 years (ranging from 24 days to 37 years). The FBOP data also indicate that half of those returning to DC were classified at a medium security level, while 15% were high, 24% were low, and 11% were in the minimum classification level. The majority (57%) of DC prisoners were classified as "infraction free" – (defined has having no guilty findings for any infractions) during their FBOP stay.

Almost half (48%) of FBOP inmates were released on "good conduct", while another 38% are released at the expiration of their sentence, mandatory release, or time served. A small portion are released on parole (10%) and 7% have a detainer from another jurisdiction that impedes their release back to the community. Upon release, 76% who received supervision as part of their sentence will be under supervision for 4 years.

Description of the FBOP Returning Cohort – by Gender

There were 165 women released from FBOP in this period compared to 1,943 men. On average, women were older than men (40.9 vs 38.1), and were more racially diverse (e.g., 16% white compared to 4% of male FBOP inmates). Women and men were equally likely to enter the facility with a GED or high school diploma (45% and 46% respectively) but women were less likely to earn a GED while incarcerated at FBOP (7% vs. 13% of men). This may be in part due to the fact that women have shorter length of stays (2 versus 3 years) and/or that women have more physical and/or mental health needs than the men. For example, observing the physical health levels results we see that 68% of male inmates have no significant physical health issues and 92% have no significant mental health issues. In contrast, 49% of women have no significant physical issues and 78% have no significant mental health issues based on the data provided by FBOP.

There are differences in offense types by gender as well. Women are less likely to have served time at the FBOP for a person offense (19% vs. 28% of men) and are more likely incarcerated for a drug or property offense (47% and 24% respectively). Women are also more likely to be infraction free (75% vs. 55% of men), although among those with at least 1 infraction, there appears to be gender parity. While equal numbers of men and women are released on good conduct, more women are placed on supervision post-release than men (86% vs. 76%).

Description of the FBOP Returning Cohort – by Age

Of the FBOP returning citizens, 13% were YAO at the time of their release. Most were male (96% vs. 92%) and more likely to be Black (97% vs. 92%). There are also substantial differences in education status at release. Upon entering FBOP, only 20% of YAOs had a GED or high school diploma compared to 50% of older adults; however, there was little difference in the percentage who earned their GED while incarcerated at FBOP. Therefore, a much higher proportion of YAOs lack a GED than non-YAOs (65% vs. 38%).

YAOs are also almost twice as likely to be incarcerated in FBOP for a person offense as non-YAOS (52% vs. 24%). They are also less likely to be infraction free – only 42% versus 59% of older adults. Finally, none of the YAOs were released on parole compared to 11% of older adults. However, while none will be on parole, of the 277 YAOs, 200 (or 72%) were sentenced to supervision upon release.

FBOP Returning Cohort vs. DOC Sentenced Population

A jail population differs from a prison population in important ways. As evidenced in the discussion that describes those in DOC custody over the study period, this is a diverse group based on a variety of demographic, criminal history, incarceration and release circumstances. However, there are few differences between those returning from FBOP to the DOC sentenced population. FBOP inmates are slightly older (38 vs. 35 years old), and are more in need of education services (42% of the FBOP returning citizens lack a GED compared to 39% of sentenced DOC inmates), and more likely to have served time for drug and weapons offenses, but otherwise are generally similar.

Key Findings from Focus Groups and Stakeholder Interviews

The opportunity to participate in quality programs during incarceration is an important aspect of the DOC facility-based service delivery on post-release outcomes. The coordination, communication, and collaboration of the inmate's transition—from the inside to the outside—between DOC and community providers are key to breaking the cycle of recidivism. During the focus groups and interviews conducted by The Moss Group, Inc, inmates, staff, stakeholders, service providers, and advocates had the opportunity to be heard on a range of topics related to the DOC's programs and services. These groups identified programming they perceived was needed, but a broad inmate population assessment could provide a clearer, more efficient data map of who should access what programming. Specific populations can be identified through this mapped assessment to develop programming for specialized populations, using best evidence-based practices to target an evaluative measure of reducing recidivism.

A structured protocol, developed by TMG, was used to conduct the focus groups and interviews. Using open-ended questions, this protocol elicited perspectives specific to the strengths and challenges of existing services, programs, and processes at DOC that are designed to facilitate successful inmate reentry into the community. The focus groups with inmates also incorporated the use of TurningPoint Technologies®, an audience response system. Focus group participants included uniformed and non-uniformed correctional staff, inmates, stakeholders, service providers, and advocates. Stakeholders, providers, and partners with strong ties to the District's criminal justice system who were unable to attend the focus groups were contacted via phone for in-depth one-on-one conversations.

A Sampling of Perceptions and Experiences of Inmates

- The relationship of inmates to the communities that they return to was a consistent theme amongst the inmates and staff who were in focus groups. Many mentioned the danger of re-entering into the same environments where offending behavior occurred. Inmates are concerned about not landing a job upon return and being forced into activities responsible for their incarceration. Upon returning, inmates have very little to no sense of "safety."
- Inmates shared that, depending on their status and sentence, they may be unable to benefit from the facility-based programs that are offered, leaving them idle and unable to access services until their return to the community.
- Inmates frequently lacked knowledge about facility-based program offerings. In some instances, inmates suggested programs that already existed, such as education. Others suggested additional skills like English as a Second Language (ESL) or providing self-help materials that will continue with them into the community.
- Inmates remarked that programs, such as Community Family Life Services, a beneficial clothing and housing stability program, along with Project Empowerment's supportive employment services, provide tangible resources for their transition into the community.
- A consistent theme was the need to relax requirements around where returning citizens can and cannot live. Inmates voiced they would be better supported toward success if they were able to maintain communication and connections with their familial ties pre-release to ease the stress of their return to the community.

Recommendations identify supportive components toward an inmate's successful return to the community, reducing recidivism and their return to incarceration. All participants in the interviews identified nuances related to the recommendations, all essentially verbalizing the conversation of recommendations toward success.

Themes from the focus groups and individual interviews emerged that consistently indicated that while the DOC reentry program is important and helpful to access community-based information when one can be involved, it serves only a small segment of the population of returning citizens and is not yet ingrained as a system. Reentry is greater than program and services components, from entry into the facility, through incarceration, and into post-release support through pre-release staff and partners into the community. Thus, the analyses focus on overall programs and services available to the pre-trial and sentenced inmate populations, not just reentry programming and services.

Assessment & Case Planning

Ensuring the right interventions are targeted toward inmates' higher risks and needs maximizes limited resources, focusing on the higher risk population that would produce a higher community benefit. Service providers in our conversations noted some familiarity with a handful of existing consumer assessment tools used by the DOC and service providers, but there is not a standardized assessment tool that is validated, consistent, and gender-responsive on the criminogenic risk and needs assessment on every inmate at intake.

Some contracted community programs use assessment tools based on their individual agency protocols and assessment practices, but only if the inmate is using that particular program and agency for services and only if the inmate is within their program eligibility guidelines. The assessment is used for an individual case plan and is maintained for the agency's service use only; it is not shared among other service or correctional staff as information on the inmates' risk and needs or used for broader program placement. Case plans vary in structure and guidance by each service provider.

Without a consistent assessment tool identifying the needs of the inmate populations, staff and inmates identify program and service needs through the inmate's self-report. Historical information is not available to staff or service providers to provide a glance at prior programming needs and experiences. Inmates, staff, and stakeholders pointed to a multitude of needs noted among the inmate's self-reporting, including housing, substance abuse, mental health care, education, and employment, along with needs to improve family support systems, a change in thinking patterns, and improving their own soft skills that would improve their success (communication skills were often mentioned).

Information Systems

To assess and work as a team toward an inmate's success, staff and service providers indicated that access to the Jail and Community Corrections System Booking Screen, which holds inmates' personal information, should be expanded. It could alert all correctional staff who have a need to know, based through their supervision and security role, to serious mental health or behavioral issues. The current limited access places them at a disadvantage for proper management and success. Some programs keep their own records, but there is not an overarching, composite formal recordkeeping of the inmates' background information or program-related accomplishments that is shared among case planning and correctional staff.

Sharing behavioral health information is still a challenge and disjointed among staff and providers, and it could be eased through a robust jail and case management information system. One improvement with the health records is an increase in inmates with mental health concerns receiving three to seven days of medication upon release, although it was noted this short-regimen many times did not cover the time it takes to get into the initial behavioral health appointment. A realistic medication regimen at release in order to maintain continuity of care until their first community-based appointment is a critical first step.

A jail management system that encompasses both the uniform security aspects along with programming evaluative features would also address a common concern among all participants: information sharing difficulties. Uniform and non-uniform staff, along with stakeholders, service providers, and advocates, stated they work toward discrete goals, such as safety and security for uniform staff and release planning for non-uniform staff and community-based successful reintegration goals for stakeholders, service providers, and advocates that were difficult to share across their individual spheres. The lack of a consistent, shared information base leads to a lack of knowledge that supports the inmate's success, as heard from the qualitative discussions with uniform and service providers and identified through the quantitative analysis. Repetitive, inefficient sharing of information also raises inaccuracies, as heard from service providers who conduct individual assessments by program with each inmate and noted in the data review.

Programs

DOC provides a variety of facility-based programs including reentry services that may assist with pre-and post-release case planning, job readiness, education, connecting with community-based providers, obtaining identification, mentoring, court intervention, housing, substance abuse, and mental health. Some programs are voluntary, other programs are unit-based or court required, and some groups of inmates are automatically enrolled in programs like GED attainment.

Most programming was only available to sentenced or FBOP inmates due to their defined release date. Inmates without release dates are not placed into programs that have defined timeframes. In addition, placement into DOC programs is based on eligibility and admission criteria, which screen many inmates out of available programs and services. Staff indicated sex offenders and higher classification inmates are not eligible for most programs and services. Yet, inmates reported lower-level offenders are often mixed with high-risk populations, with the main classification delineations based on whether pretrial or sentenced, or local (District) versus

FBOP jurisdiction. These mixed classification housing units disallow programming for everyone in the unit if a small segment falls into a disallowed group (high-risk) in the same unit. If their sentence is too short, generally under 30 days, or if they are pre-trial or without an identified release date, they are not eligible to participate in time-based programs. In addition, community-based providers are not always connected with those having no known release date either, since these individuals are not flagged as soon-to-be-released for the reentry or connective services these organizations provide.

Stakeholders, service providers, and advocates aligned their experience with programs similarly to inmates and staff experiences and advised that access to programs for inmates can vary based on the following factors:

- **Judicial Status**: Pre-trial inmates without a defined release date versus sentenced inmates who have a defined length of sentence to serve and a known release date.
- **Release Date Calculation:** there is a lengthy process for determining released dates for sentenced inmates, and inmates are not eligible to participate in programs until this date is calculated. The calculation involves sentenced credits by the DOC and the courts.
- **Length of Stay:** Those with lengths of stay fewer than 30 days or more than 180 days.
- **Program Admission Process:** Those who do have knowledge of the admission process to programs by inmates or criminal justice partners are more likely to participate.
- **Knowledge of Programs:** Inmates aware of the available pre-release programs and services and accompanying eligibility requirements are more likely to access these resources.

Two other opinions voiced by these groups included:

- Substance abuse treatment should be available for all DOC inmates and the referral process should start upon entry into the DOC through a system that identifies their criminogenic needs and risks; and
- Reentry servicees should be available from admission date and to all inmates, not just those housed in the reentry unit.

Members of the women's focus group believed there were more male-centered programs and services available at DOC, though women indicated participating in more programming than male inmates. A lack of consistent information across the population may perpetuate this gender divide on available programming. Inmates reported that some programs are listed in the inmate handbook, but the list is not exhaustive or inclusive of specialized programs, many of the programs listed weren't available any more, or were not available to them based on their housing location. Inmates indicated additional and up-to-date program information was generally shared through word-of-mouth with other inmates. Women indicated programs geared toward their needs, including trauma and family reintegration, would address underlying needs that affect their successful return to the community.

Evidence-based training focuses on the knowledge of principles that reduce recidivism. One important principle is targeting cognitive-behavioral needs. One cognitive-based barrier that arose from many of our conversations was that of an inmate's sense of hopelessness. The

hopelessness led to reduced motivation, anger, and lack of goal-oriented development. Motivation is an important aspect of offender management, which can be influenced by corrections professionals' interactions with offenders. Inmates and staff had different views on how best to enhance and instill intrinsic motivation:

- Staff consistently cited inmates' lack of willingness to improve one's self, while inmates often cited a lack of staff knowledge, understanding, and training along with available program spaces to work toward their goals.
- While inmates indicated additional programming that met more than one need would be motivating and valuable in addressing a wide variety of barriers, correctional staff believe that access to programs should be restricted and enhanced to ensure inmate accountability (i.e., file notes when inmates are late for class or programs). This is one-way staff believes the agency can separate inmates with true interest from those who simply want to leave their cells.
- Inmates indicated certificates or other concrete displays of their participation in programs would be motivating, as well as that hands-on experience was a missing link to being able to actually acquire jobs in the fields for which they were trained.

Cross Training

An area of agreement found from our diverse conversations is the need for cross training all participants, including uniform and non-uniform staff, service providers, volunteers, and inmates, on effective population-specific practices. Many non-inmate participants voiced an eagerness for all to speak the same language by sharing information of each other's roles, services, and what would improve an inmate's success upon release from the DOC. Staff indicated they receive some limited training on identifying unusual behaviors, but welcome more in-depth training on better supervision techniques to use with inmates with mental health disorders. As the need for validated assessment was previously identified, research shows "offender assessments are most reliable and valid when staff are formally trained to administer" the tool to best serve the inmate needs.

Correctional staff and program staff are not cross trained to assist each other as a unit management model would recommend to assist inmates across the board. Both correctional and program staff voiced a need for improved communication skills to interact with inmates with diverse needs and to communicate as a multi-disciplinary team for the success of the inmate. One stakeholder remarked training has progressed and evolved, particularly through the transition of CTF, formerly under the CCA, into the DOC earlier this year. Participants reflected that the new leadership "clearly articulates their (DOC) positive values", but the vision does not yet weave its way through all of the lines of staff. Staff sees their roles in security and safety realms, focusing on the present environment and behavior rather than primarily rehabilitative, focusing on the future effectiveness and success upon release. Current training is geared toward a non-descript hypothetical inmate without regard to a variety of traits and populations. A well-defined, integrated jail and case management information system could bridge this communication and information gap for the staff—uniform and non-uniform—that support pre-release services from assessed factors.

Unit Management

The current system of program-based housing limits inmates' access to the wide variety of services they may need to be successful and fragments communication among staff who supervise in single-program units that house inmates with multi-faceted needs. If an inmate is housed in the GED unit, he or she will receive intensive educational services but not have access to substance abuse education and treatment, employment endeavors, or life skills programs that are needed in concert to improve success. Unit management is the reverse of program-based housing. The cornerstone of unit management is the holistic approach administered by staff—uniform and non-uniform—who bring services and programs to address the majority of inmates' risks and needs on-site within the housing unit management community.

Both security and case management staff pointed to a desire to work cohesively and collaboratively, to "be put in the same room and talk" about how they can help one another. There was a view that they are at "odds" too often, not understanding each other's needs and purpose, but noted they are highly supportive of a team environment. Both also pointed out the need for better information sharing, from inmate information to facility scheduling through a shared jail management system

Evaluation and Feedback

It is critically important to establish a systematic method to determine if processes and practices produce the desired results of reducing recidivism and embark on positively evolving the program into a system through routine review.

Focus group and conversations elicited the following processes necessary for successful reentry:

- Inmates participating in programs and services that meet the individual needs and characteristics of the inmate.
- Identifying primary benefits to livelihood, such as improved housing, improved employment and educational endeavors, and improved familial supports.
- Releasing inmates with all information in hand including identification, housing, employment, medical insurance and social benefits verification, health needs including medication, and educational status.
- Releasing inmates with a shared release case plan that is communicated and connected to continuing services in the community.
- Providing tangible evidence of success (e.g., certificates of skill development, references validating improvement).
- Identify secondary benefits of success, including the degree of community engagement and support.
- A primary measure of success would be reducing recidivism rates.

Limitations

This study would not have been possible without the assistance and provision of data from the DOC, FBOP, PSA, and DBH. We are also grateful to the inmates, uniform and non-uniform staff of DOC, and the stakeholders and community members who participated in focus groups and interviews (see Appendix F for a list of Contributing Agencies). However, there were areas of interest that we were unable to secure data to examine. Consequently, there are limitations to the present report, primarily related to data on community supervision, pretrial supervision history, and participation experiences of those in DOC, and in the RRC or halfway house facilities. While this study is focused on the *custodial population*, nonetheless, future efforts to comprehensively assess the success of building effective reentry strategies will require data from agencies serving justice involved populations along the entire continuum. While the TAP data provided a description mental health, physical health, and substance abuse needs of a portion of the population, our goal in this project was also to explore the extant services provided to all DOC inmates and detainees while in custody. Unfortunately, with the exception of the DBH services data (which applies to less than 2% of the population), there were no data available tied to individuals to conduct a robust services analysis.

In terms of program participation, DOC provided indicators of the active mental, physical and substance abuse conditions among the population, as well as if an individual was in the GED, Reentry, or RSAT unit programs. However, beyond the DBH data, there were no data to assess completion or participation rates of these correctional programs. Nor was there an ability to measure *dosage* from various types of services or programs. In a risk-responsivity approach, program frequency, dosage, and timing are among the most important elements required to appropriately assess the impact of a program on outcomes. In turn, this type of information is critical to strategic planning and the ability to respond to changing trends.

The findings in this study and the limitations inform the following recommendations.

Recommendations

The following combine the chapter specific JRSA and TMG recommendations. Based on the findings of this study, and relying upon the extant literature, we believe implementing some or all of the following recommendations will move DOC further in its effort to align jail reentry services with evidence-based practices. Please note there are a number of reentry related efforts currently underway in the District of Columbia. However, as this project was a discrete effort, the recommendations below do not consider that other initiatives may be in the process of implementing policies and practices which address these recommendations.

Assessment and Case Planning

- Conduct a validated, consistent, gender-responsive criminogenic risk and needs assessment on every inmate at intake.
- If conducting a full assessment on intake is not feasible, implement the Proxy Risk Assessment as prescreen for higher risk individuals to receive full assessment and/or among medium and high risk as a flag for in-reach by community providers.

- Retain Proxy Risk Assessment data in DOC data system for those who cycle in and out of the jail repeatedly, so that information is readily available and can be utilized to triage and cumulatively treat the offender, without repeatedly collecting static information.
- DOC currently uses the Northpointe COMPAS Assessment tool with at least some of those in custody. We recommend that DOC explore the possibility of conducting the COMPAS assessment tool facility wide.
- Revise eligibility criteria policies to align inmates assessed risks and needs to develop appropriate services and programs.
- Revise the inmate handbook with up-to-date programming, eligibility, and admission criteria and provide to all inmates at entry.
- Tailor case planning and use of programs and services pathways to meet the varied statuses of inmates (e.g., pre-trial, sentenced, District, FBOP) risk levels, lengths of stay, gender, and ages.
- Develop policies and processes to share assessment information with correctional and programming staff and pertinent community partners invested in the successful release of the inmate, facility- and community-based. One option is use COMPAS assessment data as the foundation of reentry case plans. Share case plans and/or COMPAS data with community based providers engaging returning citizens to ensure continuity of care pre- to post-release.
- Regularly review composite assessed risks and needs to ensure the deployment of evidence-based services and programs meet the identified needs of the population, including therapy interventions, and peer support, coaching, and mentoring as recommended by inmates.

Research and Evaluation

- Develop performance measures that are inmate-, program-, and departmental-based that identify success and challenges, including a regular review of composite assessed risks and needs to ensure the deployment of evidence-based services and programs meet the identified needs of the population.
- Conduct exit surveys with randomly selected inmates at regularly scheduled intervals (i.e., quarterly or twice annually), to include program and service reviews and feedback along with operational concerns (i.e.: food issues raised) to provide a listening forum.
- Invest in building reports from the COMPAS database to easily extract the data for research and evaluation purposes.
- Measures from the COMPAS data could be used as control variables in recidivism analysis and DOC program evaluation. Control variables are used to account for factors that could otherwise explain the outcome. For example, older offenders are less likely to recidivate, thus one would want to "control" for age in the analytic model.
- Define a consistent measure of recidivism.

New Jail Management System

- Develop a collaborative electronic management system and pre- and post-release policies to share appropriate inmate information among staff, providers, and community providers to target inmate success pre- and post-release.
- Revise the timing of calculating release dates for sentenced inmates to be calculated and forecasted earlier in the sentence to guide case planning schedules.
- Include formal recordkeeping of the inmates' program-related accomplishments that could also provide tangible proof of inmate program participation and measures of "dosage".

- Track all program participation, as well as process measures (e.g., number of applications for program participation, and screening if applicants met eligibility criteria and if not, why not).
- Program Milestones and Completion rates should be maintained – including the number who completed interim steps in program, and completed any program overall.

Unit Management

- Develop a unit-management style of supervision in programming units that creates a multi-disciplinary collaborative approach among staff—uniform and non-uniform—and inmates.
- Structure and schedule regular access to case managers and service providers to communicate availability to inmates and staff.
- Hold regular unit management meetings with all staff to communicate and solve operational barriers and challenges facing staff and inmates.
- Develop policies that support the eligibility of inmates into unit management based on assessed risks and needs.
- Mirror the availability of community-based programs for seamless transition into the community

Cross Training

- Incorporate supportive training on evidence-based practices to improve recidivism success, to include cognitive behavioral needs and support, motivation to change, and implementing positive reinforcement tools.
- Cross train all participants—including uniform and non-uniform staff, service providers, volunteers, and inmates—on effective population specific practices, still incorporating training based on their specialized roles and needs (i.e.: volunteers should receive additional training on correctional behaviors and evidence-based practices in addition to operational aspects)
- Review deployment of staff and the training received based on unit assignments and the risks and needs the unit serves

Recommendations Regarding Specific Populations

- **FBOP/DOC**: **DOC Transfers to FBOP** – Consider Support Programs. A foundational tenant of successful reentry programs is that reentry begins on Day 1 of incarceration. Utilize community based programs such as mediation and mentoring to help inmates maintain family connections and/or to other supportive individuals during their time at FBOP. Use assessment data to develop a plan with the inmate to target areas that can be addressed while incarcerated at FBOP.
- **FBOP/DOC**: **FBOP Inmates to Return Early** – Consider Higher Risk Candidates. Recommend including FBOP inmates who have an infraction history while housed at FBOP and/or high security level at release. Conduct needs assessment and develop a reentry plan to address key issues prior to release.
- **Opportunity for More Halfway House Placements**. As HWH participants and DOC custodial populations are very similar, space permitting, DOC may to consider greater utilization of HWH for sentenced populations.

Establish DOC Reentry Strategy Workgroup

- Include DOC Staff, both uniform and non-uniform; key agency stakeholders; and representatives from community based service providers.
- Once a strategy is developed, a workgroup should continue to meet to provide a venue to ensure ongoing and effective communication between agency and community based providers.
- Periodic reviews of the strategic plan would allow for revisions on an ongoing basis to respond to changing trends and concerns
- **Recommended Resources for Strategic Plan Development:**
  - **Jail Reentry Planning from The Urban Institute:**
    - Life After Lockup: Improving Reentry from Jail to the Community details five critical strategies by creating six "Tracks" by length of stay and level of need (p. 83-84) and recommends actions along a continuum based on the needs, risk factors, and history of the detainees.
      Available: https://www.ncjrs.gov/pdffiles1/bja/220095.pdf
    - The Jail Administrator's Toolkit for Reentry which provides practitioner oriented information and examples of successful programs.
      Available: https://www.ncjrs.gov/pdffiles1/bja/222041.pdf
  - **Strategic Planning: Center for Effective Public Policy Coaching Packets (2007)**. This series was developed based on prison (and not jail) reentry, but provides a step-by-step approach and checklists to implement a reentry system. Topics include: "Implementing Evidence Based Practices"; "Measuring the Impact of Reentry Efforts"; "Engaging Offenders' Family in Reentry"; "Shaping Offender Behavior"; and "Building Offenders' Community Assets through Mentoring".
    Available: http://cepp.com/expertise/reentry/products-and-resources/

Conclusion

As noted in the project's literature review's executive summary, "providing the right services to the right individuals can ease the transition of returning citizens. Jail-based reentry services reduce the chances of coming back to jail by targeting criminogenic needs and lessening the negative impact that incarceration may provide."[5] Reframing reentry from isolated, admission- and eligibility-based programs and services into a philosophy that evolves through all staff and inmates can reduce recidivism through effective practices that support and guide their success.

[5]See Appendix G-- Kimchi, Anat., Olaghere, Ajima and Shawn M. Flower (2017). Literature Review: District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services. District of Columbia Criminal Justice Coordinating Council Custodial Population Study. Washington DC: Justice Research and Statistics Association.

Project Overview

The District of Columbia Custodial Population Study was commissioned by the District of Columbia Criminal Justice Coordinating Council (CJCC) pursuant to a request from the DC Council. The purpose of this project is to gain a better understanding of how justice involved individuals flow into and out of District of Columbia correctional facilities. Critical to this study is our ability to comprehensively describe the population of both District of Columbia Department of Corrections (DOC) and Federal Bureau of Prison (FBOP) inmates returning to the District of Columbia. Our goal is to understand their challenges, and to anticipate how best to serve these individuals to successfully return to the community. The study overall incorporates analysis of administrative data as well as discussions with key stakeholders including public safety leadership, staff, and custodial service providers, as well as inmates and their families, in order to inform a comprehensive strategy to generate long-term successful outcomes.

This report combines the efforts of the Justice Research and Statistics Association (JRSA) and The Moss Group, Inc. (TMG) to describe the FY2015 DOC custodial population including demographics, current offense, past offense history, length of stay in the facility, and the like. JRSA conducted the quantitative analysis for this project, detailed in the first two chapters of this report. **Chapter I Stock and Flow** focuses on the custodial population analysis – or stock and flow – which comprehensively describes the flow of criminal justice involved individuals into and out of DOC in order to explain variations in custody populations. Chapter I also examines the cohort of returning citizens from FBOP facilities to DC in FY2015. In addition to the Stock and Flow analysis, JRSA analyzed data to look at the circumstances and needs of individuals housed in DOC (**Chapter II Services Analysis**). The following questions are answered in the first two chapters of this report:

- Who flows through the DOC?
- What are the security classifications of those held by the DOC?
- What is the offending history of those entering the DOC?
- How long do persons stay in DOC pretrial?
- How long do sentenced persons stay in DOC?
- What is the most common destination of those leaving DOC?
- Who participates in Halfway Houses[6] (HWH)?
- What are the characteristics of FBOP inmates returning to DC?
- How do those returning from FBOP differ from the DOC sentenced population?
- What are the mental health needs of those in DOC?
- What mental health services were provided to those in DOC?
- What are the substance abuse treatment needs of those in DOC?
- What are the medical needs of those in DOC?
- What are the educational and employment needs?

[6] DOC refers Halfway Houses as "contracted bed space at community based privately operated Halfway Houses". The FBOP uses the term "Reentry Resource Centers (RRC).

The Moss Group, Inc., conducted focus groups and stakeholder interviews among inmates, DOC and other agency staff and community stakeholders, producing **Chapter III Service and Programs Interviews**. The following questions were explored:

- What programs are available to you while in jail?
- Were you able to get into programs or are there barriers to getting in?
- What programs or services in the facility help you in preparing to go back to the community?
- What is the process for making a release plan? Do you work with staff in the jail? Who? People from the community? Who?
- What programs or services in jail do you wish were available to prepare you to go back to the community?
- What do you need to be successful after release? How would you describe "successful"?
- If you could pinpoint one thing, person, or program that you think is most helpful in preparing you for release, what would it be?
- Do you know where you can get help with these things in the community?
- Are there programs in jail that are required? Do they help? Would you get in trouble if you didn't participate? Are there things you get, rewards, extra time out in rec, etc. if you do participate?
- Are there enough programs in jail to meet your needs?
- Describe the "typical" problems you're encountering with programs and release planning.
- In your view, what are the biggest issues that people face when they are released?
- Are staff helpful with preparing you for release?

For this report, each chapter includes an introduction, a discussion of the data sources, and the methodology or protocols used in the analysis. The results within that chapter are provided, followed by limitations and conclusions. Recommendations are highlighted in the final chapter.

CHAPTER I: CUSTODIAL POPULATION STOCK AND FLOW

Introduction

This chapter describes the FY2015 DOC custodial population including demographics, current offense (including outcomes), past offense history, length of stay in the facility, and the like. The custodial population analysis – or stock and flow – seeks to comprehensively describe the flow of criminal justice involved individuals into and out of DOC to explain variations in custody populations. This report also examines the cohort of returning citizens from FBOP facilities to DC in FY2015. Given that FBOP is a prison, and not a jail, the needs and histories of those returning from FBOP will likely vary from those detained or serving time in DOC.[7] Understanding how these two populations differ is an important component, particularly if the jail is to expand the number of eligible FBOP inmates to serve their last 6 months at the DOC. Thus, we need to be able to understand this population's specific challenges so that we may provide recommendations to CJCC related to how best serve these individuals in different custody situations to successfully return to the community.

This chapter addresses the following questions for the population of those in the custody of DOC during FY2015 and those returning from FBOP in FY2015:

- Who flows through the DOC?
- What are the security classifications of those held by the DOC?
- What is the offending history of those entering the DOC?
- How long do persons stay in DOC pretrial?
- How long do sentenced persons stay in DOC?
- What is the most common destination of those leaving DOC?
- Who participates in Halfway Houses[8] (HWH)?
- What are the characteristics of FBOP inmates returning to DC?
- How do those returning from FBOP differ from the DOC sentenced population?

To answer these questions, this chapter begins with a discussion of the data sources utilized for this examination, followed by a detailed description of the DOC and FBOP custodial populations. We explore these data in three primary ways – 1) demographically (including age, race, gender, and level education at the time of release); 2) offense and incarceration experience (such as type of offense, sentence; criminal history (DOC only); length of stay, by type (e.g., sentenced, pretrial) classification, and infractions (FBOP only)); and 3) by release status (e.g., type of release, release facility, and supervision status).

[7] See the section on Returning Citizens from the Federal Bureau of Prisons for discussion of these differences.
[8] DOC refers Halfway Houses as "contracted bed space at community based privately operated Halfway Houses". The FBOP uses the term "Reentry Resource Centers (RRC).

In addition to presenting the data overall, evidence based practices[9] indicate the need to support both gender-specific reentry efforts and gaining a better understanding of the circumstances of young adult offenders (those between the ages of 18 and 24). For this reason, we present relevant findings by these subgroups.[10] We conclude this chapter with limitations to these findings and a brief conclusion.

Data Sources

Figure 1: Data Sources: Stock & Flow

Data Source	Description	Linking Variables	Number of Observations	Number of Unique Persons
DC Department of Corrections	Custody Data File - Individuals in custody or admitted to custody DOC from October 1, 2014 to September 30, 2015 (FY2015).	PDID & Research ID	N=18,159	N=8,843
	Security Classification Data	Research ID, Booking ID, & DCDC ID	N=10,736[11]	N=8,787
Pretrial Services Agency	Criminal History Data - Local	PDID	N=160,049	N=8,533
	Criminal History Data - External	PDID	N=57,537[12]	N=5,880

[9] The importance of addressing these specific populations are outlined in the project literature review. Appendix G Kimchi, Anat., Olaghere, Ajima and Shawn M. Flower (2017). Literature Review: District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services. District of Columbia Criminal Justice Coordinating Council Custodial Population Study. Washington DC: Justice Research and Statistics Association.

[10] We considered presenting the results by race. However, there were relatively few individuals classified as other than Black (4% of the DOC and 8% of FBOP populations), rendering between race comparisons less reliable.

[11] Of 10,736 observations, 24 had a DCDC ID number that could not be associated with the Research ID and were dropped. We also dropped an additional 37 observations because we were unable to link the Booking ID number between the classification data and the primary jail file.

[12] There were 612 observations without an arrest date that had little or no additional case information (e.g., case disposition, and/or charge data). Specifically, 229 charges had no information beyond the arrest identification number. Of the remaining, 237 were dismissed, not guilty, or placed on STET docket (a diversion practice where if the individual does not commit new offenses or violates existing conditions within a set period of time, the charge is removed from the record), while 146 included a conviction. Given the lack of arrest date, these 612 charges, representing 274 unique persons were deleted from the data. Of the 274 persons with a charge deleted due to lack of data, 46 had no other charges in the PSA External Criminal History file, reducing the number of unique persons in that file from 5,926 to 5,880.

Data Source	Description	Linking Variables	Number of Observations	Number of Unique Persons
Federal Bureau of Prisons	FBOP inmates returning to DC October 1, 2014 through Sept. 30, 2015 (FY2015) with a release address in Washington DC[13]	N/A	N=2,114[14]	N=2,108

To analyze data provided by the DOC in conjunction with PSA criminal history data we utilized the researcher ID number provided by DOC. This researcher ID number linked each individual's Police Department Identification Number (PDID) back to the DOC records. Our request to PSA for criminal history data consisted of the PDID and researcher ID numbers provided by DOC. Likewise, the FBOP created an Inmate Identification number to enable the identification of individual inmates with more than one record in the dataset. To protect the identities of the subjects, none of the records submitted by the agencies contained individual names.

As noted above, the FBOP data consisted of those returning to the community during FY2015. Given this, there is the possibility of overlap with the same individuals in both the DOC data and FBOP database. However, the Inmate ID provided by the FBOP was not intended to align with the DOC PDID or Research ID, and therefore, we did not have any way to connect individual level records within these two datasets. Thus, we analyze the FBOP cohort separately from the DOC custodial population.

Methodology

Our analytic approach was to review and categorize individuals by a variety of key factors using descriptive statistics (e.g., frequencies, measures of central tendency, and measures of dispersion) for all study variables, such as descriptions of the sample (age, race, marital status). We also explored the relationship between characteristics (e.g., offense type, confinement status) to describe patterns in the flow and cycle through the facilities.

Three data sets were provided to answer these questions involving anyone in the custody of DOC during FY2015, as detailed in Figure 1.
The DOC custody data file included 18,159 observations (representing 8,443 unique persons) and contained 79 variables including a variety of demographics information including age at

[13]Prisoners returning from FBOP to the District consist of two types of offenders – Federal prisoners convicted of Federal crimes in U.S. District Court; and DC prisoners who are convicted of a felony in D.C. Superior Court. While both groups require reentry/transitional services when returning to the community, only those convicted in Superior Court would be under the jurisdiction of the District of Columbia justice agencies. The differences in these groups are discussed more at length below.

[14]Six individuals were committed and released to FBOP more than 1 time in this period. Upon examination of the data, there were generally only a few days to a few months between release and recommitment, so the charges were combined to reflect the first commitment, the second release date and facility, but the time period incarcerated was calculated by adding the two separate stays together (e.g., if the person was incarcerated for 84 days on the first charge and 121 days on the second, the total time committed was 205 days).

release, sex, race, ethnicity, home city, state, and zip code; employment and education indicators (self-reported years of education, if currently employed at intake); and if there were indicators of a physical, mental, and/or substance abuse diagnoses. Offense information consisted of commitment (or booking) ID, charge description, category and severity level; disposition; and if sentenced – overall sentence length for the case (in days) and date of sentence. Confinement data included commitment date, release date, admission type (pretrial, sentenced, parole violator), release type, and release facility. The second DOC file was the DOC classification file, which contained 10,736 records representing 8,787 unique persons. This file provided the initial and final classification security level over the individual's length of stay.

PSA provided 2 criminal history files. The first contained the local arrest data containing 160,049 observations representing 8,533 offenders. This data set included the file date of the arrest, the docket ID number (used to distinguish unique arrests); charge description, disposition date, and disposition. Disposition primarily captured if there were a conviction or non-conviction, or if the charge was nulled. The external file consisted of 57,537 records and represented 5,880 individuals in the dataset. This file captured arrest records from states outside of DC and essentially included the same variables as the internal criminal history file. This enabled us to create a single merged file of the criminal history records. After omitting any post-study period arrests, there remained 193,636 records representing 8,337 individuals.

District of Columbia Department of Corrections Custodial Population

Demographics

Table 1 provides summary statistics on the 8,840[15] unique individuals who were in custody with the DOC from the period from October 1, 2014 through September 30, 2015. The majority were African American (90%) and male (88%). They were on average 35 years old, ranging from 15 to 82 years old. Age at release was also broken into categories of 17 to 24, 25 to 30, 31 to 35 years old, and so on. Among those in custody of the DOC in this period, 2,210 (or 25%) were from the ages of 18 to 24 – the population referred to as "Young Adult Offenders" (YAO) and another 1,685 (or 19%) were from 25 to 30 years old. The DOC data included other key information including if they were a parent (57% indicated they had 2 children on average (ranging from 1 and 18 children). The vast majority of DOC detainees/inmates[16] (77%) reported living in the District of Columbia, while 18% live in Maryland, 3% in Virginia, and the rest in other locations.

DOC also provided measures of self-reported education and employment status at intake to the facility. While 62% have a high school diploma, GED, or other advanced educational experience (including 5% who attended a technical and training school), it remains that 38% of the DOC population does not have a GED. In terms of employment, most (60%) were not

[15]Originally, there were 8,843 unique individuals in the dataset. A review of the data resulted in dropping 3 people as they were released prior to the study period.

[16]Those who are held pretrial are not convicted, thus are labeled "detainees". The term "inmates" generally refers to those who have been convicted of the crime. In this document, unless referring to the pretrial population specifically, the terms 'inmates" is intended to indicate the DOC custodial population and includes both detainees and convicted/sentenced individuals.

employed when they were committed to DOC. We looked at the intersection of education and employment (also in Table 1) and see that even those with a GED or high school diploma have high rates of unemployment.

Finally, there were several indicators in the data with respect to physical and mental health (including substance abuse). While it would appear that the majority of the DOC population do not have medical, mental or substance abuse diagnosis, it is important to note that these indicators are based on the medical records while in DOC, and thus reflect *active* medical and mental health needs addressed by DOC.[17]

Table 1: Demographics DOC Population – Unique Persons

By Unique Persons (N=8,840)	In Custody October 1, 2014 to September 30, 2015				
	N[18]	Freq.	Percent	Range	Mean (SD)[19]
Gender	8840				
Male		7809	88%		
Female		1031	12%		
Race/Ethnicity	8807				
Black		7996	90%		
White		336	4%		
Hispanic		376	4%		
Asian		27	<1%		
Other		72	1%		
Average Age at Release	8839			15 to 82	34.8 (12.2)
Age by Category	8839				
17 to 24 Years Old		2210	25%		
25 to 30		1685	19%		
31 to 35		1277	14%		
36 to 40		898	10%		
41 to 45		734	8%		
46 to 50		763	9%		
51 to 55		701	8%		
56 to 60		361	4%		
61 and older		210	2%		
Parental Status	7280				
Have Children		4164	57%	1 to 18	2.27 (1.6)
No Children		3116	43%		

[17] The Services Analysis chapter includes TAP assessment data from the Department of Behavioral Health that is used to explore medical and mental health histories.
[18] N=Number of those with data available to assess.
[19] "Standard Deviation" indicates variation in the data. A larger SD more variation, smaller SD more consistency.

By Unique Persons (N=8,840)	In Custody October 1, 2014 to September 30, 2015				
	N[18]	Freq.	Percent	Range	Mean (SD)[19]
Home Zip/State	8479				
DC		6519	77%		
MD		1519	18%		
VA		248	3%		
Other		193	2%		
Education Status	7351				
No High School Diploma/GED		2764	38%		
GED		1734	24%		
High School Diploma		2449	33%		
Some College		56	<1%		
Tech or Trade School		348	5%		
Employment Status	7349				
Employed When Committed		2935	40%		
Not Employed		4414	60%		
Education & Employment	7352				
Not Employed, No GED/HS	4414	1959	44%		
Not Employed, Has GED/HS		2455	56%		
Employed, No GED/HS	2935	804	27%		
Employed, Has GED/HS		2131	73%		
Physical & Mental Health					
Physical Health	7981				
Medical Condition Indicator		2432	31%		
No Medical Condition Indicator		5549	69%		
Mental Health	8070				
Mental Illness Indicator		894	11%		
No Mental Illness Indicator		7176	89%		
Substance Abuse	7849				
Substance Abuse Indicator		409	5%		
No Substance Abuse Indicator		7440	95%		

Percentages may not add up to 100% due to rounding.

Criminal History of DOC Population

Criminal history data provided from PSA is summarized below in Table 2. The criminal careers of the 8,337[20] individuals with a criminal history record spanned a range from as little as 1 day to over 60 years. On average, the DOC population had been criminally involved for over 14 years. Their prior arrest history (inclusive of criminal activity in all jurisdictions) reflects this longevity. These individuals had an average of 12 arrests (ranging from 1 to 129), 6 prior convictions and an average conviction rate of 49% overall.

Table 2 also provides arrest information broken down by charges. These individuals had an average of 23 charges (ranging from 1 to 209 charges) during in their prior criminal career, with close to 8 charges resulting in a conviction (ranging from 0 to 89 charges convicted) with 35% of all charges resulted in a conviction. We also looked at the average number of charges *per arrest* and while most had on average 2 charges per arrest, there were as many as 24 charges per arrest, and as few as a single charge.

The majority of those in DOC custody (81%) were classified as "person" offenders based on the most serious charge over their length of their criminal career. The crimes were assigned to the various categories of person, property, drugs, public order, violations, weapons, warrants, traffic, other, and unknown.[21] Person offenses include any type of offense which could harm or injure an individual including 2nd degree murder, armed carjacking[22] and assault; "property" examples include burglary, destruction of property, and theft; drugs consist of distribution of heroin, violation of a drug free zone and possession of drug paraphernalia, "weapons" include possession, carrying, concealing a weapon (including guns, knives, and ammunition), unregistered weapon and bomb threats. "Public Order" crimes include obstructing justice, sexual solicitation, and false statement to peace officer; "violations" include escape from an institution, a bail act violation, and contempt of court; "warrants" include fugitive from justice and failure to appear; "traffic" offenses include driving under the influence, motor vehicle theft, reckless driving, and driving with a suspended or revoked license; "other" include impersonation of a police officer, fire regulations, nursing without a license, and material witness; and finally, "unknown" captures attempted crimes where there is no additional information provided, conspiracy or missing information. The breakdown by different types of offenses includes the number of charges overall, within a range, and the number of charges that lead to a conviction.

[20] Among the 503 in custody without a prior criminal history record in the PSA data, 119 were in transit/being held on a writ, and 296 were pretrial offenders. The remaining 88 may have been first time offenders. As we only included arrests that occurred on or before the earliest commitment date in the study period, we may have omitted these 88 records from the analysis if the arrest took place on the same day as the first commitment.

[21] Offenses were categorized based on a coding scheme provided by CJCC. This coding scheme had been utilized in prior studies using these data, and had been previously reviewed by PSA Risk Department.

[22] If a charge involves a weapon (e.g., assault with a deadly weapon), that charge is coded as *both* a person crime and a weapons crime and thus some are in more than one category. If the charge is for a weapon only crime (e.g. firearm possession) then it is cataloged solely as a weapons crime.

Table 2: Criminal History of DOC Population – Unique Persons

	In Custody October 1, 2014 to September 30, 2015				
	N	**Freq.**	**Percent**	**Range**	**Mean (SD)**
Criminal Career	8337				
Length of Career (in months)[23]				<1 to 730	176 (134)
Length of Career (in days)				1 to 22,226	5,383 (4081)
Career Offender Class (Most Serious Charge Over Career)	8337				
Person		6759	81%		
Property		895	11%		
Drugs		214	2%		
Public Order		60	1%		
Other		0	0%		
Weapons		193	2%		
Violations		20	<1%		
Warrants		119	<1%		
Traffic		74	<1%		
Unknown		3	<1%		
Arrest Charge & Conviction History	8337				
Total Number of Prior Arrests				1 to 129	12.10 (11.3)
Total Prior Convictions - Arrest				0 to 74	5.75 (5.8)
Prior Arrest Conviction Rate				0 to 1	.49 (.24)
Total Number of Prior Charges				1 to 209	23.23 (20.8)
Total Prior Convictions - Charges				0 to 89	7.81 (7.6)
Average Charges Per Prior Arrest				1 to 24	2.03 (1.0)
Prior Charges Conviction Rate				0 to 1	.35 (.20)
By Type of Offense[24]					
Person Offenses					
Total Number of Charges	6723			1 to 58	5.67 (5.4)
Total Number of Charges Convicted	6493			0 to 20	1.87 (1.9)
Weapons Offenses					
Total Number of Charges	4252			1 to 32	3.54 (3.3)
Total Number of Convictions	4148			0 to 19	1.11 (1.5)

[23] Criminal career was calculated based on the first date of arrest to the arrest at or before commitment at DOC.
[24] Omitted offenses categorized as "Other" and "Unknown".

	In Custody October 1, 2014 to September 30, 2015				
	N	**Freq.**	**Percent**	**Range**	**Mean (SD)**
Property Offenses					
Total Number of Charges	6344			1 to 152	7.38 (9.9)
Total Number of Convictions	6159			0 to 69	2.61 (4.16)
Drug Offenses					
Total Number of Charges	5550			1 to 64	7.53 (7.7)
Total Number of Convictions	5460			0 to 23	2.67 (2.7)
Public Order					
Total Number of Charges	4432			1 to 72	3.26 (4.3)
Total Number of Convictions	4344			0 to 44	1.11 (2.23)
Violations					
Total Number of Charges	4552			1 to 30	3.52 (3.3)
Total Number of Convictions	4482			0 to 15	1.61 (1.8)
Warrants					
Total Number of Charges	2952			1 to 20	2.15 (1.8)
Total Number of Convictions	2747			0 to 16	.14 (.56)
Traffic Offenses					
Total Number of Charges	3567			1 to 46	3.78 (3.7)
Total Number of Convictions	3514			0 to 37	1.35 (1.7)

Percentages may not add up to 100% due to rounding.

Current Offense and Incarceration Experience

While the first two tables examine the DOC population as unique persons – regardless of the number of times they were committed to the DOC, the other ways the data are discussed are by charge and by booking event. There are 8,840 unique persons who were committed to the DOC 10,680 times among those in custody during FY15. These booking events included over 18,000 charges. Additional data cleaning removed 15 additional charges for a final dataset of 18,053 charges, representing 8,840 unique individuals and 10,680 booking stays in the study period. Finally, we reviewed the charges within each unique booking stay and selected the last date released within that booking stay to consolidate the data into unique booking events.

We then reviewed the 10,680 booking events to determine for those with more than one booking event, which people were detained for a continuous period of time. We did this by observing booking events with a contiguous or consecutive date range.[25] This process was conducted to ensure that we accurately captured the length of stay in the facility. For example, one individual

[25]We also combined those stays when there was 1 or fewer days between the release date on the first booking event and the commitment date on a subsequent booking event.

had a total of 5 unique booking events during the study period. Of those 5 events, the first 2 stays were separate stays, the 3rd and 4th stay were continuous (or overlapped), and the 5th booking was a separate stay. The second example shows an individual with 3 booking events, but all events occurred immediately following the other are considered a single stay. Both examples are provided below in Figure 2.

Figure 2: Examples of Non-Continuous and Continuous Booking Stays

Stay Event	Date Committed	Date Released	Continuous?
		Example 1	
1	10/06/2014	11/07/2014	No
2	11/20/2014	12/01/2014	No
3	12/11/2014	02/20/2015	Yes – Overlaps Stay 4
4	12/11/2014	02/20/2015	Yes – Overlaps Stay 3
5	03/31/2015	12/15/2015	No
		Example 2	
1	10/27/2014	06/29/2015	Yes – Contiguous Stay
2	06/29/2015	06/30/2015	Yes – Contiguous Stay
3	07/01/2015	09/01/2015	Yes – Contiguous Stay

As indicated in Table 3 below, the population of the DOC is diverse. Among 10,680 booking events, those committed to DOC range from those sentenced with felony offenses to pretrial misdemeanants, to parole violators, to those held in transit or on a writ. Overall, approximately 27% of the population consists of sentenced inmates, while 51% are detained pretrial. Within the study period, 8,840 unique persons had from 1 to 6 booking events (or stays), with most (7,340 or 83%) having only a single stay. The remaining 1,500 had 2 to 6 stays, with an average of a little over 2 stays in the period. Over the 10,680 booking events, the average length of stay was 93 days, within a range of 1 and 2,785 days (or 7.5 years). [26]

We also reviewed the length of stay by type of stay, and the length of time appears consistent with the types of stay. For example, those sentenced for a misdemeanor spent 58 days on average in the facility versus those sentenced for a felony, who on average stayed 198 days. Those held in transit, on a writ, or a hold stayed for the longest period – on average 217 days. Another way to look at length of stay is by the number who left the facility within specific time frames such as within 24 to 48 hours, or 3 to 30 days. As noted below in the table, the majority of those committed - 70% (7,488 of 10,680 bookings) - are released within 90 days of commitment.

[26] Lengths of stay in this report may differ from the DC Department of Corrections Facts and Figures reports for two reasons. First, this study included all those who were in the facility during FY2015 – regardless of if the individual was committed prior to the start of the fiscal year, or if they were released following the end of the fiscal year. Second, in terms of time in the facility, we analyzed the data using persons as unit of analysis, so we collapsed contiguous commitments into a single continuous stay and selected the first commitment date as the start of the stay and the last release date as the end of the stay.

Table 3 also captures offense information related to the current charge, security classification level and program participation while in custody of DOC. We reviewed the current offense in two ways – all charges and by most serious charge. The two top charges among all charges and most serious are person and violation offenses. Among all charges, there are 4,638 person offenses (or 26%) and 3,896 violations offenses (22%). As noted in the discussion of the criminal history records, person offenses include any type of offense which could harm or injure an individual including homicide and kidnapping, as well as assault. Violations include a wide spectrum of offenses including contempt, escape, failure to appear, violation of protection orders and tampering with a detection device (e.g., GPS monitor). There are also a small number (450 or 6%) of gang affiliated individuals within the population.

DOC also provided classification data for those in the facility in this period. According to DOC Policy 4090.4A, custody classification is based on 9 factors including severity of current offense, prior criminal history, any history of escape and institutional violence, drug/alcohol history, as well as age, education and employment histories. Individuals are to be initially classified and then reclassified upon changes in legal status, at 90 days intervals, substantiated disciplinary actions and upon receipt of classification relevant information. DOC provided the first classification level and the final classification before release. More than half (52%) of those in the facility are classified as medium level, 10% are maximum and 6% are minimum. Approximately a third (31%) were listed as "cannot classify" or were missing data. Reviewing those cases without classification data, we find that they varied by length of stay and type of offender -- 70% of those without a classification were in the facility for 1 to 30 days, and 70% of those missing a classification were committed pretrial.

DOC provided further clarification on the "Cannot Classify" designation:

> *"Cannot Classify" indicates that an inmate "couldn't be classified due to one reason or another. Usually this happens because the inmate is not in the building, he/she is at court (most common reason), hospital etc. or on some particular status and is unable to come out of his/her cell at the time the Case Manager attempted to classify them. … An inmate that is unavailable for classification is usually classified in abstention before his/her 72 business hours are up. If you see this for an inmate that has been released it is because the inmate was most likely released and didn't return to be classified.* [27]

Finally, of all individuals committed to the facility, approximately 2% participated in the Residential Substance Abuse Treatment (RSAT) program and 1% in the Reentry program.[28] For the GED program, among the 2,764 without a GED, approximately 5% participated in the GED program.

[27] Reena Chakraborty, Ph.D., Chief of Strategic Planning and Analysis, D.C. Department of Corrections, Personal Communication, September 22, 2017.

[28] The Moss Group, Inc. (TMG) explored program participation with respect to eligibility and admission criteria during the focus groups and they found that those with short sentences (e.g., under 30 days) or "if they are pre-trial or without an identified release date, they are not eligible to participate in time-based programs". See Chapter III.

Table 3: Incarceration Descriptives DOC

By Unique Persons (N=8,840) or Booking Stay (N=10,680)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Type of Stay[29]	10680				
Sentenced Felony		1405	13%		
Sentenced Misdemeanor		1454	14%		
Pretrial Felony		3302	31%		
Pretrial Misdemeanor		2115	20%		
Parole/Probation Violator		1537	14%		
In Transit/Writ/Hold		856	8%		
Other		11	<1%		
Number of Stays (By Unique Persons)	8840			1 to 6	1.2 (.51)
One		7340	83%		
Two		1226	14%		
Three		216	2%		
Four or More		58	1%		
Average Stays 2 or More	1500			2 to 6	2.23 (.53)
Length of Stay (in Days)					
Commitment to Release – All	10680			1 to 2785	93.39 (196)
Length of Stay by Type	10680				
Sentenced Felony		1405		1 to 1952	198 (229)
Sentenced Misdemeanor		1454		1 to 635	58 (74)
Pretrial Felony		3302		1 to 2785	57 (151)
Pretrial Misdemeanor		2115		1 to 1526	31 (80)
Parole/Probation Violator		1537		1 to 918	124 (111)
In Transit/Writ/Hold		856		1 to 2606	217 (307)
Other		11		1 to 974	190 (385)
Length of Stay Category	10680				
24 to 48 Hours		1040	10%		
3 to 30 Days		4305	40%		
31 to 90 Days		2143	20%		

[29]We combined 4 variables to present the type of stay based on a hierarchy to account for those who were initially in the facility pretrial, but later sentenced. The first variable was admission type, which was coupled with the offense classification of misdemeanor or felony. Then for charges without a clear admission type, the stay was designated as pretrial or sentenced based on the "pending" variable. We also included data from the disposition, coding "sentenced and serving" as "sentenced" and those in a pretrial program (e.g., work release) as "pretrial". Those remaining without a designation at this point were coded as violators, in transit, and other based on the admission type. Finally, if there was a charge where the defendant was detained pretrial and another charge where they were serving a sentence, we cataloged the stay as "sentenced" (and as either felony or misdemeanor based on the specific charge).

By Unique Persons (N=8,840) or Booking Stay (N=10,680)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
91 to 180 Days		1611	15%		
6 to 9 Months		682	6%		
9 Months to 1 Year		372	4%		
1 Year to 18 Months		258	2%		
18 Months and More		269	2%		
Gang Affiliation (By Unique Persons)	7838				
Gang Affiliation		450	6%		
No Known Affiliation		7388	94%		
Current Offense (All Charges)	17978				
Person		4638	26%		
Property		2800	16%		
Drugs		1218	7%		
Public Order		409	2%		
Other		102	1%		
Weapons		1215	7%		
Violations		3896	22%		
Warrants		1496	8%		
Traffic		739	4%		
USMS/UCDC Commit		876	5%		
Hold Other Jurisdictions/Writ		589	3%		
Offense Severity (Lower = More Serious)[30]	10306				
Most Serious Charge				1 to 25	8.7 (4.9)
Least Serous Charge				1 to 25	11.1 (5.5)
Most Serious Current Charge	9874				
Person		3610	37%		
Property		1427	14%		
Drugs		729	7%		
Public Order		190	2%		
Other		83	1%		
Weapons		620	6%		
Violations		1491	15%		
Warrants		1322	13%		
Traffic		402	4%		

[30]As values above 25 represented fugitive status, writs, and witness, we omitted these from the average scores.

By Unique Persons (N=8,840) or Booking Stay (N=10,680)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Initial Security Level	10680				
Minimum		644	6%		
Medium		5602	52%		
Maximum		1084	10%		
Cannot Classify/Missing Data		3350	31%		
Unit Based Programs	8840				
RSAT		181	2%		
Reentry		52	<1%		
Population Lacking GED	2764				
GED		147	5%		

Percentages may not add up to 100% due to rounding.

Release Status

Release information by booking stay is provided in Table 4 by month of release, by status, by facility, and the final security level. Among the 10,680 booking events in the study period, 84% or 8,996 had a release date within the fiscal year. More than half (55%) of those released were as "self-custody" while the remaining were transferred to other justice agencies, St. Elizabeth's, or to a treatment program, a few escaped from halfway house facilities and 1 individual died. Among the 4,963 bookings released on the status of "self-custody", more than half (56%) of those bookings were released based on court order, 37% for time served (of which the majority – 97% -- were released on expiration of sentence and 3% were released time served or suspended), 5% on parole and a small portion were released on bond or other status.

Individuals were released most often from DOC – with 74% from the Central Detention Facility (CDF) or Correctional Treatment Facility (CTF); with 10% released from DC Superior Court and 10% Court Order DOC Holding, and the remaining from Halfway Houses, St. Elizabeth's and other. Note in Table 5 we provide more detailed types of release by length of stay. Similar to the initial classification, most of those in custody at DOC remain classified as medium security level (59%), although fewer are in the maximum security level (8%) and more are minimum. There remain 23% without a classification level.

Table 4: Release Descriptives DOC

By Booking Stay (N=10,680)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Released	10680				
Not Yet Released as of 10/1/15		1684	16%		
Released		8996	84%		
Releases by Month/Year	8996				
Oct 2014		857	10%		
Nov 2014		737	8%		
Dec 2014		723	8%		
Jan 2015		713	8%		
Feb 2015		672	8%		
Mar 2015		772	9%		
Apr 2015		759	8%		
May 2015		779	9%		
Jun 2015		743	8%		
July 2015		759	8%		
Aug 2015		753	8%		
Sep 2015		729	8%		
Release Status	8946				
Self-Custody		4965	55%		
US Marshal or FBOP		1767	20%		
DC Metro Jurisdiction		929	10%		
MPD Officials		32	<1%		
MPD Fugitive Unit		255	3%		
Another Jurisdiction		370	4%		
Treatment Program		485	5%		
Saint Elizabeth's		103	1%		
ICE		27	<1%		
Halfway House Escape		12	<1%		
Death/Suicide		1	<1%		
Those Released Self Custody	4963				
Court Order		2792	56%		
Time Served		1832	37%		
Parole		249	5%		
Bond Out		56	1%		
Other		34	<1%		

By Booking Stay (N=10,680)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Among Those Time Served	1832				
Expiration of Sentence		1787	97%		
Time Served or Suspended		45	3%		
Facility Released From	8996				
CDF/CTF		6665	74%		
DC Superior Court		929	10%		
Halfway Houses (Hope Village; Fairview; Extended House)		299	3%		
St. Elizabeth's Hospital		164	2%		
Court Ordered DOC Holding		930	10%		
Other (Arraignment, Weekender, Pretrial Release)		9	<1%		
Final Security Level (Before Release)	8996				
Minimum		898	10%		
Medium		5279	59%		
Maximum		720	8%		
Cannot Classify/Missing Data		2099	23%		

Percentages may not add up to 100% due to rounding.

Table 5: Detailed Types of Release by Length of Stay

Type of Release	1 to 30 days		31 to 90 Days		91 to 180 Days		181 to 365 Days		1 Year to 18 Months		18 Months and More		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cash Bond	23	<1%	2	<1%	0	0%	0	0%	0	0%	0	0%	25	<1%
Cash Collateral	26	1%	4	<1%	0	0%	4	1%	1	<1%	0	0%	35	<1%
Court Ordered Release - CDF	765	16%	238	15%	64	12%	57	8%	71	9%	29	9%	1224	14%
Court Ordered Release - Court	833	17%	89	5%	14	3%	8	1%	8	1%	2	1%	954	11%
Court Ordered Release - MHU	715	15%	118	7%	35	7%	27	4%	24	3%	6	2%	925	10%
Drug Program	207	4%	58	4%	9	2%	10	1%	10	1%	2	1%	296	3%
Time Served or Suspended	30	1%	13	1%	2	<1%	1	<1%	2	<1%	3	1%	51	1%
Sentence Expiration	617	13%	496	31%	160	31%	247	33%	232	28%	67	20%	1819	20%
Weekender Expiration	82	2%	35	2%	6	1%	3	<1%	0	0%	0	0%	126	1%
Mandatory Release - Parole	1	<1%	0	0%	0	0%	0	0%	1	<1%	0	0%	2	<1%
Parole	55	1%	85	5%	25	5%	76	10%	91	11%	3	1%	335	4%
Fugitive Waiver	1186	24%	18	1%	8	2%	7	1%	13	2%	1	<1%	1233	14%
Release to US Marshall	296	6%	432	27%	182	35%	284	38%	355	43%	211	64%	1760	20%
Release to ICE	1	<1%	1	<1%	0	0%	0	0%	0	0%	0	0%	2	<1%
Extradition	0	0%	1	<1%	0	0%	1	<1%	1	<1%	0	0%	3	<1%
Sanction	16	<1%	0	0%	0	0%	0	0%	0	0%	0	0%	16	<1%
Other	30	<1%	36	2%	10	2%	12	2%	19	2%	5	2%	112	1%
Death	0	0%	0	0%	0	0%	1	<1%	0	0%	0	0%	1	<1%
Total	**4883**		**1626**		**515**		**738**		**828**		**329**		**8919**	

Percentages may not add up to 100% due to rounding.

Profiles of DOC Population by Gender, Age, and Detainment Status

To begin to differentiate the needs of specific offender populations, we looked at these demographic, offense, incarceration experiences, and release status within the cross-sections of gender and comparing young adult offenders (those age 18 to 24) to older adult offenders. We also explored these factors by those detained pretrial versus sentenced population. The following profiles summarize the information detailed in Table 6 through Table 9 by subgroup. Note that with the exception of the profile by detainment status, we include all individuals in custody in these profiles – including those held on writs, or in transit or violators. Finally, unless otherwise indicated, differences discussed in the text were statistically significant.[31]

Gender

Among those in custody of DOC during the study period, 12% are women and 88% are men (see Table 6). While generally racially equivalent across the groups, there are more White women than men (6% vs. 3%), and more Hispanic men than women (5% vs. 2%, respectively). Women also tend to be older 36 years old versus 34.7 for men; with fewer women falling into the Young Adult Offender age category (20% vs. 26% of men). A higher percentage of women have children (68% vs. 56% of men), with women having closer to 3 children on average (ranging from 1 to 13 children) and men having closer to 2 children, but reporting between 1 and 18 children.

Consistent with the extant literature, with respect to education and employment status, women are more likely to be unemployed – 83% vs 59% and are less educated (43% of women are without a GED compared to 37% of men). Interestingly, while more women had active medical conditions while in the facility (34% vs. 30% of men); fewer women than men had indicators of mental illness (8% vs. 12%) or substance use conditions (2% vs. 6%).

Reviewing criminal histories in Table 7 by gender, women have shorter careers than men (on average 13 years compared to men with careers of almost 15 years), but have an equivalent total number of arrests and convictions. However, their arrest conviction rates do vary significantly (women are convicted on 46% of arrests and men are convicted on 49% of the time in their prior arrests). While the total number of arrests are similar, overall, women have fewer charges than men (18.5 vs. 23.8 charges) and have fewer charges, on average, per arrest (so women are charged with 1.6 charges *per arrest* compared to men who are charged with 2.1 charges *per arrest*.) However, women and men have similar conviction rates with respect to those charges – both are convicted on 35% of charges. In addition, they commit crimes in the District at about the same rates (73% of women's criminal history records were from internal DC records vs. 74% of men's records). In terms of offense types,[32] overall, women were less likely to be charged for person, property, drug, weapons and traffic offenses, but were more often charged with public order and violation charges than men. There was no difference in gender on number of warrant charges.

[31]Differences that are statistically significant if the "p-level" indicator is p<.05 or below. This notation means that the findings are highly unlikely (e.g., for p<.001 - less than a 1 out of 100 chance or p<.05 less than 5 out of 100 chances) to be the result of chance or coincidence.

[32]Not listed on Table 7 but available upon request.

Looking at the incarceration experiences by gender in Table 8, we see that a higher percentage of women are committed to the facility pretrial than men. Specifically, 66% of women are on pretrial vs. 49% of men. Within the pretrial status, a higher number of women are committed to the facility on a misdemeanor than felony (33% of women held on pretrial misdemeanor vs.18% of men). Commensurate with this admission type, women have shorter booking stays in the facility – on average 49 days vs. 99 days for men. Men and women vary on the type of offenses charged with during their current stay. Fewer women are charged with person crimes (33% vs. 37% of men) and more women are committed on warrants (19% vs. 12%). In addition, the overall seriousness of the offenses charged to women were lower than those charged to men (for most serious crime overall, the charge severity was on average 9.0 for women and 8.6 for men – with the lower the number, the more severe the crime). Women were also far less likely to be identified as gang affiliated (less than 1% of women vs. 7% of men). Few women were initially classified as maximum security – only 5% (compared to 16% of men); and a much higher percentage were assigned to minimum security (30% vs. 6% of men committed to the facility).

Finally, looking at the booking release statistics on Table 9, we see that a higher percentage of bookings of women were released (92% vs. 83% of male bookings). This is consistent with the prior discussion of charges and length of stay by gender. In addition, a lower percentage of women are released to the U.S. Marshal or the Federal Bureau of Prisons 7% of women and 22% of men committed to the facility. At release 61% of women were classified as medium security (down from 65% at first classification) and few women remained classified as maximum security – only 3% while more men were moved from maximum to medium security (16% initially to 11% upon release).

Overall, women in the DOC facility are generally older and less serious offenders, and are more often held for misdemeanor offenses. They stay on average less than 2 months. Women in DOC also have on average 3 children, and a high percentage need both employment and education assistance.

Young Adult Offenders vs. Older Adults

Another population of interest are those who are younger from the age of 18 to 24 – classified as the "Young Adult Offender" (YAO). As detailed in Table 6, a quarter of the DOC population held during the study period fell into this category. On average, this population was 21 years old, ranging from 15 to 24 years old. There are more male YAOs than female YAOs --91% were male and 9% were female, compared to older adult population with 88% male and 12% female. YAOs are also more likely to be Black (93% vs. 90%) than older adults. As expected, given YAOs are in earlier stages of life, a smaller percentage have children (43% compared to 62% of older adults); and of those that do, they have 1.5 children (ranging 1 to 10 children). YAOs are also less likely to have a high school diploma or GED (56% vs. 32%) and 68% (vs. 58% of older adults) were unemployed when committed to the facility. YAOs were also less likely to have active medical conditions, but were equally likely to have an active mental illness and substance abuse condition compared to other adults.

Comparing criminal histories in Table 7 by YAO vs. older adults, it is not surprising to see that YAOs have shorter criminal careers – they have not had the same amount of time to engage in criminal activity. Across the board, YAOs have fewer arrests and charges. However, YAOs and older offenders do not vary with respect to their prior conviction rate in either arrests or charges. YAOs are convicted on an arrest 50% of the time; while adult offenders are convicted in 49% of arrests. By charge, YAOs are convicted on 36% of charges and older adults on 35% of charges. YAOs commit crimes in the District at the same rates (74% of YAO's criminal history records were from internal DC records) as older adults. Again, given the brevity of YAOs criminal career, it is not surprising that YAOs had significantly fewer types of offenses[33] than older adults.

Reviewing the incarceration descriptives in Table 8, YAOs are most frequently committed to the facility on a pretrial felony – 44%; followed by sentenced felony (20%). In contrast, older adults are equally committed on pretrial cases (26% pretrial felony; 21% pretrial misdemeanor); and a violation (17%). A higher percentage of older adult offenders are also held in transit or on a writ (9% vs. 5% of YAOs). In terms of the current most serious charge, YAOs are far more likely to be committed on a person crime (47% vs. 33% of other adults) and less likely on drug charges (4% vs. 9%) and violations (8% vs. 18%). YAOs also committed more serious crimes based on charge severity which averaged 7.10 for YAOs and 9.3 for older adults – with the lower the number, the more severe the crime). A higher percentage of YAOs were identified as gang affiliated (10% vs. 4%). Undoubtedly related to the higher percentage of bookings on person offenses, severity of charges and gang affiliation, 22% of YAOs are classified as maximum security compared to 12% of other adult offenders.

Finally, looking at the booking release statistics on Table 9, it appears that YAOs are generally similar to older adults in most of the release measures. The exceptions are that a higher percentage of those released to self are court order releases (68% vs. 52%) and fewer YAOs are released time served than older adults (29% vs. 40%). Consistent with the initial security classification level, more YAOs remain as maximum security at release than older adults.

Overall, the characteristics of YAOs in DOC are consistent with the literature. While YAOs have had less time to accrue an extensive criminal record, they are nonetheless generally serious offenders often charged with more severe person offenses. There are also higher levels of gang affiliation among this population. The majority of YAOs are also unemployed and without a high school degree or GED. This is a challenging population that will require interventions targeted to meet these needs.

Pretrial vs. Sentenced Population

The final sub-group profile developed on the DOC population is the comparison between those in custody pretrial versus sentenced population. Note that anyone held on a writ, in transit, or on hold are omitted from this sub-group population, parole violators are cataloged as either sentenced or pretrial, based on the status of their case (although 293 violators could not be classified as either pretrial or sentenced and thus were not included in the subgroup analysis).

[33]Not listed on Table 7 but available upon request.

As indicated in Table 6, there are 7,611 unique individuals included in this examination – 58% held pretrial and 42% sentenced.

The pretrial population has more women (15% of those held pretrial are women vs. 9% of sentenced population. Those on pretrial are also younger by one year on average than the sentenced population (34 vs. 35 years old).[34] Those on pretrial were less likely to be parents (55% vs. 58%), to have an active medical condition (26% compared to 34% of the sentenced population), mental health (5% vs. 17% and indications of active substance abuse condition (2% vs. 9%). However, in terms of race, number of children, attainment of a high school diploma/GED and employment status, the groups are equivalent.

The pretrial population varies significantly from the sentenced population across all criminal history measures (see Table 7). Not only were fewer of the crimes committed were in DC (71% vs. 77% of those serving a sentence) and the pretrial population had a shorter criminal career by 2 years (13.5 years for pretrial and 15.3 years for sentenced). That 2-year difference may help explain why those held pretrial have fewer arrests (11.7 vs. 12.6), fewer charges (21.7 vs, 24.6), and lower arrest (44% vs. 55%) and charge (32% vs. 39%) conviction rates. With respect to the types of charges in the offense histories of those held pretrial versus sentenced, those in pretrial have fewer person, drug, public order, violations and traffic charges than those sentenced.[35] There was no difference in the number of property crimes or warrants.

Reviewing the incarceration descriptors in Table 8, the pretrial population stays significantly fewer days on average than the sentenced population (50 vs. 130 days). Looking to the current most serious charge those in pretrial are much more likely to be committed on a warrant (23% vs. less than 1% of the sentenced population). However, the pretrial population is less likely to be committed on a person crime (34% vs. 43%) or a violation (10% vs. 19%) than the sentenced population. Those on pretrial also commit more serious crimes based on charge severity which averaged 7.9 for pretrial and 9.1 for sentenced – with the lower the number, the more severe the crime). Pretrial are also more likely to be classified as medium level security (82% vs. 69% of sentenced population).

As the FBOP is responsible for housing sentenced offenders with longer sentences for the District, the differences in release status by pretrial and sentenced offenders are not unexpected (see Table 9). While both populations are released to self-custody similarly, only 7% of the pretrial population is released to the U.S. Marshal or FBOP, compared to 36% of the sentenced population. Also, a greater proportion of the pretrial population (20%) is transferred to Metropolitan Police Department or on a fugitive warrant than the sentenced population (4%). In addition, while 88% of the pretrial population is released on court order, only 3% of the sentenced population are released by this mechanism. Sentenced are most often released for time served and 97% are directly released from CDF/CTF. While those on pretrial are also released from CDF/CTF, they are also released from D.C. Superior Court (17%) and DOC hold (17%).

[34] In looking simultaneously at gender and age, pretrial and sentenced populations differ. Men who are sentenced are on average 34.8 years old compared to men on pretrial who are 33.8 years old. There is a similar pattern with women – sentenced women are 37 years old vs. women on pretrial, who are 35 years old.

[35] Not listed on Table 7 but available upon request.

The final classification status is very similar to the initial classification with most of the pretrial population labeled as medium security 83% - compared to 68% of the sentenced population.

In many ways, the differences between pretrial and sentenced population reflect the pending nature of pretrial status more than a difference in offenders per se. While those on pretrial were less likely to have an active medical, mental health or substance abuse condition than the sentenced individual, in terms of other demographics and education and employment status, the groups are equivalent. Of course, one of the key differences is where individuals in are released – back to the community at the end of their sentence or to FBOP for a long incarceration period. Ideally, DOC would triage these two groups according to the most likely destination, and provide services accordingly. While not necessarily a priority given limited resources and the more immediate needs of those on the return leg of their incarceration journey, it may be fruitful for the DOC to consider exploring possible support services to those likely to be transferred to the FBOP to help these individuals serve their time more productively. This type of activity may focus more on the family related services such as mediation to set up a transition plan, or services geared to helping families overcome barriers to visiting the inmate once transferred to FBOP.

Overall, the differences in these 3 groups – women vs. men; young adult offenders vs. older adult offenders; and pretrial vs. sentenced populations highlight the diverse nature of the DOC population. This in turn provides a sense of the inherent challenges in effectively and efficiently addressing the varied needs of this population in an environment where the inmates are processed in and out of the facility within relatively brief time periods.

The next section of this report addresses yet another population – those housed in halfway house facilities.

Table 6: Demographics DOC - by Gender, Age, and Detainment Status

By Unique Persons (N=8,840)	N	Gender N=8840				Age N=8839				Detainment Status* N=7611			
		Women		Men		YAO		25 +		Pretrial		Sentenced	
		N	%	N	%	N	%	N	%	N	%	N	%
Overall	*8840*	*1031*	*12%*	*7809*	*88%*	*2210*	*25%*	*6629*	*75%*	*4439*	*58%*	*3172*	*42%*
Gender	8840												
Male		0	0%	7809	100%	2004	91%	5804	88%	3768	85%	2885	91%
Female		1031	100%	0	0%	206	9%	825	12%	671	15%	287	9%
Race/Ethnicity	8807	*1025*		*7782*		*2202*		*6604*		*4417*		*3164*	
Black		936	91%	7060	91%	2057	93%	5938	90%	4056	91%	2917	92%
White		66	6%	270	3%	32	1%	304	5%	156	4%	106	3%
Hispanic		17	2%	359	5%	100	5%	276	4%	165	4%	114	4%
Other		6	1%	93	1%	13	1%	86	1%	40	1%	27	1%
Age at Release	8839	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
		36.0	11.6	34.8	12.3	21.3	1.9	39.5	10.7	34.0	12.3	35.0	12.0
Age Range		15 to 69		16 to 82		15 to 24		25 to 82		15 to 82		16 to 76	
Age by Category	8839	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
17 to 24 Years Old		206	20%	2004	26%	2210	100%	0	0%	1285	29%	773	24%
25 to 30		186	18%	1499	19%	0	0%	1685	25%	866	20%	588	18%
31 to 35		164	16%	1113	14%	0	0%	1277	19%	599	13%	491	16%
36 to 40		113	11%	785	10%	0	0%	898	13%	403	9%	329	10%
41 to 45		94	9%	640	8%	0	0%	734	11%	343	8%	257	8%
46 to 50		125	12%	638	8%	0	0%	763	12%	367	8%	259	9%
51 to 55		91	9%	610	8%	0	0%	701	10%	302	7%	284	9%
56 to 60		35	3%	326	4%	0	0%	361	5%	170	4%	132	4%
61 and older		17	2%	193	2%	0	0%	210	3%	104	2%	59	2%

By Unique Persons (N=8,840)	N	Gender N=8840				Age N=8839				Detainment Status* N=7611			
		Women		Men		YAO		25 +		Pretrial		Sentenced	
		N	%	N	%	N	%	N	%	N	%	N	%
Parental Status	7280	*306*		*6974*		*1798*		*5481*		*3349*		*2806*	
Have Children		210	68%	3954	56%	775	43%	3388	62%	1843	55%	1630	58%
		Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Number of Children		2.8	1.9	2.2	1.6	1.5	.88	2.4	1.7	2.2	1.6	2.2	1.7
Range		1 to 13		1 to 18		1 to 10		1 to 18		1 to 18		1 to 15	
		N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
DC Resident	8479	780	80%	5739	76%	1727	81%	4791	76%	3284	77%	2433	78%
Education Status	7351	*357*		*6994*		*1773*		*5577*		*3345*		*2842*	
Lacks GED		153	43%	2611	37%	998	56%	1766	32%	1226	37%	1128	39%
HS/GED or Higher		204	57%	4383	63%	775	44%	3811	68%	2119	63%	1714	61%
Employment Status	7349	*357*		*6992*		*1772*		*5576*		*3344*		*2841*	
Not Employed		296	83%	4118	59%	1212	68%	3202	58%	2021	60%	1678	59%
Employed		61	17%	2874	41%	560	32%	2374	42%	1323	40%	1163	41%
Physical Health	7981	*996*		*6985*		*2014*		*5966*		*4239*		*2874*	
Medical Condition		340	34%	2092	30%	305	15%	2127	36%	1079	26%	981	34%
No Med. Condition		656	66%	4893	70%	1709	85%	3839	64%	3160	74%	1893	66%
Mental Health	8070	*1013*		*7057*		*2060*		*6009*		*4276*		*2912*	
Mental Illness		82	8%	812	12%	243	12%	651	11%	199	5%	504	17%
No Mental Illness		931	92%	6245	82%	1817	88%	5358	89%	4077	95%	2415	83%
Substance Abuse	7849	*983*		*6866*		*2020*		*5828*		*4234*		*2839*	
Substance Abuse		15	2%	394	6%	109	5%	300	5%	98	2%	251	9%
No Substance Abuse		968	98%	6472	94%	1911	95%	5528	95%	4234	98%	2588	91%

Percentages may not add up to 100% due to rounding.

* Individuals committed solely in transit, on a writ, or a hold were excluded from this sub-group analysis.

Table 7: Criminal Histories DOC - by Gender, Age and Detainment Status

By Unique Persons (N=8,840)	Gender N=8337				Age N=8336				Detainment Status* N=7273			
	Women		Men		YAO		25 +		Pretrial		Sentenced	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Overall	*970*		*7367*		*2025*		*6311*		*4232*		*3041*	
Career (In Days)	4837	3710	5454	4122	1197	815	6725	3791	4942	4082	5595	4036
Range	1 to 15,677		1 to 22,226		1 to 12,220		1 to 22,226		1 to 22,226		1 to 19,684	
Proportion DC Internal vs. External Records	.73	.28	.74	.29	.74	.32	.74	.32	.71	.30	.76	.26
Arrest, Charge & Conviction History												
Arrest												
Total # Prior Arrests	11.6	11.3	12.1	11.3	4.7	3.9	14.5	11.9	11.7	11.8	12.6	11.1
Range	1 to 98		1 to 129		1 to 36		1 to 129		1 to 129		1 to 98	
# Total Arrest Convict	5.4	6.1	5.7	5.7	2.2	1.9	6.9	6.1	5.4	6.0	6.3	5.5
Range	0 to 63		0 to 74		0 to 15		0 to 74		0 to 74		0 to 51	
Arrest Conviction Rate	.46	.26	.49	.24	.50	.31	.49	.21	.44	.24	.55	.21
By Charge												
# Prior Charges	18.5	17.8	23.8	21.1	9.3	7.9	27.8	21.7	21.7	21.1	24.6	20.8
Range	1 to 171		1 to 209		1 to 56		1 to 209		1 to 209		1 to 171	
# Total Charge Convict	6.8	7.6	7.9	7.6	2.9	2.8	9.4	8.0	7.1	7.9	8.5	7.2
Range	0 to 89		0 to 88		0 to 33		0 to 89		0 to 88		0 to 69	
Avg. # Chg Per Arrest	1.6	.69	2.1	1.0	2.1	1.3	2.0	.96	1.9	.90	2.1	.94
Range	1 to 11		1 to 24		1 to 17		1 to 24		1 to 11.5		1 to 17.5	
Charges Convict Rate	.35	.21	.35	.19	.36	.27	.35	.17	.32	.20	.39	.19

Percentages may not add up to 100% due to rounding.

* Individuals committed solely in transit, on a writ, or a hold were excluded from this sub-group analysis.

Table 8: Incarceration Descriptives DOC - by Gender, Age and Detainment Status

By Booking Stay (N=10,680)	Gender N=10680				Age N=10679				Detainment Status* N=9352			
	Women		Men		YAO		25 +		Pretrial		Sentenced	
	N	%	N	%	N	%	N	%	N	%	N	%
Type of Stay	*1265*		*9404*		*2779*		*7889*		*5747*		*3605*	
Sentenced Felony	78	6%	1327	14%	546	20%	859	11%	---	---	1405	39%
Sentenced Misd.	191	15%	1263	13%	254	9%	1200	15%	---	---	1454	40%
Pretrial Felony	418	33%	2884	31%	1226	44%	2076	26%	3302	57%	---	---
Pretrial Misd.	415	33%	1700	18%	440	16%	1675	21%	2115	37%	---	---
Violator	112	9%	1425	15%	183	7%	1354	17%	330	6%	746	21%
In Transit/Writ/Hold	51	4%	805	9%	130	5%	725	9%	---	---	---	---
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Stay (in Days)	49	87	99	179	91	165	94	174	50	128	130	171
Range	1 to 1,053		1 to 2,785		1 to 2,423		1 to 2,785		1 to 2,785		1 to 1,952	
Stay by Type (Days)												
Sentenced Felony	142	159	201	232	204	228	193	230	---	---	198	229
Range	1 to 1,053		1 to 1,952		1 to 1,726		1 to 1,952		---		1 to 1,952	
Sentenced Misd.	45	48	60	77	62	71	57	75	---	---	58	74
Range	1 to 289		1 to 635		1 to 392		1 to 635		---		1 to 635	
Pretrial Felony	27	61	61	160	60	145	54	155	57	151	---	---
Range	1 to 391		1 to 2,785		1 to 2,423		1 to 2,785		1 to 2,785		---	
Pretrial Misd.	27	52	32	85	27	70	32	82	31	80	---	---
Range	1 to 430		1 to 1,526		1 to 820		1 to 1,526		1 to 1,526		---	
Violator	108	80	126	313	137	135	123	107	117	98	143	115
Range	5 to 379		1 to 918		5 to 918		1 to 852		3 to 852		1 to 918	
In Transit/Writ/Hold	153	189	221	385	113	179	236	321	---	---	---	---
Range	1 to 921		1 to 2,606		1 to 1,061		1 to 2,606		---		---	

By Booking Stay (N=10,680)	Gender N=10680				Age N=10679				Detainment Status* N=9352			
	Women		Men		YAO		25 +		Pretrial		Sentenced	
	N	%	N	%	N	%	N	%	N	%	N	%
Gang Affil. (Persons)	*979*		*6859*		*2027*		*5810*		*4221*		*2840*	
Gang Affiliated	2	<1%	448	7%	198	10%	252	4%	179	4%	167	6%
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Offense Severity (Lower More Severe)	*1251*		*9055*		*2734*		*7571*		*5745*		*3573*	
Most Serious Charge	9.0	5.1	8.6	4.9	7.1	4.1	9.3	5.1	7.9	4.3	9.1	5.7
Range	1 to 25		1 to 25		1 to 25		1 to 25		1 to 25		1 to 25	
Least Serous Charge	11.6	5.7	11.0	5.5	9.8	5.5	11.5	5.5	9.8	5.3	12.4	5.9
Range	1 to 25		1 to 25		1 to 25		1 to 25		1 to 25		1 to 25	
Most Serious Charge	*1208*		*8666*		*2665*		*7208*		*5722*		*3528*	
Person	394	33%	3216	37%	1255	47%	2355	33%	1958	34%	1525	43%
Property	189	16%	1238	14%	380	14%	1047	14%	847	15%	533	15%
Drugs	91	8%	638	7%	102	4%	626	9%	407	7%	273	8%
Public Order	64	5%	126	2%	18	<1%	172	2%	100	2%	86	2%
Other	4	<1%	79	1%	20	<1%	63	<1%	1	<1%	1	<1%
Weapons	29	2%	591	7%	268	10%	352	5%	423	7%	166	5%
Violations	157	13%	1334	15%	208	8%	1283	18%	570	10%	653	19%
Warrants	225	19%	1097	12%	382	14%	940	13%	1309	23%	2	<1%
Traffic	55	5%	347	4%	32	1%	370	5%	107	2%	289	8%
Classification Level	*777*		*6553*		*1873*		*5457*		*3443*		*2864*	
Minimum	234	30%	410	6%	62	3%	582	11%	214	7%	397	14%
Medium	505	65%	5097	78%	1398	75%	4203	77%	2761	82%	1978	69%
Maximum	38	5%	1046	16%	410	22%	674	12%	374	11%	490	17%

Percentages may not add up to 100% due to rounding.

* Individuals committed solely in transit, on a writ, or a hold were excluded from this sub-group analysis.

Table 9: Release Descriptives DOC - by Gender, Age, and Detainment Status

By Booking Stay (N=10,680)	Gender N=10680				Age N=10679				Detainment Status* N=9352			
	Women		Men		YAO		25 +		Pretrial		Sentenced	
	N	%	N	%	N	%	N	%	N	%	N	%
Released	*1265*		*9415*		*2784*		*7895*		*5747*		*3605*	
Not Yet Released	99	8%	1585	17%	391	14%	1293	16%	391	11%	635	18%
Released	1166	92%	7830	83%	2393	86%	6602	84%	5356	89%	2970	82%
Release Status	*1150*		*7796*		*2393*		*6562*		*5311*		*2965*	
Self-Custody	667	58%	4298	55%	1307	55%	3658	56%	2993	56%	1723	58%
US Marshal or FBOP	83	7%	1684	22%	495	21%	1271	20%	358	7%	1049	36%
DC Metro/Fugitive	172	15%	1044	13%	370	15%	846	13%	1074	20%	110	4%
Other Jurisdiction/ICE	77	7%	320	4%	122	5%	275	4%	356	7%	25	<1%
Treatment Program	126	11%	359	5%	67	3%	418	6%	417	8%	56	2%
Other/Saint Elizabeth's	25	2%	91	1%	22	<1%	94	1%	113	2%	2	<1%
Released Self-Custody	*656*		*4296*		*1305*		*3658*		*2991*		*1723*	
Court Order	409	61%	2375	55%	887	68%	1897	52%	2635	88%	57	3%
Time Served	230	35%	1609	38%	374	29%	1465	40%	174	6%	1538	89%
Parole	15	2%	235	5%	25	2%	225	6%	106	4%	117	7%
Bond Out	10	1%	46	1%	14	1%	41	1%	51	2%	4	<1%
Other	3	<1%	31	<1%	4	<1%	30	<1%	25	1%	7	<1%
Facility Released From	*1166*		*7830*		*2393*		*6602*		*5356*		*2958*	
CDF/CTF	771	66%	5894	76%	1703	71%	4961	76%	3129	58%	2870	97%
DC Superior Court	179	15%	750	10%	210	9%	719	11%	907	17%	17	<1%
Halfway Houses	41	4%	258	3%	82	3%	217	3%	253	5%	44	2%
St. Elizabeth's	44	4%	120	1%	28	1%	136	2%	160	3%	2	<1%
Court Order DOC Hold	130	11%	800	10%	369	15%	561	8%	905	17%	19	1%
Other	1	<1%	8	<1%	1	<1%	8	<1%	2	<1%	6	<1%

By Booking Stay (N=10,680)	Gender N=10680				Age N=10679				Detainment Status* N=9352			
	Women		Men		YAO		25 +		Pretrial		Sentenced	
	N	%	N	%	N	%	N	%	N	%	N	%
Final Security Level	*1166*		*6190*		*1815*		*5081*		*3562*		*2721*	
Minimum	252	36%	646	10%	99	5%	799	16%	306	9%	546	20%
Medium	433	61%	4846	78%	1426	78%	3852	76%	2952	83%	1856	68%
Maximum	22	3%	698	11%	290	16%	430	8%	304	8%	319	12%

Percentages may not add up to 100% due to rounding.

* Individuals committed solely in transit, on a writ, or a hold were excluded from this sub-group analysis.

Profile of DOC Population in Halfway House Facilities

There are three halfway houses (HWH) where the DOC maintains custody of inmates and detainees. Of the 295 unique individuals whose last jail location was a halfway house,[36] 129 (44%) were housed in Hope Village; 111 (38%) in Extended House, and 41 (14%) were in Fairview. Fourteen more (4%) were categorized as escapes or abscond without the name of the facility). Note that most of the information provided for the entire DOC custodial population in the prior tables is provided in a single table (Table 10) for those placed in a halfway house.

With few exceptions, those in HWH are similar to those housed in the DOC facility (see Table 1 through Table 4). Those in HWH are less racially diverse (94% are Black), and are less likely to have an active medical[37] (23% of HWH participants vs. 31% of DOC inmates) or mental health need (6% vs. 11%). In terms of offense history,[38] there are only a few differences. Those who participated in HWH have fewer prior drug convictions (2.2 vs. 2.7) commit a higher proportion of their crimes in the District (78% vs. 74%) than others in the DOC population.

In terms of incarceration experience, the majority (85%) of those sent to halfway houses are on pretrial status – with 50% charged with felony offenses and 35% charged with misdemeanor offenses. Among those sentenced, all but 1 were a sentenced misdemeanant. Reviewing the most serious current charge offense severity, those in halfway house have a more severe charge on average than those maintained in the DOC. On average, the offense severity averages 7.4 for HWH participants, vs. 8.7 among DOC. (Again, the lower the number, the more severe the offense). In addition, the higher percentage of the person crime as the most serious offense amongst the HWH participants – 50% vs. 37% of DOC and that most of those in HWH are pretrial (which when compared to the sentenced population overall also have a higher offense severity level (see Table 8). Despite this, a greater proportion of those in the HWH were classified as minimum security initially than those in the DOC (10% vs. 6%). At the point of release, among the 301 bookings housed in halfway houses, 299 were released. Most were released as self-custody (94%) on a court order (83%) or time served (17%). The differences are driven by how individuals are placed into HWH facilities. Pretrial HWH commitments are court ordered, and sentenced commitments are voluntary, among those who meet HWH criteria.[39]

In summary, while DOC custodial populations housed in halfway houses are more often on pretrial status, and are of lower security classification than those in DOC, given that there are so few differences between those in HWH and those secured in DOC, this may indicate an opportunity for additional utilization of HWH facilities, if space were available. The advantage of a HWH setting is that individuals, while still under custodial control, are able to receive community based services as well as seek, obtain, and/or maintain employment that can extend without interruption into their return to the community.

[36]In some cases, individuals released from a halfway house had a separate booking stay in the jail that did not include a HWH. The HWH profile summarizes only data related to the HWH stay.

[37]The medical, mental health and substance abuse indicators are captured as either yes or no, so any active conditions could have occurred during any portion of the stay – including any period when the individual was housed at DOC CTF or CDF facilities.

[38]Not listed in Table 10 but available upon request.

[39]Reena Chakraborty, Ph.D., Chief of Strategic Planning and Analysis, D.C. Department of Corrections, Personal Communication, September 22, 2017.

Table 10: Descriptives – Halfway House DOC Inmates

By Unique Persons (N=295) or Booking Stay (N=301)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Demographics					
Gender	295				
Male		254	86%		
Female		41	14%		
Race/Ethnicity	295				
Black		278	94%		
White		5	2%		
Hispanic		10	3%		
Asian		0	0%		
Other		2	<1%		
Average Age at Release	295			18 to 74	34.7 (12.9)
Age by Category	295				
17 to 24 Years Old		82	28%		
25 to 30		58	20%		
31 to 35		37	13%		
36 to 40		26	9%		
41 to 45		22	7%		
46 to 50		25	9%		
51 to 55		22	8%		
56 to 60		14	5%		
61 and older		9	3%		
Parental Status	257				
Have Children		149	58%	1 to 18	2.4 (2.0)
No Children		108	42%		
Home Zip/State	293				
DC		240	82%		
MD		46	16%		
VA		4	2%		
Other		3	1%		
Education Status	254				
No High School Diploma/GED		103	41%		
GED		49	20%		
High School Diploma		91	36%		
Some College		2	1%		
Tech or Trade School		9	4%		

By Unique Persons (N=295) or Booking Stay (N=301)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Employment Status	254				
Employed		117	46%		
Not Employed		137	54%		
Education & Employment	254				
Employed, No GED/HS	117	28	24%		
Employed, Has GED/HS		89	76%		
Not Employed & No GED/HS	137	75	55%		
Not Employed & Has GED/HS		62	45%		
Physical & Mental Health					
Physical Health	295				
Medical Condition Indicator		68	23%		
No Medical Condition Indicator		227	77%		
Mental Health	295				
Mental Illness Indicator		17	6%		
No Mental Illness Indicator		278	94%		
Substance Abuse	295				
Substance Abuse Indicator		9	3%		
No Substance Abuse Indicator		286	97%		
Incarceration Experience					
Type of Stay	301				
Sentenced Felony		1	<1%		
Sentenced Misdemeanor		44	15%		
Pretrial Felony		148	50%		
Pretrial Misdemeanor		107	35%		
Parole/Probation Violator		1	<1%		
Number Stays	295			1 to 5	1.5 (.77)
One		196	66%		
Two		67	23%		
Three or More		32	11%		
Average Stays 2 or More	99			2 to 5	2.41 (.67)
Length of Stay (in Days)	301			5 to 2142	90 (149)
Length of Stay Category	301				
1 to 30 days		84	28%		
31 to 90 Days		131	43%		
91 to 180 Days		26	9%		
181 Days to 1 Year		25	8%		

By Unique Persons (N=295) or Booking Stay (N=301)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
1 Year to 18 Months		27	8%		
18 Months and More		8	3%		
Gang Affiliation	295				
Gang Affiliation		13	4%		
No Known Affiliation		282	96%		
Offense Severity (Lower = More Serious)	301				
Most Serious Charge				1 to 25	7.4 (4.6)
Least Serous Charge				1 to 25	9.2 (5.6)
Most Serious Current Charge	299				
Person		150	50%		
Property		62	21%		
Drugs		32	11%		
Public Order		7	2%		
Other		0	0%		
Weapons		23	8%		
Violations		18	6%		
Warrants		0	0%		
Traffic		7	2%		
Initial Security Level	234				
Minimum		24	10%		
Medium		187	80%		
Maximum		23	10%		
Unit Based Programs	295				
RSAT		2	<1%		
Reentry		1	<1%		
Population Lacking GED	103				
GED		0	0%		
Release Experience					
Released	301				
Not Yet Released		2	<1%		
Released		299	99%		
Releases by Month/Year	299				
Oct 2014		29	10%		
Nov 2014		21	7%		
Dec 2014		31	10%		

By Unique Persons (N=295) or Booking Stay (N=301)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Jan 2015		24	8%		
Feb 2015		24	8%		
Mar 2015		19	6%		
Apr 2015		30	10%		
May 2015		28	9%		
Jun 2015		33	11%		
July 2015		32	11%		
Aug 2015		16	5%		
Sep 2015		12	4%		
Release Status	299				
Self-Custody		281	94%		
US Marshal or FBOP		2	<1%		
DC Metro/Fugitive		1	<1%		
Other Jurisdiction/ICE		0	0%		
Treatment Program		3	1%		
Other/Saint Elizabeth's		0	0%		
Escape		12	5%		
Released Self-Custody	281				
Court Order		233	83%		
Time Served		48	17%		
Parole		0	0%		
Bond Out		0	0%		
Other		0	0%		
Final Security Level	280				
Minimum		29	10%		
Medium		227	81%		
Maximum		24	9%		

Returning Citizens from the Federal Bureau of Prisons

As FBOP inmates were formerly incarcerated in a prison – not in a jail – we anticipated that the needs and histories of these inmates may vary in substantial and significant ways from a jail population. For example, those returning from prison facilities have served longer sentences than jail detainees/inmates; with commensurate differences in the crimes for which they were convicted. Given this longer length of stay, FBOP prisoners have more opportunity to participate in GED/Education and/or substance abuse treatment programs than jail inmates. Understanding how these two populations differ is an important component of this project. This will be particularly important if the jail is to house eligible FBOP inmates in their last 6 months in the District of Columbia Department of Corrections (DOC) and in the Residential Reentry Centers (RRC).

Methodology

In order to gain this comprehensive understanding of the FBOP custodial population, we included analysis of a release cohort of FBOP inmates returning to the District of Columbia in FY2015. JRSA filed a data research application with FBOP in late November 2016; our application was approved in mid-December and data were received in early February 2017.

The data set received consisted of inmates who were released in FY2015 and had a release address in Washington, DC.[40] There are 2,114 observations (representing 2,108 unique persons) and 31 variables including demographics (age at release, race, sex, ethnicity, citizenship) and information on General Equivalency Diploma (GED) status (if needed, earned, or had prior to admission). FBOP also provided medical and mental health care levels at the time of release (based on a scale of 1 to 4, with 1 indicating no significant current issues and 4 noting a more urgent health need).[41] Confinement variables included sentence start date, actual release date, release method, detainer indicator, term of sentence, term of supervision, commitment date, court of jurisdiction, offense category, security level at time of release, and release facility.

Demographics

As indicated in Table 11 below, the majority of 2,108 Federal prisoners returning to the District of Columbia from October 1, 2014 to September 30, 2015 were African American (92%) and male (92%). These individuals were on average 38 years old, ranging from 17 to 79 years old. Age at release was also broken into categories of 17 to 24, 25 to 30, 31 to 35 years old, and so on. Among those released from FBOP in this period, 277 (or 13%) were from the ages of 18 to 24 – often referred to as "Young Adult Offenders" (YAO). FBOP also included information on education status as well as the mental and physical health condition upon release. More than half

[40]FBOP staff noted in the data description that the "criteria is different from numbers provided in the past that are based on Court of Jurisdiction (FDCS/FDCD)."

[41]There were also 2 screening categories which were to be replaced with a medical care assignment after a medical examination (Office of Research and Evaluation, personal communication, February 23, 2017). Given the preliminary nature of these screening designations, we omitted these categories from our discussion of the physical and mental health needs of FBOP returning citizens.

(58%) of those returning from FBOP either had a GED or high school diploma or earned a GED while incarcerated. The remaining 42% needs a GED.[42]

As noted above, with respect to the physical health conditions of returning citizens, the data categorized individuals into one of 4 levels[43] where a level 1 indicated no current significant issues, level 2 indicated someone was in recovery from a recent physical ailment (e.g., cancer patients who had been in remission for less than 2 years); level 3 indicated an ongoing physical impairment that was extensively monitored (e.g., partial remission from a cancer diagnosis); and level 4 indicating active treatment (e.g., receiving chemotherapy or radiation) where the individual required daily nursing care or therapy. For the 1,721 individuals returning with a medical designation, most (66%) were a level 1 with no significant physical health issues. A third (32%) were level 2 with a recently resolved issue; and 2% were either a level 3 (N=22) or level 4 (N=5) – indicating a need for mid to high level intensive treatment services.

For identifying mental health needs, a similar categorization scheme is utilized. Those with a level 1 mental health designation indicated no significant impairment or history of serious impairment. For those that had mental health issues in the past, these individuals seek help in order to respond to issues as they arise. The vast majority of the 1,680 individuals with mental health designation fall into this category – 1,521 or 90%. For a level 2, individuals with a mental illness engage in routine services and/or receive intensive services when in a crisis (e.g., placed on suicide watch); 142 (or 9%) of FBOP returning citizens require level 2 services. Finally, 17 (or 1%) fall into either a level 3 category (whereby the receive a higher frequency of services (e.g., weekly) or receiving inpatient services in a residential psychological program (N=13) or level 4, whereupon the individual is nonfunctional in either the general population or a level 3 residential inpatient setting (N=4).

While not listed in Table 11, we also looked at the intersection of the number of individuals with both physical and mental health need designations (N=1,587) and we see that most (64%) had neither a physical or mental health issue upon release. Another 26% had a level 2 physical health issue, but no mental health concerns identified. The remaining 11% had physical and/or mental health needs that will likely require assistance upon returning to the community.

[42]FBOP staff advised that "Needs GED is the term BOP uses to capture anyone who does not have a GED, including those who may still need basic education, ESL, or have other issues that prevent GED completion". (Office of Research and Evaluation, personal communication, September 20, 2017).

[43]See summary from the District of Columbia's Corrections Information Council for more details: https://cic.dc.gov/sites/default/files/dc/sites/cic/page_content/attachments/BOP%20Medical%20Care%20Levels%205.17.17.pdf

Finally, data was provided for 346 individuals with a drug treatment program (DAP) assignment at release.[44] Of those 346, a third (33%) completed DAP prior to release, 15% began but did not complete the program; and 15% were eligible but declined to participate. The remaining (37%) were not qualified for participation in DAP, which requires program candidates to report a history of substance abuse.

Nonetheless, participation, completion and/or a referral to the DAP program for screening (even those ineligible under FBOP requirements) may indicate a need for substance abuse treatment upon release.[45] Options can range from residential treatment to aftercare or outpatient services in the community and/or participation in community based peer support organizations (e.g., 12 step groups such as Alcoholics Anonymous or Narcotics Anonymous).

Table 11: Demographics FBOP Returning Citizens

	Released from October 1, 2014 to September 30, 2015				
	N	**Freq.**	**Percent**	**Range**	**Mean (SD)**
Gender	2108				
Male		1,943	92%		
Female		165	8%		
Race/Ethnicity	2108				
Black		1,949	92%		
White		109	5%		
Hispanic		33	2%		
Other		17	<1%		
Average Age at Release	2108			17 to 79	38.35 (12.01)
Age by Category	2108				
17 to 24 Years Old		277	13%		
25 to 30		383	18%		
31 to 35		341	16%		
36 to 40		279	13%		
41 to 45		191	9%		
46 to 50		223	11%		
51 to 55		219	10%		

[44]Based on FBOP Policy P5330.11 there are three types of drug treatment interventions available, including a Drug Education Program (DRUG ED), a non-residential Drug Abuse Program (NR DAP) and a Residential Drug Abuse Program (RDAP). The eligibility criteria for participation in RDAP include those that who do not have a detainer, are not immigration offenders, and must be sentenced to at least 24 months to participate. https://www.bop.gov/policy/progstat/5330_011.pdf. If one were to only consider those who meet these requirements, the number of eligible participants are reduced to 823 (39%) of the cohort. In addition, while data notes indicate that approximately 25 of the 346 participated or completed a RDAP, there was some ambiguity as to whether all of those with a DAP assignment at release were referring to RDAP or the NR DAP program. Therefore, we err on the side of caution and simply present those who were eligible for DAP, regardless of degree of participation or completion, as an indicator of a need for substance abuse treatment upon release.

[45]Also, those sentenced for drug offenses may also require substance abuse treatment upon release. Looking at the individuals with a DAP status, the majority (63% -- 169 of 346) were serving time for a drug offense.

	Released from October 1, 2014 to September 30, 2015				
	N	**Freq.**	**Percent**	**Range**	**Mean (SD)**
56 to 60		118	6%		
61 and older		77	4%		
Education Status	2035				
Has GED/Diploma		939	46%		
Earned GED at FBOP		252	12%		
No GED		844	42%		
Physical & Mental Health	2108				
Physical Health	1721				
Level 1 – No Significant Issues		1144	66%		
Level 2 – Past Issues, Resolved		550	32%		
Level 3 & 4 – Ongoing/Serious		27	2%		
Mental Health	1680				
Level 1 – No Significant Issues		1521	90%		
Level 2 – Routine or Crisis		142	9%		
Level 3 & 4 –Intensive/Inpatient		17	1%		
Drug Program (DAP)	346				
Completed DAP		114	33%		
Partial Completion		53	15%		
Eligible, Declined/No Interest		51	15%		
Not Qualified		128	37%		

Percentages may not add up to 100% due to rounding.

Offense and Incarceration Experience

Offense and incarceration descriptors are provided in Table 12 below. Areas explored include court jurisdiction, governing offense, sentence and length of stay, security classification level at release, and institutional infraction history.

The majority of those serving time in FBOP and returning to live in DC post release were sentenced in either DC Superior or District Court (1,806 of 2,108 or 86%), while another 10% were sentenced from Maryland or the Virginia Eastern District Courts. The earliest sentence date was September 6, 1977; the latest was August 5, 2015.

FBOP offense data was provided in 12 categories which, for ease of presentation, were collapsed into 6 offense types of person, sex, drugs, property, weapons and other offenses. For example, the 263 individuals serving time for homicide/aggravated assault were combined with 317 people convicted of robbery into the person offense type category. Likewise, those serving time for burglary/larceny (N=214) and for counterfeiting and embezzlement (N=3) were categorized with those serving time for fraud, bribery and extortion (N=82) to collapse these offenses as property offenses. As indicated below in Table 12, prisoners returning to DC were incarcerated for a

variety of offenses, but most frequently for drug crimes (780 of 2108 or 37%); followed by person offenses (580 or 28%); and weapons charges (256 or 12%).

Sentence length was computed into days and presented three ways:

1) "Sentenced Imposed" – which is the length of time the court sentenced the individual, (excluding 32 life sentences);
2) "FBOP Commitment to Release" the amount of time actually served in FBOP (calculated from the date the individual was committed to FBOP to the release date); and
3) "Sentenced Served" are the number of days served from the sentence start to the release date (so may include time spent in DOC or other non-FBOP facilities).

On average, with prisoners returning to DC with sentences ranging from 3.5 to 75 years served a little over 2 years at FBOP (ranging from 9 days to 29 years); with an average sentence served for their offenses of 2.5 years (ranging from 24 days to 37 years). The FBOP data also included final security classification prior to release. The data indicate that half of those returning to DC were classified at a medium security level, while 15% were high, 24% were low, and 11% were in the minimum classification levels.

The final measure of incarceration experience was an indicator of compliance while in custody in the form of the number of times individuals were found guilty of committing "prohibited acts" – or infractions. Prohibited Acts are categorized by 4 levels with level 100 indicating the most serious infraction and level 400 as least serious. For example, a level 100 infraction of the "greatest severity" runs the gamut from homicide and sexual assault and rioting to the making or use of narcotics. A level 200 classified as "high severity" includes threatening bodily harm, bribing staff, stealing, and tattooing. A level 300 offense is of "medium severity" and includes possession of money without authorization, refusing to obey an order or insolence, and circulating a petition. Finally, a level 400 infraction a "low severity" offense, consists of issues such as feigning illness, and using abusive or obscene language (see Appendix A for additional examples of each infraction level).

While not a substitute for conducting a risk needs assessment tool upon release, this information – particularly those with a more robust infraction history - may provide some guidance as to the number of returning citizens who may have more difficulties adjusting to returning home. Overall, the 2,108 FBOP prisoners averaged 1.81 custodial infractions while incarcerated (within a range of 0 to 103 infractions) over their stay in the facility. However, the majority (57%) were "infraction free" – having no guilty findings for any infractions. The remaining 914 individuals had a varied record – on average having 4 guilty findings from a range of 1 to 103[46]; and engaging in 1.59 different types of infractions among the 4 categories. This variety of activity is also evident by the number of individuals engaged in the each of different levels of infractions – 278 individuals had 1.43 infractions of the greatest severity (ranging from 1 to 8 infractions); 425 had from 1 to 70 high severity infractions, with an average of 2.54 infractions; and 727 had on average 3.16 medium severity within a range of 1 to 42. Only 30 inmates were found guilty of the lowest level infraction with an average of 1.12 within a range of 1 to 2 infractions.

[46]Having a higher number of infractions is significantly related to longer length of stay. Those with 5 or fewer infractions were in FBOP on average 1,046 days compared to 2,154 days for those 6 or more infractions ($p<.000$).

We also reviewed the total number of infractions among those with 1 or more infractions (N=914) to identify those with higher numbers of infractions. Two-thirds (66%) have between 1 to 3 infractions; with another 16% have between 4 and 5 infractions. Thus, approximately 18% (or 166 individuals) had 6 or more infractions, with 9 individuals identified as outliers with 30 or more infractions. Of the 166 with more than 5 infractions, most (129 of 166 or 78%) were classified as medium and high security levels at release.

Table 12: Incarceration Descriptives - FBOP Returning Citizens

	Released from October 1, 2014 to September 30, 2015				
	N	**Freq.**	**Percent**	**Range**	**Mean (SD)**
Court Jurisdiction	2108				
DC Superior or District		1806	86%		
Maryland/Eastern Virginia		217	10%		
Other		85	4%		
Types of Offense	2108				
Person		580	28%		
Sex		48	2%		
Drugs		780	37%		
Property		299	14%		
Weapons		256	12%		
Other		145	7%		
Sentence Imposed (in Days) (Excludes 32 Life Sentences)	2076			30 to 27375	1290 (2022)
Length of Stay (in Days)					
FBOP Commitment to Release	2108			9 to 10643	777 (1147)
Sentence Start to Release	2108			24 to 13853	950 (1410)
Final Security Level	2108				
High		313	15%		
Medium		1051	50%		
Low		508	24%		
Minimum		236	11%		
Infractions - # Guilty Findings	2108				
Average # Infractions - All				0 to 103	1.81 (5.2)
Infraction Free		1194	57%		
1 or More Infractions		914	43%	1 to 103	4.1 (7.2)
Among those with 1 or More	914				
1 to 5 Infractions		748	82%		
6 or More Infractions		166	18%		

Infractions by Type	914*			1 to 4	1.59 (.7)
Level 100 – Greatest Severity		278		1 to 8	1.43 (.9)
Level 200 – High Severity		425		1 to 70	2.54 (5.3)
Level 300 – Medium Severity		727		1 to 42	3.16 (4.0)
Level 400 – Low Severity		30		1 to 2	1.17 (.4)

Percentages may not add up to 100% due to rounding.
**Note: Total will exceed N (number of prisoners), as have more than 1 type of infraction.*

Release Status

Table 13 details the release status for FBOP inmates returning to the community. Almost half (48%) are released with a status of "good conduct", while another 38% are released at the expiration of their sentence, mandatory release, or time served. A small portion are released on parole (10%) and 4% are released from substance abuse treatment. However, 7% (148 of 2108) have a detainer from another jurisdiction that impedes their release back to the community. Specifically, among the 1023 released on good conduct, 66% (98) released on good conduct have a detainer, as do 26% (39 of 793) of those released at the expiration of their sentence. A few (11 or 7%) released on parole also have a detainer. Upon release, 76% who received supervision as part of their sentence will be under supervision for 4 years.[47]

One key area of interest is understanding how far away DOC inmates are housed in FBOP facilities over the period of their incarceration. While FBOP tries to retain DC prisoners in facilities within 500 miles of the District[48], nonetheless, they could be in any location nationwide. Unfortunately, we are unable to answer that question. The data provided by FBOP identified the release facility, but they were unable to provide any information prior to that final facility due to data limitations.[49]

Nonetheless, we present the top dozen facilities from where FBOP inmates were released, based on the number from each facility and ordered by distance of the facility from DC. As indicated below in Table 13, the majority of FBOP inmates (59%) return through the DC CCM (Community Corrections Management) facility. CCM offices oversee returning citizens in Reentry Resource Centers (RRC) – also commonly referred to as "halfway houses" - such as Hope Village and Fairview; in jails, juvenile facilities, administrative offices, and home confinement. We had hoped to disaggregate the number released to the DC CCM by type of community corrections setting and cross reference that information with other FBOP data, however, the CCM designation information was not provided in the individual level dataset. However, FBOP provided a summary of the information and we include the figure provided in Appendix B. Based on that information, among the 1,246 adult FBOP inmates returning to the DC CCM, we see that 51% (N=637) were released via RRC; 32% (N=401) through the jail; 17% (N=206) home confinement, and 2 individuals were administratively released.

[47]Among the 1,610 sentenced to supervision, 171 were released on parole.
[48]https://www.bop.gov/inmates/custody_and_care/designations.jsp
[49]FBOP staff advised "it would be very difficult to try to go back and determine where the individuals in this release cohort spent their incarceration … they could have and most certainly did spend their time in multiple facilities in the BOP." (Office of Research and Evaluation, personal communication, February 28, 2017).

An important limitation to this report is that we were unable to obtain any data on the RRCs. Thus, beyond the information provided by the FBOP noted above (and similar release facility information in the DOC dataset[50]) we know little about the experiences of FBOP returning citizens engaged in these facilities.

Table 13: Release Descriptives - FBOP Returning Citizens

	Released from October 1, 2014 to September 30, 2015				
	N	**Freq.**	**Percent**	**Range**	**Mean (SD)**
Total # of Unique Cases	2108				
Release Status	2108				
Good Conduct		1023	48%		
Full Term, Mandatory		793	38%		
Parole		200	10%		
Substance Abuse Treatment		92	4%		
Detainer Upon FBOP Release	2108	148	7%		
Released on Supervision	2108	1610	76%		
Supervision Term (in Months)	1609			0 to 666	48.8 (53.1)
Facility Released From (Top 12 – Distance and Freq.)	2108			**Distance (Miles)**	
District of Columbia CCM		1246	59%	0	
Baltimore CCM (MD)		92	4%	22	
Petersburg Med FCI (VA)		31	1%	133	
Cumberland FCI (MD)		41	2%	137	
Fairton FCI (NJ)		46	2%	142	
Hazelton USP (PA)		61	3%	178	
Allenwood Med FCI (PA)		22	1%	203	
Rivers CI (NC)		97	5%	215	
Raleigh CCM (NC)		141	7%	250	
Canaan USP (PA)		25	1%	261	
Gilmer FCI (WV)		51	2%	291	
Beckley FCI (WV)		22	1%	315	
All Others		233	11%	Varies	

Percentages may not add up to 100% due to rounding.

[50]As the DOC data includes Fairview and Hope Village as release facilities, we can examine descriptors of those who are released from these facilities while in DOC custody. However, DOC did not provide information beyond the moment of release from DOC custody.

Profiles of FBOP Returning Citizens by Gender and Age

To begin to differentiate the needs of specific offender populations, we looked at demographic, offense, incarceration experiences, and release status within the cross-sections of gender and young adult offenders vs. older adults for the FBOP returning population. The following profiles summarize the information detailed on Table 14, Table 15, and Table 16 by subgroup.

Gender

There were 165 women released from FBOP in this period compared to 1,943 men. On average, women were older than men (40.9 vs 38.1), and were more racially diverse (e.g., 16% white compared to 4% of male FBOP inmates). In terms of educational background, women and men were equally likely to enter the facility with a GED or high school diploma (45% and 46% respectively) but women were less likely to earn a GED while incarcerated at FBOP (7% vs. 13% of men). This may be in part due to the fact that women have shorter length of stays (2 versus 3 years) and/or that women have more physical and/or mental health needs than the men. For example, observing the physical health levels results we see that 68% of male inmates have no significant physical health issues and 92% have no significant mental health issues. In contrast, 49% of women have no significant physical issues and 78% have no significant mental health issues.

We see differences in offense types by gender as well. Women are less likely to have served time at the FBOP for a person offense (19% vs. 28% of men) and are more likely incarcerated for a drug or property offense (47% and 24% respectively). Women are also more likely to be infraction free (75% vs. 55% of men), although among those with at least 1 infraction, there appears to be gender parity.

While equal numbers of men and women are released on good conduct, more women are placed on supervision post-release than men (86% vs. 76%). Looking specifically at release facilities, among the 165 women released from FBOP, the majority (75%) were released to the DC CCM (compared to the men with 58% released from DC CCM). There were also 25 women released from facilities categorized as "other". We explored this category specifically for women and found that the women were released from the following facilities:

- Philadelphia FDC (PA) 11 of 25 (44%);
- Carswell FMC (TX) 5 of 25 (20%)
- Alderson FPC (WV) 4 of 25 (16%)
- Brooklyn MDC (NY) 3 of 25 (12%)
- Hazelton FCI (WV) and Tallahassee FCI (FL) – 1 from each.

Overall, the gender differences for those released from FBOP are consistent with the extant literature. Women tend to be older, experience shorter stays, are less likely to be violent offenders and have a higher degree of need for medical and psychological services than men.

Young Adult Offenders vs. Older Adults

Of the FBOP returning citizens, 277 (or 13%) were young adult offenders (YAO) at the time of their release. Most YAOs were male (96% vs. 92% of non-YAOs) and more likely to be Black than non-YAOs (97% vs. 92%). Not surprisingly, there are substantial differences in education status at release. Upon entering FBOP, only 20% of YAOs had a GED or high school diploma compared to 50% of non-YAOs; however, there was little difference in the percentage who earned their GED while incarcerated at FBOP. Therefore, a much higher proportion of YAOs require a GED than non-YAOs (65% vs. 38%).

In terms of differences in types of offenses and release status, YAOs are almost twice as likely to be incarcerated in FBOP for a person offense as non-YAOS (52% vs. 24%). They are also less likely to be infraction free – only 42% versus 59% of older adults. Finally, none of the YAOs were released on parole compared to 11% of older adults.[51] However, while none will be on parole, of the 277 YAOs, 200 (or 72%) were sentenced to supervision upon release.

[51]While parole was abolished for Federal inmates under the Sentencing Reform Act of 1984, DC offenders remain eligible for parole through the U.S. Parole Commission.

Table 14: Demographics FBOP - by Gender and Age

	N	Gender				Age			
		Women		Men		YAO (18 to 24)		Adult (25 +)	
		N	%	N	%	N	%	N	%
Overall	*2108*	*165*	*8%*	*1943*	*92%*	*277*	*13%*	*1831*	*87%*
Gender	2108								
Male		0	0%	1943	100%	267	96%	1676	92%
Female		165	100%	0	0%	10	4%	155	8%
Race/Ethnicity	2108								
Black		128	78%	1821	94%	270	97%	1679	92%
White		27	16%	82	4%	3	1%	106	6%
Hispanic		4	2%	29	1%	2	<1%	31	2%
Other		6	4%	11	1%	2	<1%	15	<1%
Age at Release	2108	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
		40.9	10.5	38.1	12.10	22.1	1.6	40.81	10.9
Age Range	2108	19 to 65		17 to 79		17 to 24		25 to 79	
Age by Category	2108	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
17 to 24 Years Old		10	6%	267	14%	277	100%	0	0%
25 to 30		19	12%	364	19%	0	0%	383	21%
31 to 35		26	16%	315	16%	0	0%	341	19%
36 to 40		25	15%	254	13%	0	0%	279	15%
41 to 45		22	13%	169	9%	0	0%	191	10%
46 to 50		32	19%	191	10%	0	0%	223	12%
51 to 55		19	12%	200	10%	0	0%	219	12%
56 to 60		7	4%	111	6%	0	0%	118	6%
61 and older		5	3%	72	4%	0	0%	77	4%
Education at Release	*2035*	*155*	*8%*	*1880*	*92%*	*246*	*12%*	*1789*	*88%*
Has GED/Diploma		70	45%	869	46%	50	20%	889	50%
Earned GED at FBOP		10	7%	242	13%	35	14%	217	12%
Lacks GED		75	48%	769	41%	161	65%	683	38%

	N	Gender				Age			
		Women		Men		YAO (18 to 24)		Adult (25 +)	
		N	%	N	%	N	%	N	%
Physical Health	*1721*	*140*	*8%*	*1581*	*92%*	*194*	*11%*	*1527*	*89%*
Level 1 – No Significant Issues		68	49%	1076	68%	168	86%	976	64%
Level 2 – Past Issues, Resolved		66	47%	484	31%	25	13%	525	34%
Level 3 & 4 – Ongoing/Serious		6	4%	21	1%	1	<1%	26	2%
Mental Health	*1680*	*148*	*9%*	*1532*	*91%*	*220*	*13%*	*1460*	*87%*
Level 1 – No Significant Issues		115	78%	1406	92%	208	94%	1313	90%
Level 2 – Routine or Crisis		28	19%	114	7%	10	5%	132	9%
Level 3 & 4 – Intensive/Inpatient		5	3%	12	1%	2	1%	15	1%
Drug Program (DAP)	*346*	*31*	*9%*	*315*	*91%*	*23*	*7%*	*323*	*93%*
Completed DAP		12	39%	102	32%	4	17%	110	34%
Partial Completion		3	2%	50	16%	4	17%	49	15%
Eligible, Declined/No Interest		3	2%	48	15%	5	22%	46	14%
Not Qualified		13	42%	115	37%	10	43%	118	37%

Percentages may not add up to 100% due to rounding.

Table 15: Incarceration Descriptives FBOP – By Gender and Age

	N	Gender				Age			
		Women		Men		YAO (18 to 24)		Adult (25 +)	
		N	%	N	%	N	%	N	%
Overall	*2108*	*165*	*8%*	*1943*	*92%*	*277*	*13%*	*1831*	*87%*
Types of Offense	2108								
Person		31	19%	549	28%	145	52%	435	24%
Sex		0	0%	48	2%	4	1%	44	2%
Drugs		78	47%	702	36%	36	13%	744	41%
Property		39	24%	260	13%	34	12%	265	14%
Weapons		1	<1%	255	13%	42	15%	214	12%
Other		16	10%	129	7%	16	6%	129	7%
Length of Stay (Days)	2108	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Sentence to Release		644	800	976	1447	548	472	1011	1492
Range		54 to 3,754		24 to 13,853		52 to 2,584		24 to 13,853	
Final Security Level	2108								
High		0	0%	313	16%	35	13%	278	15%
Medium		0	0%	1051	54%	207	75%	844	46%
Low		99	60%	409	21%	31	11%	477	26%
Minimum		66	40%	170	9%	4	1%	232	13%
Infractions - # Guilty	2108								
Infraction Free		124	75%	1070	55%	115	42%	1079	59%
1 or More Infractions		41	25%	873	45%	162	58%	752	41%
Among those with 1 or More	914								
1 to 5 Infractions		35	85%	713	82%	131	81%	617	82%
6 or More Infractions		6	15%	160	18%	31	19%	135	18%

Percentages may not add up to 100% due to rounding.

Table 16: Release Descriptives FBOP – By Gender and Age

	N	Gender				Age			
		Women		Men		YAO (18 to 24)		Adult (25 +)	
		N	%	N	%	N	%	N	%
Overall	*2108*	*165*	*8%*	*1943*	*92%*	*277*	*13%*	*1831*	*87%*
Release Status	2108								
Good Conduct		75	45%	948	49%	133	48%	890	49%
Full Term, Mandatory		75	45%	718	37%	142	51%	651	35%
Parole		3	2%	197	10%	0	0%	200	11%
Substance Abuse Treatment		12	7%	80	4%	2	1%	90	5%
Detainer Upon Release	2108	2	1%	146	7%	22	8%	126	7%
On Supervision	2108	141	86%	1469	76%	200	72%	1410	77%
Facility Released From	2108								
District of Columbia CCM		124	75%	1122	58%	159	57%	1087	59%
Baltimore CCM (MD)		2	1%	90	5%	2	1%	90	5%
Petersburg Med FCI (VA)		0	0%	31	2%	5	2%	26	1%
Cumberland FCI (MD)		0	0%	41	2%	11	4%	30	2%
Fairton FCI (NJ)		0	0%	46	2%	10	4%	36	2%
Hazelton USP (PA)		8	5%	53	3%	4	1%	57	3%
Allenwood Med FCI (PA)		0	0%	22	1%	4	1%	18	1%
Rivers CI (NC)		0	0%	97	5%	6	2%	91	5%
Raleigh CCM (NC)		6	4%	135	7%	28	10%	113	6%
Canaan USP (PA)		0	0%	25	1%	1	1%	24	1%
Gilmer FCI (WV)		0	0%	51	3%	15	5%	36	2%
Beckley FCI (WV)		0	0%	22	1%	3	1%	19	1%
All Others		25	15%	208	11%	29	11%	204	11%

Percentages may not add up to 100% due to rounding

Sentenced DOC Population vs. FBOP Returning Citizens

A jail population differs from a prison population in important ways. As evidenced in the discussion that describes those in DOC custody over the study period, this is a diverse group based on a variety of demographic, criminal history, incarceration and release circumstances. However, to complete this section of the report, we focus on comparing the 3,172 individuals sentenced to DOC (based on information contained in Table 6 through Table 9) to the 2,108 returning from FBOP (based on data in Table 11 through Table 16).

Looking at demographics, DOC sentenced inmates are similar to FBOP returnees with respect to race and gender. However, FBOP inmates are older (38 years old compared to 35 years older among DOC inmates). This is most likely driven by the higher percentage of Young Adult Offenders (YAO) in DOC (YAOs comprise 25% of the population in DOC but only 13% of the FBOP population). These two populations also differ somewhat in educational needs – 42% of the FBOP returning citizens lack a GED compared to 39% of sentenced DOC inmates.

In addition to demographics and education status, we also broadly compare the physical and mental health needs of the two populations. Both DOC and FBOP data indicate that 66% of their populations have no active or significant medical conditions. In terms of mental health, 83% of the DOC sentenced population has no active mental illness while in FBOP, 90% have no significant issues.

Looking at the type of offenses, those returning from FBOP are more likely to be drug and weapons offenders than those sentenced to DOC, with more serious offenses of person and violation crimes. With respect to incarceration experiences, those returning from FBOP served longer sentences than those in DOC (777 days in FBOP vs. 131 days for DOC, on average). This is to be expected as the FBOP is charge with maintaining DC inmates convicted in U.S. District Court and the DOC maintains those convicted in Superior Court.[52]

Based on the factors reviewed in these data,[53] except for the differences noted above, in many ways FBOP returning citizens and DOC sentenced individuals appear more similar than different. It may be helpful to discern more substantive issues such as family support, substance abuse, and employment skills using a validated risk needs assessment tool for both those returning from FBOP to the District and the sentenced DOC population to aid in case planning for transition to the community.

[52]See https://cjcc.dc.gov/node/212652 for an overview of the District of Columbia Criminal Justice System.

[53]A key factor which we were unable to compare was the criminal history files of those in FBOP vs. the DOC sentenced population. It is possible that FBOP offenders are more serious offenders overall, and thus planning for this population would need to take this type of issue into consideration.

Limitations and Conclusion: Stock and Flow

While this study explored a variety of factors based on data provided by DOC, FBOP, and PSA, there were areas of interest that we were unable to secure data to examine. Consequently, there are limitations to the present report, primarily related to data on community supervision, pretrial supervision history, and participation experiences of those in RRC or halfway house facilities. While this study is focused on the *custodial population*, nonetheless, future efforts to comprehensively assess the success of building effective reentry strategies will require data from agencies serving justice involved populations along the entire continuum.

Overall, this report sought to answer the following questions:

- Who flows through the DOC?
- What are the security classifications of those held by the DOC?
- What is the offending history of those entering the DOC?
- How long do persons stay in DOC pretrial?
- How long do sentenced persons stay in DOC?
- What is the most common destination of those leaving DOC?
- Who participates in Halfway Houses (HWH)?
- What are the characteristics of FBOP inmates returning to DC?
- How do those returning from FBOP differ from the DOC sentenced population?

The DOC custodial population can best be described as diverse. Men and women are primarily African American/Black and range from 15 to 82 years old. More than half are parents, and many are lacking a GED and are unemployed. These individuals are committed as pretrial detainees, sentenced inmates, held on a writ, in transit, or due to a parole or probation violation. The most common charge was for a person offense, followed by violations and property crimes. Most are classified as medium security. Those committed to DOC had varied criminal justice histories, with criminal careers ranging from 1 day to 60 years, but on average had been justice involved for over 14 years. These individuals have numerous arrests, with an average conviction rate of 49%.

Over the course of the study period, most individuals experienced a single stay in the facility, but a portion returned to the facility multiple times (from 2 to 6 times). While more than half of the population was released within 30 days, those held pretrial remained in the facility between 31 and 57 days; those sentenced stayed between 58 and 198 days on average. DOC custodial populations housed in halfway houses are more often on pretrial status, and are of lower security classification than those in DOC, yet overall, there are few differences between those in halfway houses versus and those secured in DOC. While more than half of all DOC inmates were released outright at the end of their stay, slightly less than half left the facility in transit to another jurisdiction or justice agency (e.g., FBOP). Those returning from FBOP are similar to the DOC sentenced population in many ways. Slightly older, more in need of education services and more likely to have served time for drug and weapons offenses, but generally similar.

Following recommendations, the next chapter in this report – Chapter II Services Analysis -- looks exclusively at those in the DOC custodial population in terms of need for services. The chapter is primarily focused on assessment data provided by the Department of Behavioral Health, which provides a comprehensive description of the physical, mental, and substance abuse needs of a subset of those in custody of the DOC in the study period. While DOC maintains data related to specific diagnosis of health and behavioral health concerns, it was not provided as DOC's policy is not to provide individual level diagnoses except to behavioral health or medical providers for the purpose of provision of care.
Recommendations are based on a variety of resources including the findings of this study and the extant literature. It is possible that DOC may already conduct a recommended action (e.g., creating transition plans for inmates transferring to FBOP for longer stays).

Recommendations: Stock and Flow

Tailor Reentry Services by Level of Risk and Length of Stay

One of the primary challenges in jail reentry is how to address the needs and concerns of those with very short lengths of stay, but at high risk to re-offend or at high risk of being re-booked into jail.[54] One of the key challenges for reentry services in a jail setting is how to serve those who are in the facility who vary in level of risk and lengths of stay. Among those in DOC, 70% are released within the first 90 days of commitment. Specifically - 10% are released the first 2 days, 40% are released from 3 to 30 days, and 20% are released within 31 to 90 days.

Recommendation: Tailor Reentry Services by Level of Risk and Length of Stay

- *Even among those in for short stays, resource information could be provided;*
- *Apply to all admission categories – pretrial, sentenced, and violators*
- *Longer stays = more intense targeted services*
- *Limited resources = target those benefit most.*

While short stays hamper the ability to completely assess, plan, and treat the DOC custodial population, there are existing strategies that can be leveraged to build effective reentry practices despite this limitation (See "Recommended Planning Resources" below).[55] Almost everyone committed to DOC – irrespective of admission status (e.g., pretrial, sentenced, or violators) could receive some service even if limited to the provision of resource information.

[54]The proxy is not intended to replace jail classification screening. "Risk screening for the purpose of triage and targeted treatment does not replace jail classification. Objective jail classification procedures are essential to establish a safe and secure jail environment in which jail transition services and practices can be realized" (p. 3). Christensen, G., Jannetta J., & J.B. Willison, (2012) The Role of Screening and Assessment in Jail Reentry Transition from Jail to Community Initiative Practice Brief Washington, DC: The Urban Institute and National Institute of Corrections Available: https://www.urban.org/sites/default/files/publication/25876/412669-The-Role-of-Screening-and-Assessment-in-Jail-Reentry.PDF

[55]See also Flower, S. M. (2013). *Baltimore City Jail Reentry Strategies Project: Final Report*. Greenbelt, MD: Choice Research Associates. For an example of a multi-track reentry strategy based on risk and length of stay. Available: http://www.choiceresearchassoc.com/documents/final_jail_reentry_strategies_report_09_01_2013.pdf

However, given limited resources, it is best to "carefully choose those inmates who really stand to benefit from your services .... and [exclude] those who are not likely to be released to the street (i.e., deportation, transfer to state and federal prison)" and "Targeting your services to the right inmates is as important as developing the services". [56]

Implement the Proxy Risk Assessment Tool

Given the short time that many individuals are in the facility, how do you quickly identify the people with short lengths of stay to prioritize for intervention? While not practical to conduct a full COMPAS assessment (or other similar validated tool) on those released within 48 hours, we recommend that DOC use the Proxy Risk Assessment tool on commitment to the facility.

The Proxy Risk assessment is a short self-report tool consisting of 3 questions:

1. What is your current age?;
2. How old were you the first time you were arrested? (Including juvenile arrests); and
3. How many prior arrests do you have? (Including juvenile arrests).

The Proxy is Scored as follows:

- **Current Age**: A value of 0, 1, or 2 is assigned based on the offender's age, relative to that of the remainder of the sample. Where a score of 2 = within the first third of the sample (youngest), 1 = within the middle third of the population, and 0 = within the last third of the sample (oldest).
- **Age of First Arrest (AFA)**: A value of 3, 2, or 1 is assigned based on the offender's age at first arrest (including juvenile arrests). Where a score of 3 = within the first third of the sample (youngest), 2 = within the middle third of the population, and 1 = within the last third of the sample (oldest).
- **Prior Arrests**: A value of 3, 2, or 1 is assigned based on the number of times an offender has been arrested (including juvenile arrests). Where a score of 3 = within the last third of the sample (highest number of priors), 2 = within the middle third of the population, and 1 = within the first third of the sample (least number of priors).

Recommendation: Implement the Proxy Risk Assessment

- *3 Question self-report Tool;*
- *Conduct at commitment;*
- *Use to triage full assessment: Higher Risk = COMPAS;*
- *Proxy medium or high risk flagged for in-reach by community providers;*
- *Maintain data in DOC data system to cumulatively treat frequently committed individuals.*

The key is that the scores are based on the population upon which the risk assessment is conducted and the higher the score, the higher the risk, within a range of 2 to 8 points. The answers of these 3 questions can be quickly scored, and those that are medium or high risk could be flagged for in-reach by community providers.

[56] Mellow, J., Mukamal, D.B., LoBuglio, S.F., Solomon, A.L., & J.W.L. Osborne (2008). The Jail Administrator's Toolkit for Reentry. Washington, DC: The Urban Institute and National Institute of Corrections, pg. 83 Available: www.ncjrs.gov/pdffiles1/bja/222041.pdf

In addition, other jurisdictions use the proxy as a pre-screen, with those scoring as medium and high risk are administered a more comprehensive tool such as the COMPAS, which provides more information related not only to risk of recidivism, but provides feedback on criminogenic needs. Ideally, the proxy risk information would be entered and stored in DOC data system, so that for those individuals who cycle in and out of the jail repeatedly, their information is readily available and can be utilized to triage and cumulatively treat the offender.

Establish Reentry Strategy Workgroup

There are a number of challenges in setting up an effective jail reentry strategy. For example, a substantial proportion of DOC commitments are released with charges dismissed upon court-order. By law, DOC must release these individuals within 5 hours of receiving the court-order. Indeterminate release dates are also another logistical challenge. Currently "there is inadequate capacity and no process/procedure for working with this population".[57] Complicating the issue is that these individuals are charged with a variety of offenses, and span the risk spectrum including high risk factors such as gang affiliation. While options to address this population may be limited, these issues could be considered through strategic planning process.

Recommendation: Establish Reentry Strategy Workgroup

- *Establish Reentry Strategy Workgroup;*
- *Include DOC Staff, Community Service Providers, and Other Key Agencies*
- *Avenue for open communication and problem solving; and*
- *Periodic Review of Plan; Revise as Needed*

We recommend that DOC establish a Reentry Strategy Workgroup consisting of DOC staff, both uniform and non-uniform; key agency stakeholders; and representatives from community based service providers. Once a reentry strategy is developed, ideally the workgroup would continue to meet to provide a venue to ensure ongoing and effective communication between agency and community based providers. Further, a periodic review of the strategic plan would allow for revisions on an ongoing basis so to respond to changing trends and concerns.

Recommended Planning Resources:

- **Jail Reentry Planning: The Urban Institute**
  - Life After Lockup: Improving Reentry from Jail to the Community details five critical strategies by creating six "Tracks" by length of stay and level of need (p. 83-84) and recommends actions along a continuum based on the needs, risk factors, and history of the detainees.
    Available: https://www.ncjrs.gov/pdffiles1/bja/220095.pdf
  - Transition from Jail to Community Implementation Toolkit is an online learning resource to develop a reentry strategy.
    Available: http://tjctoolkit.urban.org/
  - The Jail Administrator's Toolkit for Reentry which provides practitioner oriented information and examples of successful reentry programs.
    Available: https://www.ncjrs.gov/pdffiles1/bja/222041.pdf

[57] Reena Chakraborty, Ph.D., Chief of Strategic Planning and Analysis, D.C. Department of Corrections, Personal Communication, September 22, 2017

- **Center for Effective Public Policy Coaching Packets (2007)**.
  This series was developed based on prison (and not jail) reentry, but provides a step-by-step approach and checklists to implement a reentry system. Topics include: "Implementing Evidence Based Practices"; "Measuring the Impact of Reentry Efforts"; "Engaging Offenders' Family in Reentry"; "Shaping Offender Behavior"; and "Building Offenders' Community Assets through Mentoring".
  Available: http://cepp.com/expertise/reentry/products-and-resources/

DOC Transfers to FBOP – Consider Supporting Services

The DOC population consists of both pretrial and sentenced populations. One of the key differences is where individuals are released – back to the community and/or to FBOP for a long incarceration period. Approximately 20% will be transferred to FBOP.

A foundational tenant of successful reentry programs is that reentry begins on the first day of incarceration. Ideally, DOC would triage the custodial population according to the most likely destination, and provide services accordingly. For example, using COMPAS assessment data, work with the inmate to develop a plan which helps them to target and address criminogenic needs while serving time in FBOP (e.g., complete their GED or participate in substance abuse treatment programs).

Recommendation: Consider Support for DOC Inmates Transferring to FBOP

- *Reentry begins first day of incarceration;*
- *Use Assessment data to define target areas to address while at FBOP;*
- *Explore ways to maintain family connections including mediation to develop a transition plan;*
- *Encourage Mentoring Programs*

While not necessarily a priority given limited resources and the more immediate needs of those on the return leg of their incarceration journey, it may be fruitful for the DOC to consider encouraging other services to those likely to be transferred to the FBOP to help these individuals serve their time more productively. This type of activity might focus on the family related services such as mediation to set up a transition plan, and/or partner with community service providers who offer assistance on helping families overcome barriers to visiting the inmate once transferred to FBOP. DOC may also wish to consider establishing or expanding mentoring programs where the mentor walks with the inmate through their FBOP sentence, and continues upon their return to the community.

Returning Citizens from FBOP – Consider Higher Risk

Among those returning from FBOP are those convicted of Federal crimes, and others convicted in the D.C. Superior Court, and are under the jurisdiction of District of Columbia justice agencies. Part of the DOC reentry plan is to bring home these "state" prisoners incarcerated by FBOP 6 to 12 months prior to the end of their sentence so that they may serve out the remaining sentence in the District. The advantages of this strategy are that this gives the inmate an opportunity to connect to services and family before being released to the community. Among the FBOP inmates returning to DC in FY2015, we found a small group (N=166) who had more than 5 institutional infractions, and most of which are medium or high security level upon release (129 of 166 or 78%). This group of individuals – although perhaps higher risk than other DC prisoners returning from FBOP - should be considered for the pool of eligible inmates to be transitioned early to DOC. This gives DOC an opportunity to conduct risk assessment and address key issues prior to release. Bringing these individuals back early could also provide the opportunity to complete a GED. In addition, 80% of these individuals will also be on supervision once released thus providing an opportunity to productively engage community services while under criminal justice oversight.

Recommendation: Consider Higher Risk FBOP for Final Months at DOC

- *Don't exclude based on infraction history at FBOP or security level at release;*
- *Conduct risk assessment to establish plan;*
- *Opportunity to address key issues prior to release.*

Halfway House Participants vs. DOC

In our examination of those secured at DOC compared to Halfway house participants, we found few differences. DOC custodial populations housed in halfway houses are more often on pretrial status and are of lower security classification than those in DOC, yet overall, there are few differences between those in halfway houses versus and those secured in DOC. Those in HWH are less racially diverse (94% are Black), and are less likely to have an active medical or mental health diagnosis and have fewer prior drug convictions and commit a higher proportion of their crimes in the District (78% vs. 74%) than others in the DOC population. Space permitting, DOC may want to consider increasing the number of sentenced individuals transferred to a HWH. The advantage of a HWH setting is that individuals, while still under custodial control, are able to receive community based services as well as seek, obtain, and/or maintain employment that can extend without interruption into their return to the community.

Recommendation: Opportunity for More Halfway House Placements

- *HWH participants and DOC very similar;*
- *Space permitting, greater utilization of HWH for sentenced population?*

CHAPTER II: SERVICES ANALYSIS

Introduction

This chapter summarizes information gathered from the Treatment Assignment Protocol (TAP) Assessment conducted by a DBH clinician.[58] In addition, we detail mental health services provided through DBH to those in the FY2015 DOC custodial population during their period of stay.[59]

The following are the key questions under consideration in this study that are addressed in this chapter:

- What are the mental health needs of those in DOC?
- What mental health services were provided to those in DOC?
- What are the substance abuse treatment needs of those in DOC?
- What are the medical needs of those in DOC?
- What are the educational and employment needs?

To answer these questions, we begin with a discussion of the data sources utilized for this examination, followed by the summary of information gleaned from individuals who completed the TAP assessment. We then detail the mental health services provided while in custody. It is important to note that there is a major data limitation which narrows our investigation into services provided in DOC – particularly with respect to any discussion of program participation and completion. While we highlight the information provided in the first chapter with respect to the existence of a participation indicator variable for GED, RSAT and Reentry programs, there are no data with which to report on the number of participants who successfully completed these programs. In addition, for those who did not complete the program, there is no indication as to number of sessions attended nor any reasons why they did not finish. Further, there are no dates of participation – thus we cannot be sure precisely when individuals were engaged in any program provided in DOC.

Despite these limitations, we believe this report will provide a window into the mental health and substance abuse needs of a subset of the DOC custodial population. As noted in the Stock and Flow Report, in addition to presenting the data overall, evidenced based practices indicate the need to support both gender-specific reentry efforts as well as gaining a better understanding of the circumstances of young adult offenders (those between the ages of 18 and 24). For this reason, we present relevant findings by these subgroups.[60] We conclude this chapter with limitations to these findings and a brief conclusion.

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[58]Based on the DBH data, it is unclear whether the TAP was conducted inside the jail or in the community.

[59]While the DBH data includes mental health services based on continuity of care (from custody to community) to those in the jail, there are no DBH providers of custodial substance abuse treatment services. Other mental health and substance abuse treatment services are provided by Unity Healthcare, the DOC Contractor. The Unity Healthcare data was not provided for this report.

[60]We considered presenting the results by race. However, there were relatively few individuals classified as other than Black (4% of the DOC and 8% of FBOP populations), rendering between race comparisons less reliable.

Data Sources

Figure 3: Data Sources: Services Analysis

Data Source	Description	Linking Variables	Number of Observations	Number of Unique Persons
Department of Behavioral Health	TAP Assessment Data – Individuals in custody or admitted to custody DOC from October 1, 2014 to September 30, 2015 (FY2015).	Research ID	N=1,567	N=1,567
	Mental Health Services	Research ID	N=366[61]	N=129
DC Department of Corrections	Custody Data File - Individuals in custody or admitted to custody DOC from October 1, 2014 to September 30, 2015 (FY2015).	PDID & Research ID	N=8,840[62]	N=8,840
	Mental Health Diagnosis (Deidentified) of those in custody or admitted to custody DOC from October 1, 2014 to September 30, 2015 (FY2015).	N/A	N=2,260[63]	N/A
	Substance Abuse Diagnosis (Deidentified) of those in custody or admitted to custody DOC from October 1, 2014 to September 30, 2015 (FY2015).	N/A	N=838[64]	N/A

[61]The file originally contained 74,835 observations, representing 1,796 unique persons. However, the data included records of services provided both after the study period. After those activities were deleted, 6,295 records remained. After reviewing for services during custodial stays, the number of observations reduced to 366.

[62]Assessment and Services data was provided at the individual level. While the original DOC file contained both charges and booking stays, we report only by unique person for this report.

[63]The file originally contained 2,644 observations, but 384 identical records were deleted from the file.

[64]The file originally contained 896 observations, but 58 identical records were deleted from the file.

Methodology

Our approach to this report was to review and categorize individuals by a variety of key factors using descriptive statistics (e.g., frequencies, measures of central tendency, and measures of dispersion) for all study variables, such as descriptions of the sample of those with TAP assessment data (age, race, marital status) and the substance use and mental health histories captured in the TAP. Where available, we also note mental health services provided to DOC inmates by DBH providers while incarcerated including the number of sessions and by service category (e.g., "Initial & Ongoing"; 'Transition Planning'). We also combined the TAP assessment data with the DOC Custody data in order to look more deeply at the service needs within the cross section of commitment status (e.g., pretrial versus sentenced) and length of stay.

District of Columbia Department of Corrections Service Needs

As detailed in Figure 1, three data sets[65] were provided by the Department of Behavioral Health (DBH) to explore these issues among those in the custody of DOC during FY2015. The first was the TAP Assessment data for 1,567 individuals. The TAP assessment is conducted on those who present a need for treatment, and most often those in short intervention programs where the release date is known.[66] The TAP includes over 150 variables that explores everything from drug of choice and frequency of use, to number of prior treatment experiences, to current and history of medical conditions, to occupation and income information, to marital status and to whom the individual feels close to in their family (e.g., sibling, mother, father, child, etc.). The tool also captures the interviewer's assessment of the individuals' motivation to change using the Prochaska & DiClemente's Stages of Change scale[67], as well as the interviewer's assessment of the degree of importance to which the individual feels the need for treatment now (on a scale from "Not at All" to "Extremely").

While this information is very useful, unfortunately, we did not specifically request, nor did we receive, the date the assessment was conducted, so we are unsure as to whether the TAP was completed before, after, or while in DOC.[68] For this reason, we present the TAP information as a snapshot of the needs and issues among those in custody at the DOC in FY2015. While the

[65] In April 2017, DOC advised that the Northpointe COMPAS risk assessment full SQL database was available for our review and extraction of data for inclusion in this report. While we had initially hoped to be able to extract the raw data tables to include in the analysis, this action required that we create SQL queries. While DOC generously provided the data dictionary from Northpointe (which was several thousand pages long), a copy of the data relationship table, and copies of the risk assessment tools, we were still unclear as to which of the thousands of variables made up the core of the assessment scores. Ultimately, we determined that the level of complexity in extracting the COMPAS data demanded resources beyond what was available within the scope of the present study, and did not pursue this as a data source for the project.

[66] Reena Chakraborty, Ph.D., Chief of Strategic Planning and Analysis, D.C. Department of Corrections, Personal Communication, September 22, 2017. We were also advised by Dr. Chakraborty that another challenge is DBH and providers are limited, so they "focus their efforts on the seriously and persistently mentally ill" … and less on "episodic illness (such as anxiety or depression) … that may resolve with medication assisted treatment."

[67] Based on Prochaska, J.O., & C.C. DiClemente (1984) The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy. Homewood, IL: Dow Jones-Irwin. For more information see: https://en.wikipedia.org/wiki/Transtheoretical_model

[68] DBH advised that the date of the assessment is not a default field and is difficult to extract (Laura Heaven, LICSW, Chief, Data and Performance Management Email communication, September 12, 2017). Given the short time remaining on the project, we decided to move forward without the assessment date or location.

TAP includes measures of experiences in the prior 30 days, given we do not know when the TAP was taken, we focus primarily on data which measure lifetime experiences and concerns. The other consideration is that the TAP may be conducted as an intake or as a follow-up instrument. Among the 1,567 TAP assessments, 338 were follow-ups. Given that follow-ups are often conducted to assess change as a result of treatment or intervention, we omitted the TAP follow-ups, and focused on the intake TAP Assessment data. The final number of individuals with an intake TAP was 1,229.

The DOC custody file that was used in the Stock and Flow report was also utilized for this report. The DOC custody data file originally contained 18,159 observations (based on charges), representing 8,443 unique persons. Once the data was cleaned, the final data set contained 10,680 unique booking events representing 8,840 individuals. In addition, DOC provided two deidentified files containing the mental health (with 2,260 observations) and substance abuse (838 observations) diagnoses of those in custody during the study period.

Before detailing the life history and experiences of those who completed a TAP, it is important to ascertain how similar this group of individuals are in comparison to others in custody. This will allow us to assess the degree to which we can generalize (or infer) that the TAP findings represent a larger section of the population. As noted above, the TAP is only done when there is an indicator of a present need; it is not universally conducted. We explored a variety of factors in this comparison including demographics, criminal history, and incarceration experience. There are a number of statistically significant differences between those who completed a TAP and those who did not. Key differences are detailed in Table 17, below. Note that unless otherwise indicated, differences discussed in the text were statistically significant.[69]

There were gender differences between those who completed the TAP and those who did not. Of the 1,229 completed TAP assessments, 83% were completed by men, 17% by women. In contrast, 89% of those who did not complete a TAP were men, 11% were women. TAP completers were also older (41 vs. 34 years old), non-White (98% vs. 96%) and much more likely to be DC residents (89% vs. 72% among those who didn't complete the TAP). While there was no difference in parent status – a statistically equivalent number of individuals had children - the groups varied on the number of children with those who completed the TAP having on average 2.4 children and those without the TAP having 2.2 children. TAP completers are also more likely to have an active medical condition – 42% vs. 29%. Among those without a GED, fewer TAP completers participated in DOC GED programs – 2% vs. 3.6%. Finally, more participated in the Residential Substance Abuse Treatment (RSAT) -- almost 5% compared to 1.6% of the non-TAP group.

Reviewing criminal histories, those with TAP data, likely in part because they were older, had longer criminal careers (a difference of 2,565 days on average, or 7 years longer) with commensurate higher number of arrests, charges, and convictions (although there was no difference in conviction rates between the two groups). For example, those assessed for TAP had 16.7 total arrests vs. 11.3 arrests for those without TAP data. Looking by type of offenses,

[69]Differences that are statistically significant if the "p-level" indicator is $p<.05$ or below. This notation means that the findings are highly unlikely (e.g., for $p<.001$ - less than a 1 out of 100 chance or $p<.05$ less than 5 out of 100 chances) to be the result of chance or coincidence.

the TAP group have more charges and convictions for person offenses, property, and drug offenses than the non-TAP group. The TAP group also had more public order, violations, warrants and traffic charges, but there were no differences in convictions in these offense types between those who completed the TAP and those who did not.

In terms of length of stay, the TAP group were in the facility for short periods on average (83 days vs. 102)[70] but they also had slightly more stays (1.24 vs. 1.20). There were also significant differences between the groups with respect to the severity of the most serious current offense – those in the TAP group had a lower severity (9.61 vs. 8.57) and on average were in the lower classification group than those who did not complete the TAP (more falling into the minimum security level with an average score of 1.96 vs. more of those who did not complete the TAP were in the medium security level with an average score of 2.07). There was also fewer gang affiliated members who completed the TAP (4% vs. 6%).

A higher percentage of those sentenced completed the TAP (47% versus 41%) but this varies when reviewing the admission categories. For example, a lower percentage of TAP completers were committed as a sentenced felon (9% vs. 15%); but a higher percentage were admitted as sentenced misdemeanants (17% vs. 13%). There is a similar pattern with respect to pretrial – more misdemeanants than felons. There are also more individuals admitted as a parole/probation violator (26% vs. 13%) and fewer admitted as in transit, on writ or hold (6% vs. 9%) that completed the TAP.

Table 17: Significant Differences Between TAP Assessment Vs. No TAP

	TAP Assessment			No TAP Assessment			Significant Difference
	N	Mean	SD	N	Mean	SD	
Demographics/DOC Programs							
Gender: Proportion Male	1229	.83	.37	7611	.89	.31	-.06***
Age	1229	41.2	11.5	7610	33.9	12.0	7.2***
Age: Prop. Young Adult Offenders	1229	.06	.24	7610	.28	.45	-.22***
Race: Proportion Not White	1229	.98	.12	7611	.96	.20	.02***
DC Resident	1229	.89	.30	7611	.72	.45	.17***
Number of Children	620	2.4	1.7	3542	2.2	1.6	.14*
Proportion Medical Condition	1123	.42	.49	6858	.29	.45	.14***
Education: Lacks GED	1059	.33	.47	6292	.38	.48	-.05***
DOC Program: GED	348	.01	.00	2416	.03	.19	-.02**
DOC Program: RSAT	1229	.045	.21	7611	.016	.12	.02***

[70]DOC also advised that "DBH tends to focus on District Residents (since that is their jurisdiction) and also misdemeanants and short term sentenced felons or parole violators in short intervention programs since they will soon be reentering the community (release dates are known)." Reena Chakraborty, Ph.D., Chief of Strategic Planning and Analysis, D.C. Department of Corrections, Personal Communication, September 22, 2017.

	TAP Assessment			No TAP Assessment			Significant Difference
	N	Mean	SD	N	Mean	SD	
Criminal History							
Proportion DC Internal Offenses	1219	.79	.23	7118	.72	.29	.06***
Criminal Career (Days)	1219	7573	3956	7118	5007	3984	2565***
Total Prior Arrests	1219	16.7	12.6	7118	11.3	10.9	5.37***
Prior Arrests Convicted	1219	8.07	6.5	7118	5.35	5.5	2.72***
Total Prior Charges	1219	31.4	22.8	7118	21.8	20.1	9.62***
Average Prior Charges Per Arrest	1219	1.96	.69	7118	2.05	1.1	-.08***
Prior Charges Convicted	1219	10.7	8.4	7118	7.32	7.4	3.38***
Type of Offenses							
Person Charges	1054	6.58	5.9	5669	5.49	5.3	1.09***
Person Convictions	1046	2.03	2.1	5447	1.84	1.9	.19**
Property Charges	1041	9.16	12.1	5303	7.02	9.3	2.13***
Property Convictions	1037	3.26	4.9	5122	2.47	3.9	.78***
Drug Charges	1048	9.38	8.8	4502	7.10	7.3	2.27***
Drug Convictions	1045	3.18	3.0	4415	2.54	2.6	.64***
Public Order Charges	744	3.6	4.0	3688	3.18	4.4	.47**
Violations Charges	805	4.26	3.7	3747	3.36	3.2	.89***
Warrant Charges	464	2.35	2.1	2488	2.11	1.72	.24*
Traffic Convictions	568	1.58	1.8	2946	1.30	1.72	.27**
Incarceration Experience							
Length of Stay	1229	83	120	7611	102	191	-18.58**
Number of Stays	1229	1.24	.54	7611	1.20	.49	.04**
Security Classification – Initial	906	1.96	.44	5164	2.07	.50	-.11***
Most Serious Charge Severity Code (Lower Number = More Severe)	1201	9.69	5.09	7270	8.57	5.0	1.11***
Gang Affiliated	1102	.04	.19	6736	.06	.24	-.02**
Proportion Sentenced	1057	.47	.49	6554	.41	.49	.06***
Admission Category							
Proportion Sentenced Felony	1229	.09	.29	7611	.15	.36	-.05***
Proportion Sentenced Misd.	1229	.17	.38	7611	.13	.34	.04***
Proportion Pretrial Felony	1229	.21	.40	7611	.32	.47	-.12***

	TAP Assessment			No TAP Assessment			Significant Difference
	N	Mean	SD	N	Mean	SD	
Proportion Pretrial Misd.	1229	.20	.40	7611	.16	.37	.04***
Proportion Violator	1229	.26	.44	7611	.13	.34	.13***
Proportion In Transit/Hold	1229	.06	.23	7611	.09	.29	-.03***

***Difference between those with a TAP to those without a TAP group is significant p<.00
**Difference between those with a TAP to those without a TAP group is significant p<.01
*Difference between those with a TAP to those without a TAP group is significant p<.05

Given the number of differences between those who completed the TAP and those who did not, caution should be exercised in inferring the following medical, psychological, and employment histories to the entire custodial population. However, the findings below can be informative for older inmates, with commensurate longer criminal histories (including a higher number of public order and violations charges), but whose charges are less severe and are less likely to be gang members. In addition, those with a TAP are more likely to be sentenced or pretrial misdemeanants or violators than those without TAP assessment data.

Tap Assessment Findings

Demographics and Relationships

Table 1 provides summary statistics on the 1,229 unique individuals in custody with DOC from the period from October 1, 2014 through September 30, 2015 with a TAP assessment. Data provided by DBH. The majority of those who completed the TAP are male (83%), Black (96%) and single (76%). While many (57%) advised they do not have children under 18 years old, those who have minor children have 2 children on average, ranging from 1 to 11 children. A third of those (32%) are custodial parents, with an average of 1.7 children living with them (ranging from 1 and 6). Approximately 12% of those with minor children are not living with one or more of their children due to a protection order.

During the TAP Assessment, individuals may select the people with whom they have a close, long lasting relationship. Among those who responded, 21% (255 of 1229) did not indicate any close relationships. The remaining 974 stated they had close relationships with 3 different types of family members or friends (ranging from 1 to 5). Specifically, 58% stated they have close friends, 68% are close to their mother, 45% are close their father, 76% are close to their sibling, and 59% stated they have a close relationship to their children. Finally, approximately 44% (540 of 1229) of those who completed the TAP declared they were religious. Among these individuals, while most (42%) are Christian, 21% are of the Islamic faith, and 37% selected "other" religions.

Table 18: TAP Demographics and Relationships

Unique Persons (N=1,229)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Average Age at Release*	1229			18 to 75	41.2 (11.5)
Gender	1165				
Male		968	83%		
Female		197	17%		
Race/Ethnicity	1159				
Black		1117	96%		
White		14	1%		
Other		28	2%		
Marital Status	1182				
Single		896	76%		
Married		115	10%		
Widowed/Divorced/Separated		171	14%		
Religion	1229				
No Religion or No Preference		689	56%		
Declared Religious Preference		540	44%		
Parental Status	1126				
No Children Under 18 Years Old		644	57%		
Have Children Under 18		482	43%	1 to 11	2.10 (1.4)
Living with Children Under 18	467	150	32%	1 to 6	1.70 (.97)
Have Children not living with due to Protection Order	482	59	12%		
Relationships – Friends & Family Close, Long Lasting	1229				
No Close Relationships		255	21%		
One or More Close Relationships		974	79%		
Number – Including Friends	974			1 to 5	3.06 (1.4)
Number - Family Members Only	974			1 to 4	2.57 (1.0)
By Type of Relationship					
Friends	974	563	58%		
Mother		663	68%		
Father		437	45%		
Brother/Sister		740	76%		
Children		578	59%		

*From DOC Custodial Data, not TAP Assessment Data

Economic Indicators

There are several indicators in the TAP assessment with respect to the economic circumstances including residential stability, home ownership, occupation, and source of primary income. In terms of housing stability, there were 563[71] TAP completers who responded to this question. Among them, 473 had at least 1 year at their current residence, and averaged 9.3 years, ranging from 1 to 52 years. Among all TAP respondents, 180 (or 15%) owned their own home. Likely the result of living in a city with a robust public transportation system, only a fifth (20%) have a driver's license. Among those with a driver's license, 144 (or 59%) report that they have an automobile available for use.

The TAP also captures the longest period of time the respondent held a full-time job. Among the 827 reporting, the average time employed was 47.7 months, but with a large range from 1 to 432 months. This employment variable was categorized into time periods and indicates that a third (29%) held their longest full-time position for 1 year or less; another third (32%) held positions for 1 to 3 years; and the remaining 38% held positions for more than 3 years. These findings may appear out of sync with the high rates of unemployment in the DOC sample overall, but recall that the question is asking about employment over a *lifetime*. In addition, with the average age of those completing the TAP of 41 years old, there is opportunity to accrue this experience.

Those assessed also reported whether they had a profession, trade, or skill (631 of 1228 or 51%) answered in the affirmative. In terms of occupations, among the 845 with a stated occupation, most (70%) were laborers or in the service industry. Finally, while 47% overall reported no income, the other 53% reported that their primary source of income was generally from 3 sources – wages (31%); TANF or Public Assistance (29%) and Disability (29%). Another 10% reported other income sources including a small number who were retired or receiving a pension. Five respondents indicated their primary source of income was through illegal activities.

[71]The remaining 90 indicated 0 years – which could either mean less than 1 year or a true zero. Given the data provided, we are unable to definitively determine which is correct, so we omit those 90 from the calculation.

Table 19: TAP Economic Indicators

Unique Persons (N=1,229)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Years at Current Residence	473			1 to 52	9.30 (10.3)
Own Residence	1229	180	15%		
Has Driver's License	1228	244	20%		
Car Avail for Employment	244	144	59%		
Longest Full Time Job (Mos.)	827			1 to 432	47.7 (53.69)
1 to 6 Months		38	5%		
3 to 6 Months		71	9%		
6 to 9 Months		29	3%		
9 Months to 1 Year		102	12%		
More than 1 Year to 2 Years		161	20%		
More than 2 Years to 3 Years		110	13%		
More than 3 Years to 5 Years		134	16%		
5+ Years		182	22%		
Has Profession, Trade or Skill	1228	631	51%		
Occupation	1033				
No Occupation		188	18%		
Stated Occupation		845	82%		
Type of Occupation	845				
Laborer		332	39%		
Service		262	31%		
Professional/Management		101	12%		
Crafts/Operatives		89	10%		
Sales		50	6%		
Farm Owner/Farm Labor		11	1%		
Primary Income Source	994				
No Income		464	47%		
Has Income		530	53%		
Type of Income	530				
Wages		163	31%		
TANF/Public Assistance		155	29%		
Disability		154	29%		
Other (Retirement/Pension)		53	10%		
Illegal Means		5	<1%		

Percentages may not add up to 100% due to rounding.

Physical and Mental Health

As indicated below in Table 3, those who completed the TAP assessment have both physical and mental health conditions. More than half (58%) have been hospitalized at least one time in the past, 29% have one or more chronic medical diagnoses, and 41% are on medications for a physical problem. In addition, while 84 (or 7%) of respondents have a vison problem, and a few (6) have a hearing problem, observing across those two issues simultaneously, 9 individuals have both a hearing and a vision problem.

Looking at other physical health conditions, TAP respondents report having from 1 to 7 illnesses over their lifetime, with on average 1.5 conditions per person. Among those with 1 or more reported physical health conditions, most have between 1 and 3 problems – with 13 individuals reporting 4 or more. Lung and breathing problems are most often reported by 125 (or 10%); followed by sexually transmitted diseases and either Hepatitis A, B, and/or C (both at 6%). In terms of interviewer's assessment of the client's desire or need for immediate treatment on their medical conditions, more than half (53%) rated treatment was "not at all important", and 11% were rated "extremely important".

Mental health conditions are even more prevalent. Over 40% report they have been prescribed medications for psychological or emotional problems in the past. In addition, 46% report they have a psychiatric problem in additional to an alcohol and/or drug problem. While these measures are based on self-report and not a medical diagnosis, and those completing the TAP are doing so to receive mental health and/or substance abuse services, nonetheless, TAP respondents have very high rates of anxiety (46%) and depression (53%). In the general population, anxiety disorders impact 18% of individuals and depression approximately 7%, annually.[72] Similarly, those who completed the TAP have high rates of hallucinations (22%), as well cognitive issues (i.e., trouble understanding and concentrating) at 30%; and 20% have trouble controlling violent behavior. Many also report having attempted suicide – 13% - also disproportionate to suicide statistics in the general public.[73]

Looking at the number of reported mental health conditions among those reporting one or more condition, they have an average of 3.14, ranging from 1 to 6 mental health problems. A little over 40% (42%) of clients were assessed as feeling that immediate treatment for mental health conditions was "not at all important" by the interviewer, while 12% were viewed as feeling that treatment was "moderately" and 16% felt it was "considerably" important. Twelve percent were rated as it was "extremely important" to address mental health problems now.

[72] https://adaa.org/understanding-anxiety/depression
[73] https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf

Table 20: TAP Physical and Mental Health

Unique Persons (N=1,229)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Physical Health					
Ever Hospitalized	1071	623	58%		
Have Chronic Medical Problem	1229	359	29%		
Currently on Medications	1229	504	41%		
Vision Issues	1229	84	7%		
Hearing Problems	1229	15	1%		
History or Current Diagnosis					
Has One or More of:*	1229	405	33%	1 to 7	1.5 (.87)
Abscess		26	2%		
Arthritis		71	6%		
Cardiac		41	3%		
Diabetes		51	4%		
Cirrhosis or Liver		14	1%		
Hepatitis A, B, C (1 or More)		74	6%		
Sexually Transmitted Diseases		78	6%		
Lung/Breathing Problems		125	10%		
Interviewer Assess: Treatment - How Important **Now** to Client? *Scale 0 to 4 where 0=Not at All and 4 = Extremely*	358			0 to 4	1.15 (1.4)
Not at all		190	53%		
Slightly		40	11%		
Moderately		52	15%		
Considerably		37	10%		
Extremely		39	11%		
Mental Health					
Prescribed Medications for Psychological or Emotional	1229	511	42%		
Co-Occurring (Psychiatric + Alcohol/Drug Problems)	1229	563	46%		
Lifetime History of					
Has One or More of:*	1229	719	58%	1 to 6	3.14 (1.49)
Depression		651	53%		
Anxiety		561	46%		
Hallucinations		273	22%		

Unique Persons (N=1,229)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Cognitive Issues		370	30%		
Controlling Violent Behavior		243	20%		
Attempted Suicide		164	13%		
Interviewer Assess: Treatment - How Important **Now** to Client? *Scale 0 to 4 where 0=Not at All and 4 = Extremely*	646			0 to 4	1.46 (1.5)
Not at all		274	42%		
Slightly		56	9%		
Moderately		138	21%		
Considerably		100	16%		
Extremely		78	12%		

*Will total to more than 100% as 1 or more can be selected.

Substance Use and Treatment Experiences

The last area of the TAP captures substance use and treatment experiences (see Table 21). Among those who completed the TAP Assessment, the drug of choice and age of first use varied widely. Alcohol was the most frequent primary drug of choice with (26%), followed by heroin or other opiates (21%) and cocaine/crack (18%). While 37% did not have a secondary drug choice, alcohol (21%), cocaine/crack (15%) and marijuana/hash (13%) were the top 3 choices. The average age of first use of both the primary and secondary drug was 19, although this varied widely.

Looking at the intersection of drug choices among the 709 who declared both a primary and secondary drug choice, the most frequent combinations are provided in Figure 4. Specifically, for the 125 TAP completers whose primary drug was PCP, the most frequently stated secondary drug choice was Marijuana/Hash. Likewise, among the 147 primary Heroin/Opiate users, the top secondary drug choice was cocaine/crack.

Figure 4: Primary and Most Frequent Secondary Drug Combinations N=709

Primary Choice	N	Top Secondary Choice	N
Alcohol	185	Cocaine/Crack	79
Cocaine/Crack	127	Alcohol	79
Heroin/Opiates	147	Cocaine/Crack	60
Marijuana/Hash	112	Alcohol	52
PCP	125	Marijuana/Hash	54
Other Drug	13	Alcohol	6

In order to compare those with the self-reported drug of choice contained in the TAP data to the substance abuse diagnosis in the custodial population, DOC provided a deidentified[74] data set of 838 observations of substance abuse diagnosis for those in custody during the study period. While we are unable to associate a specific individual to a specific drug of choice, we can broadly compare the distribution of the types of substances between those with TAP data and those in DOC. The DOC population differed somewhat from those with TAP data in terms of choice of substance. (Which may be in part due to the fact that the DOC data does not distinguish between primary or secondary drug type). DOC diagnoses indicate that the majority of those in the DOC use marijuana (46%), followed by heroin or other opiates (19%), alcohol (18%), cocaine and crack (14%), and other drug types (3%).

TAP completers are also heavy tobacco users. Of the 1,117 with responses to this question, 879 (or 78%) use some form of tobacco – most frequently cigarettes (97%), with a few smoking cigars and pipes (2%) or using smokeless tobacco (less than 1%). Among the 854 cigarette smokers, many (43%) report smoking between less than ½ a pack to ½ a pack a day; and another 39% report smoking ½ a pack to 1 pack a day.

The TAP provides other indicators that provide a window into the degree to which addictions are impacting the lives of these respondents. For example, 17% admit that the sometimes use other drugs such as prescriptions, over the counter medications, alcohol or an illicit drug to relieve withdrawal symptoms. Almost half (47%) have noticed the need to increase the amount of use to achieve the same effect or high and over 80% have had someone ask them to stop using. In terms of treatment experiences, more than 70% have had either detoxification or substance abuse treatment prior to completing the TAP. On average, these 857 individuals have attended treatment 2.8 times, ranging from 1 to 30 times. In addition, 58% report they have attended 12 step or self-help group meetings.

Lastly, we include the interviewer's assessment of the client's readiness to change, and almost half (49%) are in the "contemplation" stage. This stage is also termed the "getting ready" stage and may be ambivalent as they assess the positive and negatives of making a change in their life and find these are equally weighted. If one can reduce the number of negative impacts of change, the individual would be more likely to move forward to changing their behavior. The next most frequent stage cited is preparation (or determination) – 21% of interviewers assessed TAP respondents at this stage. These individuals will take steps to begin the change process within 30 days – including actions such as admitting to trusted others that they want to change. Approximately 15% of the TAP respondents are the in the "precontemplation" stage where they "typically underestimate the pros of changing, overestimating the cons, and often are not aware of making such mistakes".[75] While 3% are in the "relapse" (reengaging in previously ceased behaviors) or "maintenance" (where behavior changed more than 6 months prior) stages, the remaining respondents are in the "action" stage – where they have implemented changes in behavior within the past 6 months and require support to ensure that they do not slip back into

[74]DOC policy limits sharing "individual level diagnosis except to behavioral health or medical providers for the purpose of provision of care". Reena Chakraborty, Ph.D., Chief of Strategic Planning and Analysis, D.C. Department of Corrections, Personal Communication, September 13, 2017.

[75]https://en.wikipedia.org/wiki/Transtheoretical_model

old patterns. We next explore these data by looking at the intersection of gender, age, and detainment status (sentenced vs. pretrial).

Table 21: TAP Substance Use and Treatment Experiences

Unique Persons (N=1,229)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Substance Use					
Only 1 Primary Drug Choice	1118	409	37%		
Both Primary & Secondary		709	63%		
Primary Drug of Choice	1138				
Alcohol		299	26%		
Cocaine/Crack		203	18%		
Heroin/Other Opiates		240	21%		
Marijuana/Hash		192	17%		
PCP		177	15%		
Other Drugs		23	2%		
None		4	<1%		
Primary - Age of First Use	1080			5 to 69	19.6 (8.1)
Secondary Drug of Choice	1122				
Alcohol		232	21%		
Cocaine/Crack		173	15%		
Heroin/Other Opiates		58	5%		
Marijuana/Hash		141	13%		
PCP		76	7%		
Other Drugs		29	3%		
None		413	37%		
Secondary - Age of First Use	676			1 to 63	19.9 (8.6)
IV Drug User?	1227				
No		1056	86%		
Yes, or Denied IV Use		171	14%		
Have Ever…	1229				
Used Drugs to Relive Withdrawal Symptoms		205	17%		
Need to Increase Amount to Achieve Same Effect?		577	47%		
Often Use More than Intended Over Longer period of Time?		644	52%		

Unique Persons (N=1,229)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Had Blackouts		322	26%		
Lots of Time Getting Substance		395	32%		
Anyone Every Ask You Stop?		1015	83%		
Support at Home for Detox?		630	51%		
Tobacco User	1117	879	78%		
Treatment Experiences					
History of Treatment	1229				
No History of Treatment		372	30%		
One or More Experiences		857	70%		
Treatment: Alcohol or Drugs	857			1 to 30	2.83 (2.4)
Both Treatment and Detox		209	24%		
Only Treatment, No Detox		469	55%		
Only Detox		179	21%		
Attend 12 Step/Self-Help Group	1228	709	58%		
Readiness to Change	1094				
Pre-Contemplation		164	15%		
Contemplation		534	49%		
Preparation (Determination)		234	21%		
Action		125	11%		
Maintenance		15	1%		
Relapse		22	2%		

*Will total to more than 100% as 1 or more can be selected.

Profiles of TAP Assessment Data by Gender and Age

We conducted statistical significance tests on most of the areas in the TAP comparing the responses by gender, age (young adult offenders between 18 and 24 vs. older adults) and by detainment status (pretrial versus sentenced population). With the exception of a statistically significant difference in age between those on pretrial (on average 42 years old) and those sentenced (40 years old) and that the pretrial population is more likely to report visual issues (8% vs. 4% in the sentenced population) there were no other differences. For this reason, we only break down the TAP assessment data by gender and age. Information from Table 22 through Table 25 is used to build the profiles of TAP respondents.

Gender

In terms of life circumstances, women and men significantly differ in a number of areas (see Table 22). Women are significantly younger (39 years old vs. men who average 41 years old), are less likely to be married (6% vs. 10% of men), and are more likely to be parents of minor children (55% vs. 40%). In terms of relationships with family and friends, more women TAP respondents advise they are close to their children (54% vs. 46%), while a higher percentage of men report being close to a brother or sister (62% of men vs. 52% of women). There are no differences in the percentage of men and women who report close relationships to other family members or friends.

With respect to economic indicators (Table 23), there are but a few differences by gender -- women are less likely to own their own home – 10% vs. 16% of men. Women are also more likely to report not having any income and are more likely to rely on public assistance and disability than men. However, there are interesting patterns in occupation and income source that are worth highlighting. While women and men are equally likely not to state an occupation, for those who do have a job, the types of jobs vary along customary gender lines – more men are laborers (44%) and more women are engaged in the service industry (48%).

In terms of physical and mental health status, there were a few statistical differences by gender (Table 24). Women were more likely to report a chronic medical problem (36% vs. 28% of men); were more likely to be on medications for a physical condition (53% vs. 38%) and were more likely to suffer from both arthritis (10% vs. 5%) and lung or breathing problems (18% of women vs. 8% of men). There are also some key differences in reports of mental health concerns among women compared to men. Among TAP respondents, 64% of women (compared to 42% of men) report a co-occurring disorder – where one experiences both mental health concerns as well as substance abuse condition. A very high percentage of women also report depression in their lifetime (69% vs. 50% of men); anxiety (59% vs. 43%), cognitive difficulties (40% vs. 28%), at least one suicide attempt (26% of women vs. 11% of men) and are significantly more likely to be taking medications for psychological problems (59% of women compared to 38% of men). Not only were more women reporting these various issues, but on average had a greater variety of concerns than men (3.36 compared to 3.08 for men).

Finally, turning to substance abuse and treatment experiences (Table 25), women and men vary in their primary drug of choice – with fewer women choosing alcohol, heroin, and marijuana than men.[76] Specifically, 15% of women select alcohol as their primary drug of choice vs. 26% of men; 14% select heroin (vs. 20% of men); and 7% of women vs. 17% of men select marijuana. However, women are more likely to engage in cocaine/crack (27% vs. 14% of men) and PCP (21% vs. 13%). With the exception of reporting blackouts – with women more likely to report (32 vs. 25% of men), the other substance and treatment experience questions are statistically equivalent between men and women.

[76] Patterns of drug use by gender differ somewhat when comparing those in DOC with a substance abuse diagnosis to those with TAP data. While compared to men fewer women choose alcohol (15% vs. 18%) and marijuana (35% vs. 48%), women are more likely to engage in heroin use (29% vs. 18%). Both genders use other drugs equally (3%).

Young Adult Offenders vs. Older Adults

While there were some significant differences in the YAO vs. older adult groups, the small number of individuals in the YAO group indicates caution in overstating these results.[77] Nonetheless, we present this summary as a means to inform the ongoing conversation regarding YAOs in the District of Columbia.[78]

It is expected that the by age group would vary significantly – YAOs in the sample average 22 years old compared to 42 years old of the older sample. In addition, there is a significant difference in race – 100% of YAOs are non-white vs. 98% of older offenders. YAOs are also significantly less likely to declare a religious affiliation – 29% vs. 45%. %). In terms of relationships with family and friends, a higher percentage of older offenders are close to their friends (47% make this assertion vs. 31% of YAOs). Older and younger offenders also differ in the number of people they feel close to – older offenders have more people they feel close to – on average 2.4 people vs. 1.9 people among YAOs.

Looking at Table 23 for differences on economic factors by age group the only significant difference is the amount of time YAOs spent in their longest job versus older offenders. Again, not a startling finding given that YAOs have had less time to accrue job experiences. One other notable difference is that more YAOs are employed in sales (17% vs. 5%) vs. older TAP respondents who are more likely to be involved in crafts/operatives industry (no YAOs are in that field compared to 11% of older offenders).

YAOs were less likely to report a number of health related diagnoses compared to older offenders (see Table 24). This is likely an artifact that younger people are less likely to have health problems generally. Older offenders reported they were more likely to have experienced a hospitalization in their lifetime than YAOs (59% vs. 39%); to have a chronic illness (30% vs. 15%); and to be taking prescribed medications (42% vs. 22% of YAOs). A higher percentage of older offenders also reported conditions of abscess, arthritis, cardiac/heart related problems, diabetes, cirrhosis or liver problems, and more likely to report having Hepatitis C.

Similar to the gender comparison on mental health diagnosis, older offenders report higher levels of co-occurring disorder (47% of older offenders vs., 33% of YAOs); depression (54% vs. 36%); anxiety (47% vs. 22%) and hallucinations (23% vs. 9%). Older offenders are also more likely to be taking medications for psychological conditions (42% of older TAP completers compared to 30% of YAOs).

[77] The minimum number of subjects in a study is generally 50 to 100 because the smaller the group, the more likely those responding in the extreme ("outliers") influence the overall findings. Another issue is statistical power – with lower numbers of people in the sample, the less likely one is to find a statistically significant finding even when a difference is present (also referred to as a false negative).

[78] For example, see https://cjcc.dc.gov/page/districts-youth-rehabilitation-act-analysis

Across numerous areas related to substance use, YAOs differed significantly from older respondents.[79] Older offenders were more likely to be an IV drug user (14% vs. 7% of YAOs), and more likely to use of alcohol (25% vs. 13% of YAOs chose this as their primary choice of drug). A higher percentage of older offenders also selected cocaine/crack (17% vs. 3%), and heroin (and other opiates) as their primary drug compared to YAOs (20% vs. 6%) (Table 25). They were also had more of the severity of use markers – being more likely to use drugs to relieve withdrawal symptoms (17% vs. 9%); using more than intended (53% vs. 40%) and having blackouts (27% vs. 10%). In contrast, YAOs are much more likely to declare marijuana and hash as their primary drug of choice – 44% vs. 13% of older offenders. Younger respondents also report start using their primary drug of choice 15 years old – compared to older offenders who stated they first began using substances at 19 years old, on average. There are no significant differences in these age groups with respect to treatment experiences.

Overall, women differ from men and YAOs differ from older offenders on these mental, physical and substance abuse problems in important ways. While informative, we again note two important limitations to these results. First, we do not know when or where these assessments were completed. Second, because we were unsure of the timing of these assessments, we explored these data from the perspective of lifetime experiences – we did not utilize any data related to the recent past (the TAP often queries respondents to review the "last 30 days"). Consequently, these findings may not be entirely accurate. Nonetheless, these comparisons can inform future service provision efforts by providing a context for those in custody. Generally speaking, these results are consistent with other studies on jail populations. Often individuals require a myriad of services to meet the challenges of returning home.

[79]Drug use of YAOs and older adults in DOC with a substance abuse diagnosis differ in terms of magnitude, but not pattern, from the TAP data. Older offenders were more likely to use alcohol (21% vs. 7%), cocaine/crack (17% vs. 2%), and heroin (and other opiates) as compared to YAOs (25% vs. 5%). YAOs are much more likely to use marijuana – 140 of the 171 reported YAOs in the DOC data (or 82%) compared to 33% of older adults.

Table 22: TAP Demographics by Gender and Age

	N	Gender N=1,229				Age N=1,229			
		Women		Men		YAO		25 +	
		N	%	N	%	N	%	N	%
Overall	*1229*	*208*	*17%*	*1021*	*83%*	*67*	*5%*	*1162*	*95%*
Male	1229	0	0%	1021	100%	54	81%	967	83%
Female		208	100%	0	0%	13	19%	195	17%
Age at Release	*1229*	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
		39.1	10.4	41.6	11.6	22.4	1.58	42.3	10.8
Age Range		20 to 65		18 to 75		18 to 24		25 to 75	
		N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Religious Preference	*1229*	93	44%	447	44%	20	30%	520	45%
Marital Status - % Married	1182	12	6%	103	10%	4	6%	111	10%
Parental Status	*1126*	*189*		*937*		*56*		*1070*	
Have Children Under 18		105	55%	377	40%	26	46%	456	43%
		Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Living with # Children <18		1.87	1.04	1.63	.94	1.4	.70	1.7	.99
Range		1 to 4		1 to 6		1 to 3		1 to 6	
		N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Close Relationships	*1229*	*208*		*1021*		*67*		*1162*	
No Close Relationships		41	20%	214	21%	20	30%	235	20%
One or > Close Relationships		167	80%	807	79%	47	70%	927	80%
Number of Close Relationships		**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Including Friends		2.86	1.47	3.10	1.38	2.78	1.18	3.07	1.41
Range		1 to 5		1 to 5		1 to 5		1 to 5	
Family Only		2.31	1.24	2.51	1.16	2.34	1.10	2.49	1.18
Range		1 to 4		0 to 4		0 to 4		0 to 4	

	N	Gender N=1,229				Age N=1,229			
		Women		Men		YAO		25 +	
		N	%	N	%	N	%	N	%
By Type of Relationship		*167*		*807*		*47*		*927*	
Friends		92	55%	471	58%	21	45%	542	58%
Mother		100	60%	563	70%	38	81%	625	67%
Father		66	40%	371	46%	18	38%	419	45%
Brother/Sister		108	65%	632	78%	35	74%	705	76%
Children		112	67%	466	58%	19	40%	559	60%

Percentages may not add up to 100% due to rounding.

Table 23: TAP Economic Indicators - by Gender and Age

	Gender N=1,229				Age N=1,229			
	Women		Men		YAO		25 +	
	N	%	N	%	N	%	N	%
Overall	*208*	*17%*	*1021*	*83%*	*67*	*5%*	*1162*	*95%*
Own Residence	20	9%	160	16%	9	13%	171	15%
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Years at Current Residence	8.6	9.0	9.41	10.5	11.0	8.9	9.2	10.4
Range	1 to 40		1 to 52		1 to 21		1 to 52	
Longest Full Time Job (Mos.)	45.0	47.4	48.3	54.9	11.3	8.8	49.3	54.2
Range	1 to 300		1 to 432		1 to 36		1 to 432	
Profession/Occupation	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Has Profession, Trade or Skill	95	46%	536	53%	28	42%	603	52%
Occupation	*173*		*860*		*53*		*980*	
No Occupation	29	18%	159	19%	17	32%	171	17%
Stated Occupation	144	82%	701	81%	36	68%	809	83%
Type of Occupation	*144*		*701*		*36*		*809*	
Laborer	24	17%	308	44%	14	39%	318	39%
Service	69	48%	*193*	27%	10	28%	252	31%
Professional/Management	29	20%	72	10%	5	14%	96	12%
Crafts/Operatives	2	1%	87	12%	0	0%	89	11%
Sales	18	12%	32	5%	6	17%	44	5%
Farm Owner/Farm Labor	2	1%	9	1%	1	3%	10	1%
Primary Income Source	*169*		*825*		*46*		*948*	
No Income	60	35%	404	49%	28	61%	436	46%
Has Income	109	65%	421	51%	18	39%	512	54%

	Gender N=1,229				Age N=1,229			
	Women		Men		YAO		25 +	
	N	%	N	%	N	%	N	%
Type of Income	*109*		*421*		*18*		*512*	
Wages	10	9%	153	36%	7	39%	156	31%
TANF/Public Assistance	44	40%	111	26%	2	11%	153	30%
Disability	48	44%	106	25%	6	33%	148	29%
Other (Retirement/Pension)	7	6%	46	11%	2	11%	51	10%
Illegal Means	0	0%	5	1%	1	6%	4	<1%

Percentages may not add up to 100% due to rounding.

Table 24: TAP Physical and Mental Health - by Gender and Age

	Gender N=1,229				Age N=1,229			
	Women		Men		YAO		25 +	
	N	%	N	%	N	%	N	%
Physical Health	*208*	*17%*	*1021*	*83%*	*67*	*5%*	*1162*	*95%*
Ever Hospitalized	107	51%	516	51%	21	31%	602	52%
Have Chronic Medical Problem	75	36%	284	28%	10	15%	349	30%
Currently on Medications	111	53%	393	38%	15	22%	489	42%
Vision Issues	15	7%	69	7%	3	4%	81	7%
Hearing Problems	3	1%	12	1%	0	0%	15	1%
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
History or Current Diagnosis	1.6	.97	1.4	.84	1.0	.27	1.5	.88
Range	1 to 6		1 to 7		1 to 2		1 to 7	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Has One or More of:*	77		328		13		392	
Abscess	4	2%	22	2%	0	0%	26	2%
Arthritis	21	10%	50	5%	0	0%	71	6%
Cardiac	10	5%	31	3%	0	0%	41	4%
Diabetes	5	2%	46	5%	0	0%	51	4%
Cirrhosis or Liver	2	1%	12	1%	0	0%	14	1%
Hepatitis A, B, C (1 or More)	12	6%	62	6%	0	0%	74	6%
Sexually Transmitted Dis.	13	6%	65	6%	2	3%	76	7%
Lung/Breathing Problem	39	19%	86	8%	10	15%	115	10%
Mental Health								
Prescribed Medications	122	59%	389	38%	20	30%	491	42%
Co-Occurring	133	64%	430	42%	22	33%	541	47%

	Gender N=1,229				Age N=1,229			
	Women		Men		YAO		25 +	
	N	%	N	%	N	%	N	%
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Lifetime History of	3.36	1.5	3.09	1.4	2.8	1.4	3.1	1.4
Range	1 to 6		1 to 6		1 to 6		1 to 6	
	N	%	N	%	N	%	N	%
Has One or More of:*	*150*		*569*		*27*		*692*	
Depression	144	69%	507	50%	24	36%	627	54%
Anxiety	122	59%	439	43%	15	22%	546	47%
Hallucinations	54	26%	219	21%	6	9%	267	23%
Cognitive Issues	84	40%	286	28%	14	21%	356	31%
Controlling Violent Behavior	46	22%	197	19%	12	18%	231	20%
Attempted Suicide	54	26%	110	11%	6	9%	158	14%

Percentages may not add up to 100% due to rounding.
*Will total to more than 100% as 1 or more can be selected.

Table 25: Substance Use and Treatment Experiences - By Gender and Age

	Gender N=1,229				Age N=1,229			
	Women		Men		YAO		25 +	
	N	%	N	%	N	%	N	%
Substance Use	*208*	*17%*	*1021*	*83%*	*67*	*5%*	*1162*	*95%*
Only 1 Primary Drug Choice	57	32%	352	38%	28	47%	381	36%
Both Primary & Secondary	124	68%	585	62%	32	53%	677	64%
Primary Drug of Choice	*208*		*1021*		*67*		*1162*	
Alcohol	32	15%	267	26%	9	13%	290	25%
Cocaine/Crack	56	27%	147	14%	2	3%	201	17%
Heroin/Other Opiates	30	14%	210	21%	4	6%	236	20%
Marijuana/Hash	16	8%	176	17%	30	45%	162	14%
PCP	44	21%	133	13%	12	18%	165	14%
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Primary - Age of First Use	20.6	7.3	19.4	8.2	15.4	3.1	19.8	8.2
Range	5 to 45		5 to 69		10 to 23		5 to 69	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
IV Drug User or Denied	25	12%	146	14%	5	7%	166	14%
Used Drugs Relive Withdrawal	26	13%	179	18%	6	9%	199	17%
Increase Amount For Same Effect?	95	46%	482	47%	25	37%	552	48%
Use More than Intended?	106	51%	538	53%	27	40%	617	53%
Had Blackouts	67	32%	255	25%	7	10%	315	27%
Spend Lots of Time Getting Substance	72	35%	323	32%	15	22%	380	33%
Anyone Every Ask You to Stop?	167	80%	848	83%	52	78%	963	83%
Support at Home for Detox?	105	50%	525	51%	40	60%	590	51%
Tobacco User	157	75%	722	71%	48	72%	831	72%

	Gender N=1,229				Age N=1,229			
	Women		Men		YAO		25 +	
	N	%	N	%	N	%	N	%
Treatment Experiences	*208*		*1021*		*67*		*1162*	
No History of Treatment	59	28%	313	31%	36	54%	336	29%
One or More Experiences	149	72%	708	69%	31	46%	826	71%
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
Treatment: Alcohol or Drugs	3.1	2.6	2.7	2.4	2.1	1.4	2.8	2.4
Range	1 to 20		1 to 30		1 to 5		1 to 30	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
By Type of Treatment:	*149*		*708*		*31*		*826*	
Both Treatment and Detox	35	24%	174	25%	3	10%	206	25%
Only Treatment, No Detox	84	56%	385	54%	25	80%	444	54%
Only Detox	30	20%	149	21%	3	10%	176	21%
Attend 12 Step/Self-Help Group	116	56%	593	58%	28	42%	681	59%

Percentages may not add up to 100% due to rounding.

Mental Health Services Provided by DBH

DBH provided records for those who received mental health provider services during the study period. Data included diagnosis codes, dates of services, service category and units (amount of time) spent with those in custody during FY2015. While we provide a summary of the services provided by DBH to those in custody in the study period, we must caution against overstating these findings given the small number of individuals who received these services – 1.5% of the population (126 of 8,440 unique persons).[80]

In an effort to better understand those who received services versus those who did not, we compared individuals with the DOC provided indicator of an active mental illness (N=864) to those who received services from a DBH provider (N=126) while in DOC custody.[81] In order to compare those in the DBH dataset with the 864 with a DOC mental health indicator ("MHI"), DOC provided a deidentified[82] data set of 2,260 observations of mental health diagnosis for everyone in custody during the study period. While we are unable to associate a specific individual to a diagnosis, we can broadly compare the distribution of the types of mental illness between those who received DBH services and those with a MHI.

The following examination of differences between those who were in custody and *received mental health* ("RMH") services from DBH providers and those in custody with a MHI generally informs the discussion of mental health needs within those receiving services in the DOC.

Observing significant differences[83] between the RMH and MHI groups, we note they differ in gender, age, and racial composition. Women are more likely to be recipients of DBH services -- 18% of the RMH group are women vs. 9% of those who had an active mental illness while in DOC (the MHI group). Those in the RMH group are also are older (40 years old vs. 35), and are more likely to be non-white (99% vs. 95%) and are more likely to be a DC resident (94% vs. 78%) (which is not surprising as DBH only serves DC residents).

The RMH and MHI groups also vary in criminal histories and incarceration experiences. Those in the RMH group have a significantly longer criminal career (18 years vs. 15 years) – with a commensurate higher number of prior arrests. However, the RMH group have significantly lower arrest and charge conviction rates (44% arrest and 34% charge conviction rates for RMH; 53% arrest and 38% charge conviction rates for the MHI group). Looking at total arrests and charges

[80] As noted previously, DBH provides services to a narrow slice of the custodial population. They focus on those who are seriously and persistently mentally ill, sentenced populations who are residents of the District. In addition, services provided in the jail by DBH must be locally funded as Medicaid coverage is limited. See http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision.

[81] There were 27 unique persons who had both a mental health indicator from DOC and who also received DBH services. We conducted statistical tests using two samples – one that excluded those who were in both groups, and one which included those individuals who were in both groups. The pattern of which variables differed significantly across demographics, criminal history, and incarceration experience were virtually the same.

[82] DOC policy limits sharing "individual level diagnosis except to behavioral health or medical providers for the purpose of provision of care". Reena Chakraborty, Ph.D., Chief of Strategic Planning and Analysis, D.C. Department of Corrections, Personal Communication, September 13, 2017.

[83] Details not shown, but available upon request.

by type of offense, the only significant difference between the is those in the RMH group have a higher number of person arrests and charges than the MHI group. A higher percentage of the RMH group is pretrial (55% vs. 28% of the MHI group) and have shorter lengths of stay (101 days on average vs. 189 days). Finally, with respect to the most serious current charge, the RMH group has fewer person charges and more property charges, but otherwise the groups appear very similar with respect to the current offense.

Therefore, overall, the discussion related to provision of services by DBH may be more applicable to women and with older inmates who are DC residents and are held on pretrial. In addition, while the RMH group was engaged in the justice system for longer periods of time, they have fewer convictions, and while their criminal histories contain more person offenses, the most serious current charge is less likely to be a person crime.

Diagnosis at the individual level, as well as a breakdown of dosage of services (measured in number of sessions and time spent per client) and types services provided to those in custody of DOC are contained in Table 26.[84] As noted below, among the 96 with a diagnosis, almost half (49%) had a mood disorder. This includes those with Bipolar (ranging from mild to severe, and with and without psychosis) and Depression. Another third (35%) were diagnosed as Schizoid/Psychotic, including Schizophrenia, Schizoaffective disorder, Delusions, and Psychosis. There were 6% with Anxiety or Adjustment disorder, including PTSD; Another 4% with Impulse Disorder and Addiction; and then the final 5% fall into catchall "other" category.

Diagnoses from the deidentified data provided by DOC population indicated some differences from the diagnoses of those who received DBH services. In the DOC data with 2,260 observations, more than half (57%) had a mood disorder (compared to 49% of the RMH group). This includes those with Bipolar Disorder and Depression. There were also fewer cases of Schizoid/Psychotic (15% in DOC vs. 35%) but a higher number of those diagnosed with Anxiety or Adjustment disorder, including PTSD (24% compared to 6%); fewer in the Impulse Disorder and Addiction (less than 1% of DOC diagnoses vs. 4% of RMH); and 3% in the catchall "other" category.

Dosage and types of services are reported by booking stay, rather than by individual person. DBH providers spent on average 185 minutes (or about 3 hours ranging from 15 minutes to 38 hours), over 2.7 sessions (ranging 1 to 23 sessions). More than 1 service can be provided to each individual, but most often DBH providers conducted an initial and ongoing session with 58 of 132 (or 44%) in the custodial population; provided transitional support to 29 (or 22%); specialty services and/or crisis management services to 18 (14%) and the remaining 33 (25%) received intensive community based services through ACT (or Assertive Community Based) services.

Release information is also provided in Table 26. Of the 132 booking stays, 90 (68%) were released from DOC custody. We have data on release status for 83 of those 90, and note that 71% were released into self-custody. The remaining are released to the U.S. Marshall or FBOP (7%); MPD Officials (6%); a treatment program (6%) and 7 were released to St. Elizabeth's and to "other" (1 person escaped from a halfway house). We also provide the facility released from.

[84]The small number (N=126) of individuals served by DBH does not provide sufficient data to conduct a sub-group analyses by gender, age, or detainment status.

While more than half (53%) were released from CDF/CTF; 18% were released from St. Elizabeth's, 15% from either Superior Court or from Court Ordered DOC Holding; and the remaining 13% from the various community based privately operated halfway houses of Hope Village, Fairview, and Extended House.

Table 26: Diagnosis, Mental Health Services Provided to DOC Inmates, and Release

By Unique Persons (N=126) or Booking Stay (N=132)	**In Custody October 1, 2014 to September 30, 2015**				
	N	**Freq.**	**Percent**	**Range**	**Mean (SD)**
Diagnosis[85] (By Unique Person)	96				
Mood Disorder		47	49%		
Schizoid/Psychotic		34	35%		
Anxiety/Adjustment		6	6%		
Impulse/Addiction		4	4%		
Other		5	5%		
Services Provided	132				
Number of Sessions		132		1 to 23	2.7 (3.35)
Time Spent (In Minutes)		132		15 to 2,310	185 (262)
*Types of Service**	132				
Initial and Ongoing		58	44%		
Transition Support		29	22%		
ACT/Intensive Comm. Based		33	25%		
Specialty Services/Crisis Mgmt.		18	14%		
Released	132				
Not Yet Released as of 10/1/15		42	32%		
Released		90	68%		
Release Status	83				
Self-Custody		59	71%		
US Marshal or FBOP		6	7%		
MPD Officials		5	6%		
Treatment Program		6	6%		
Other/Saint Elizabeth's		8	9%		
Facility Released From	90				
CDF/CTF		48	53%		
DC Superior Court		11	12%		

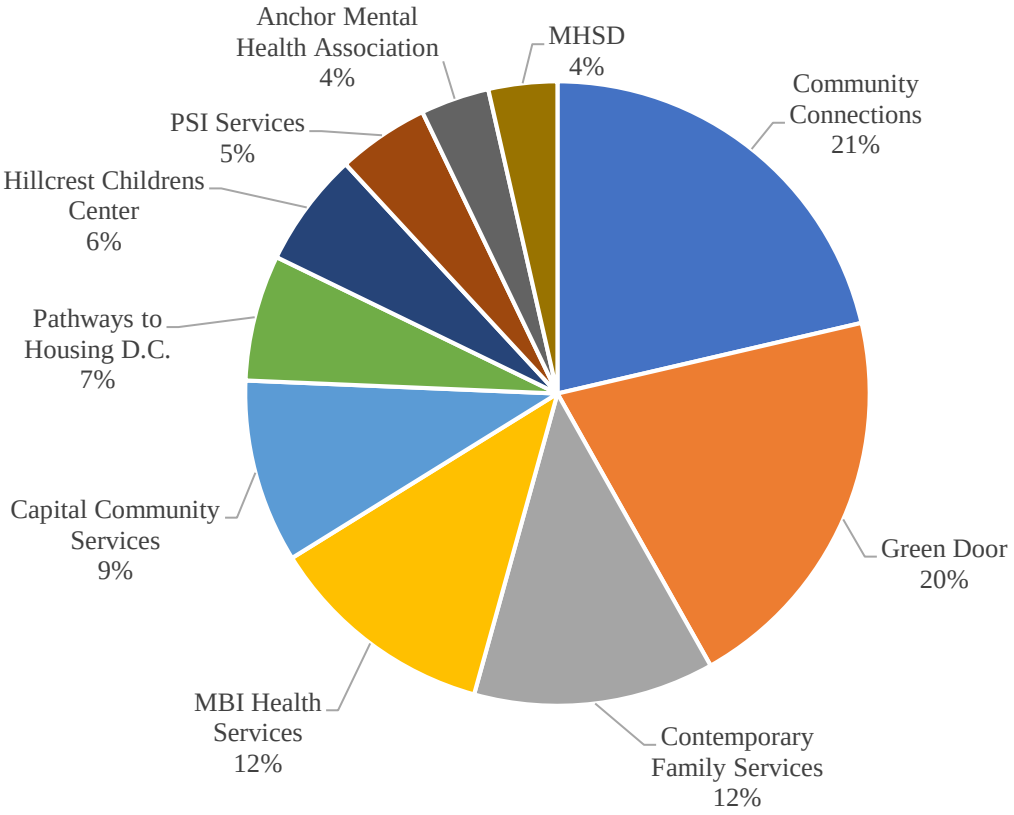
[85] Diagnosis codes from the International Classification of Diseases (ICCD) were provided by DBH for 96 of 126 individuals. We used http://www.icd10data.com/ICD10CM/Codes to look up the codes and categorize the diagnoses into these categories based on http://www.triadmentalhealth.org/what-is-mental-illness/

By Unique Persons (N=126) or Booking Stay (N=132)	In Custody October 1, 2014 to September 30, 2015				
	N	Freq.	Percent	Range	Mean (SD)
Halfway Houses (Hope Village; Fairview; Extended House)		12	13%		
St. Elizabeth's Hospital		16	18%		
Court Ordered DOC Holding		3	3%		

*Will total to more than 100% as 1 or more types of services can be provided.

Illustrated in Figure 5 below are the top 10 DBH providers of services based on the number of sessions provided. For the 126 individuals who received services, they had a total of 366 sessions. Community Connections provides approximately a fifth (21%) of these sessions, followed by Green Door with 20%, and Contemporary Family Services with 12% of sessions.

Figure 5: Top Ten DBH Providers By Number of Sessions N=366



Limitations and Conclusion: Services Analysis

The following are the key questions under consideration in this study that are addressed in this chapter:

- What are the mental health needs of those in DOC?
- What mental health services were provided to those in DOC?
- What are the substance abuse treatment needs of those in DOC?
- What are the medical needs of those in DOC?
- What are the educational and employment needs?

Based primarily on the TAP assessment this study found that those in custody have a number of complex needs. These individuals suffer from high rates of psychological concerns, and experience long term and serious substance abuse problems, and high rates of co-occurring disorders. In terms of physical health status, close to a third have one or more health diagnoses including lung and breathing problems, to Diabetes, to arthritis. While half reported they had a profession, trade or skill, over two-thirds rely on public assistance and disability as their primary income. Based on data from DOC, we also know that many are lacking a GED.

There are important limitations to these findings. First, those who completed TAP were different from those who did not complete the TAP in many ways – from demographic composition of those in custody to criminal histories to incarceration experiences. Given the number of differences between those who completed the TAP and those who did not, caution should be exercised in inferring the following medical, psychological, and employment histories to the entire custodial population. However, these findings can still be informative for older inmates, with commensurate longer criminal histories (including a higher number of public order and violations charges), but whose charges are less severe and are less likely to be gang members. In addition, those with a TAP are more likely to be sentenced or pretrial misdemeanants or violators than those without TAP assessment data. Overall, these comparisons can inform future service provision efforts by providing a context for those in custody. Generally speaking, these results are consistent with other studies on jail populations. Often individuals require a myriad of services to meet the challenges of returning home.

DOC, PSA, and DBH provided the data necessary to conduct the services analysis section of the study. By combining these data sets together, and focused on the TAP assessment data, this report provides a snapshot of the needs and treatment experiences of older misdemeanant inmates with longer criminal histories but are non-violent and engage in less serious types of crimes such as public order and violations charges. With respect to the DBH services provision data, we compared those who received DBH services to those in the DOC with an active mental health indicator and found that information gleaned from those who received DBH provider services, may be more relevant to women and older inmates who are DC residents and are held on pretrial. DBH service recipients are engaged in the justice system for longer periods of time, have fewer convictions, and while they have a history of more person crimes, their most serious current charge is less likely to be a person crime.

While this information helps to describe these populations, our goal in this study was also to explore the extant services provided to all DOC inmates and detainees while in custody. Unfortunately, with the exception of the DBH services data (which applies to less than 2% of the population), there were no data available to conduct a robust services analysis.

DOC provided indicators of the active mental, physical and substance abuse conditions among the population, as well as if an individual was in the GED, Reentry, or RSAT unit programs. However, beyond the DBH data, there were no data to assess completion or participation rates of these programs. Nor was there an ability to measure *dosage* from various types of services or programs. In a risk-responsivity approach, program frequency, dosage, and timing are among the most important elements required to appropriately assess the impact of a program on outcomes. In turn, this type of information is critical to strategic planning and the ability to respond to changing trends.[86]

Recommendations: Services Analysis

Expand COMPAS Facility-Wide and Invest in Building Reports

In this report we utilized the TAP assessment data to describe the physical, mental, and substance abuse status of those in DOC custodial population in FY2015. However, based on the comparison between those who completed the TAP and those who did not, there were significant differences across all measures including gender, age, criminal history and current incarceration experience. Thus, while the TAP was informative in describing a portion of the population (sentenced or pretrial misdemeanants or violators who were older inmates, with longer criminal histories including a higher number of public order and violations charges, but whose charges are less severe and are less likely to be gang members), it does not represent the entire population.

Unfortunately, there was little data available for this study that could address the key social-psychological criminological issues of those detained in DOC. However, the DOC currently uses the Northpointe COMPAS Assessment tool with at least some of those in custody. First, we recommend that DOC explore the possibility of conducting the COMPAS assessment tool facility wide (excluding those who leave the facility within the first few days). Second, the COMPAS data is not easily extractable as it is a SQL database. While one can create queries or customized reports to extract data from SQL databases, it is often a complex and difficult process.

Recommendation: Assess Full Population and Use Data to Inform Reentry Plans & Research

- *Expand COMPAS assessment facility wide;*
- *Invest in building reports to easily extract data;*
- *Use data to create reentry plans;*
- *Integrate COMPAS data into JMS;*
- *Allow community based service providers to utilize same case plan; and*
- *Use data as controls in recidivism analysis.*

[86]The original solicitation requested a trend analysis over the prior 12-year period. We were unable to complete this portion of the request as data was not readily available to conduct this analysis. However, DOC provides quarterly and annual reports. See https://doc.dc.gov/page/inmate-demographics-and-statistics

There are two areas where customized reports/data from the COMPAS[87] are worth the investment required to internally or externally develop these reports. The first area is case management. The COMPAS data is used to develop the reentry case plans. Automating the plan based on the assessment tool data, and making that plan and/or data are available to all case managers and community based service providers would ensure that the individual receives services that are targeted to their specific needs. This would also reduce assessment fatigue because the returning citizen would not be required to answer the same questions repeatedly. The second area where DOC would benefit from investing in data reports for COMPAS is research. If the COMPAS data were extractable – or ideally interactable into the DOC jail management system – this would allow DOC to assess the needs, concerns, and circumstances of the population on an ongoing basis. Measures from the COMPAS data could also be used as control variables in recidivism analysis of the population. Control variables are used to account for factors that could otherwise explain the outcome. For example, older offenders are less likely to recidivate, thus one would want to "control" for age in the analytic model.

Develop New Jail Management System to Track Program Activity

DOC would benefit from a new jail management system that has the capacity to track all program participation across the facility. Specifically, we recommend that the system capture the program ***process*** (e.g., who applies to participate in each program, and how many, and if there is an eligibility criterion, who met that criteria and who did not). ***Participation*** includes measures of dosage – including the number of sessions and/or hours provided overall, and attendance to track the same on an individual level (e.g., number of group sessions counseling attended). ***Outcomes*** can include program milestones (e.g., number of participants who completed a housing application) and/or measures such as number who obtained their GED. The number who completed the program should also be tracked, as well as the reasons that others did not. It would be important also to have a mechanism that tracks not only DOC-led programs, but programs conducted by community level providers in the facility.

Recommendation:
New Jail Management System
Track Program Participation, Process, and Outcomes

- *Applications – Measures level of interest*
- *Screening – Met eligibility criteria and if not, why not;*
- *Program Participation – total number served and attendance at individual sessions ("dosage"); and*
- *Milestones and Completion rates – number who completed interim steps in program, and completed program overall. Of those who do not complete, why not?*

With this type of information, DOC would be in a position to conduct ongoing assessment of the types of programs conducted within DOC. When these data are then associated with other justice records such as PSA criminal history data, this provides the opportunity to conduct an evaluation to determine the effectiveness of these programs. This would help DOC to weed out those programs that are not effectively serving the DOC population and thus not meeting the goals of the DOC.

[87]For more about the COMPAS, see Practitioner's Guide COMPAS Core http://www.northpointeinc.com/downloads/compas/Practitioners-Guide-COMPAS-Core-_031915.pdf

CHAPTER III: SERVICE AND PROGRAMS INTERVIEWS SUMMARY

Background

This chapter reflects the themes and recommendations that emerged from the focus groups and individual interviews conducted with DOC correctional staff and inmates, along with stakeholders, service providers, volunteers, and advocates within the District, that were conducted from March to June 2017.

Setting the Stage

The DOC vision is to become a benchmark corrections agency, serving with pride, professionalism, and passion in caring for human lives.[88] As part of its mission, the agency strives to support returning citizens. The DOC documents on its webpage its support for returning citizens by outlining programs to prepare inmates for release and providing links to community-based programs for post-release support.

The District's continuing support for success

In recent years, the District has maintained a strong lens toward community support for its returning citizens. It has

- Conducted a reentry review of DC DOC women's reentry services in 2012
- Developed a DC DOC reentry strategic plan in 2013
- Compiled a data needs assessment in 2015 and maintained support for the Mayor's Office on Returning Citizen Affairs (MORCA) community-based program
- Gained Mayoral commitment to employment partnerships with community providers in 2015
- Supported consolidation of the Central Treatment Facility (CTF) from the private CCA organization into the DC DOC and the companion Central Detention Facility's (CTF) operations effective in February 1, 2017
- Held community roundtable discussions
- Had a commitment from CJCC to review the on-site services and programs currently provided within the DC DOC to maximize the use of effective practices to support returning citizens

The opportunity to participate in quality programs during incarceration is an important aspect of facility-based service delivery on post-release outcomes. The coordination, communication, and collaboration of the inmate's transition—from the inside to the outside—between DOC and community providers are key to breaking the cycle of recidivism.

Inmates, staff, stakeholders, service providers, and advocates had the opportunity to be heard on a range of topics related to the DOC's programs and services. These groups identified programming they perceived was needed, but a broad inmate population assessment could provide a clearer, more efficient data map of who should access what programming. Specific populations can be identified through this mapped assessment to develop programming for specialized populations, using best evidence-based practices to target an evaluative measure of reducing recidivism.

[88] "DOC Vision Statement." *DC Department of Corrections.* https://doc.dc.gov/page/dc-doc-vision.

As an outgrowth of our interviews about programs and services provided by the DOC, inmates had a range of responses about their expectations for their post-incarceration lives. Most look forward to resuming life with their families, getting jobs, and moving forward with positive life choices. Inmates were vocal about the challenges they faced and where DOC may be more supportive. A glimpse at these community goals can help shape the programmatic needs.

A sampling of perceptions and experiences of inmates

- The relationship of inmates to the communities that they return to was a consistent theme amongst the inmates and staff who were in focus groups. Many mentioned the danger of re-entering into the same environments where offending behavior occurred. Inmates are concerned about not landing a job upon return and being forced into activities responsible for their incarceration. Upon returning, inmates have very little to no sense of "safety."

- Inmates shared that, depending on their status and sentence, they may be unable to benefit from the facility-based programs that are offered, leaving them idle and unable to access services until their return to the community.

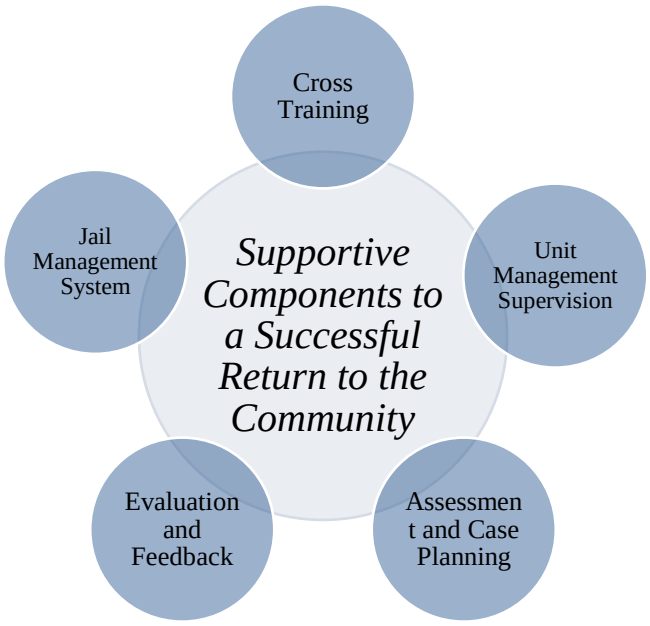
- Inmates frequently lacked knowledge about facility-based program offerings. In some instances, inmates suggested programs that already existed, such as education. Others suggested additional skills like English as a Second Language (ESL) or providing self-help materials that will continue with them into the community.

- Inmates remarked that programs, such as Community Family Life Services, a beneficial clothing and housing stability program, along with Project Empowerment's supportive employment services, provide tangible resources for their transition into the community.

- A consistent theme was the need to relax requirements around where returning citizens can and cannot live. Inmates voiced they would be better supported toward success if they were able to maintain communication and connections with their familial ties pre-release to ease the stress of their return to the community.

Recommendations identify supportive components toward an inmate's successful return to the community, reducing recidivism and their return to incarceration. All participants of our interviews identified nuances related to the recommendations, all essentially verbalizing the conversation of recommendations toward success.

Figure 6: Supportive Components to Successful Return to Community



As we look at goals for success, we asked where inmate participants think they'll be in a year: "somewhere good in life." Addressing the recommended supportive and successful components for returning to the community can positively punctuate the end goal of somewhere good in life.

Methodology

The TMG model for this project has been shaped by research and evidence-based literature, practitioner experience, knowledge of correctional reentry programs and services delivery, and collaborative partnerships with federal, state, and private entities. The review protocol was customized to meet the needs of the DOC. The participant interviews within the DOC included discussion of the following:

- Foundations of case planning
- Jail-based services and programs for specific populations
- Jail-based programming and access to services
- Jail-based best practices for success

The project protocol incorporated a review of service themes:

The review was accomplished through the following:

- Structured protocols for focus groups and conversations of programs and services provided by the DOC
- Review of inmate and staff census population sheets for the days of on-site focus groups
- Focus groups with a random sample of female and male inmates, and custody and non-custody staff members and key non-DOC staff, including community stakeholders, service providers, and advocates
- Individual calls with key stakeholders

TMG selected members of an assessment team from our cadre of subject matter experts who have relevant experience for each review area of the project. Further, team members were selected because of their commitment to serving the field in building solutions as partners with the client, their skills in critical thinking and analysis, and their resourcefulness in contributing to pragmatic, realistic recommendations.

The assessment team consisted of subject matter experts with significant experience in reentry correctional practices and the development and delivery of programs and services in a correctional environment.

The team included the following members:

- Anadora "Andie" Moss, TMG project advisor
- Judy Kirby, TMG project director
- Reggie Wilkinson, TMG senior advisor and consultant
- Cherie Townsend, TMG project director and consultant
- Stevyn Fogg, TMG project manager and consultant
- Malik Washington, TMG consultant
- Simone Greene, TMG project coordinator
- Shannon Murphy, TMG project manager

A structured protocol, developed by TMG, was used to conduct the focus groups and interviews. The questions were developed and reviewed by subject matter experts to ensure consistency with project objectives and to ensure that they would inform recommendations to support addressing identified gaps informed by reentry best practice. Using open-ended questions, this protocol elicited perspectives specific to the strengths and challenges of existing services, programs, and processes at DOC that are designed to facilitate successful inmate reentry into the community. The focus groups with inmates also incorporated the use of TurningPoint Technologies®, an audience response system. TurningPoint Technologies enabled participants to electronically and anonymously answer a series of questions via remote technology at the beginning of the inmate and staff focus group sessions. It provided an interactive opportunity to collect quick quantitative data while building a positive relationship between the participants and the facilitators, as well as among the inmates.

The protocols are provided in Appendix C.

Focus Groups and Individual Interviews Selection, Engagement, and Response

A notice in English and Spanish advising inmates and staff of the upcoming focus groups was developed, approved by the DOC, and posted by facility staff the week before an informational session and the subsequent focus groups. It explained that conversations would be held to outline information about how offender needs may be best met through programs and services within the jail. Confidentiality of the process was stressed and that inmates should not be retaliated against for participating in the focus groups.

Focus group participants included uniformed and non-uniformed correctional staff, inmates, stakeholders, service providers, and advocates. Stakeholders, providers, and partners with strong ties to the District's criminal justice system who were unable to attend the focus groups were contacted via phone for in-depth one-on-one conversations.

Inmates – Inmate informational sessions were coordinated by Reentry Coordinator Regina Gilmore (now retired) on March 7, 2017. TMG support staff invited inmates from seven male and two female housing units to these sessions. To select those inmates, staff used census sheets based on the day's population to choose 8 to 20 inmates per housing unit. Staff used a consistent pattern to select from each census. For example, 18 inmates from a male housing unit with a census of 146 were selected by choosing every fifth inmate from inmates in alphabetical order from inmate 8-48 and 98-143. Inmates who chose to participate in the informational session were given a brief 20-minute overview of the project, including its purpose and how their voice would inform our report to JRSA and subsequently CJCC.

Correctional staff were provided with the names of those inmates who were invited to the informational session to coordinate movement for the March 8 and 9, 2017, focus groups. Records of who attended were intentionally not included. Inmates who did not attend gave some of the following reasons: being in court, not wanting to miss a visit from a family or friend, or simply choosing not to participate. Of the 107 inmates randomly selected, 46 (43 percent) attended five on-site focus groups at the DOC. Inmate participants were 19 years of age to over 50 years and were comprised of:

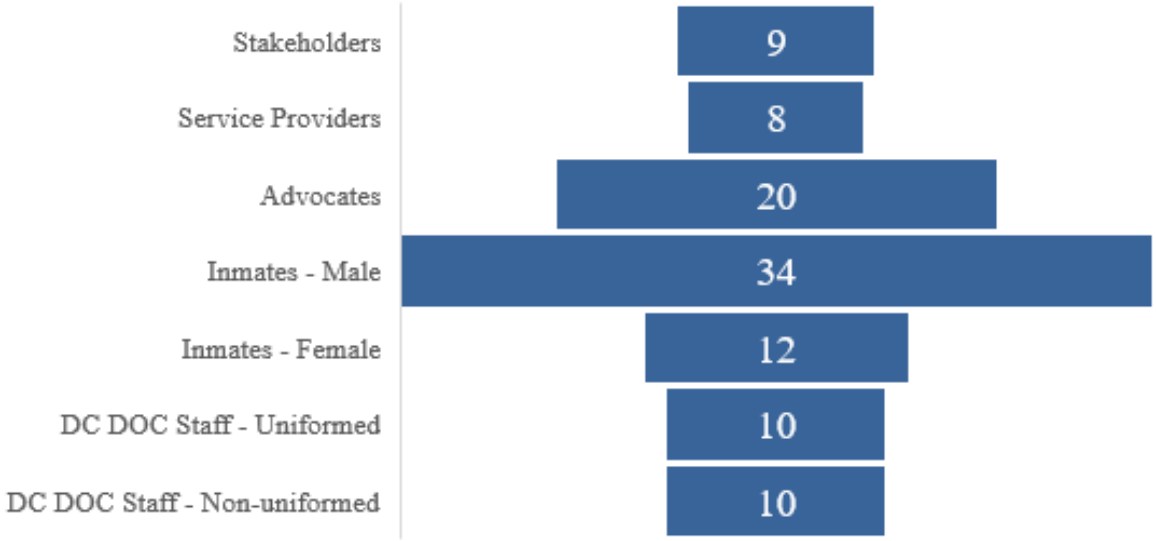
- pre-trial defendants
- convicted and awaiting sentencing
- serving a District sentence
- awaiting transfer to the Federal Bureau of Prisons (FBOP)

Correctional staff – Twenty total staff from both CDF and CTF, ten uniformed and ten non-uniformed staff, were randomly selected from staff census and based on their ability to be released from their assigned posts to participate in two focus group sessions. Uniform staff and non-uniform staff were in separate sessions, which were composed of male and females with correctional experience ranging from five to 20+ years. Staff's operational responsibilities consisted of uniformed officers overseeing facility security and operations, along with non-uniformed program and service delivery providers, such as case managers.

Stakeholders, service providers, and advocates – In consultation with CJCC, TMG and JRSA identified 53 partners, to include stakeholders who attend stakeholder update meetings, jail- and community-based service providers, District advocates for improving the lives of incarcerated persons, and public-sector leaders. Invitations describing the collaboration with CJCC and JRSA's DOC custodial population study were sent to the stakeholders. Invitations included information about the analysis of custodial populations in DOC facilities to ensure facilities are maximizing the use of effective jail-based reentry practices and opportunities to support returning citizens, ultimately leading to reductions in recidivism.

Invitations were sent to 53 people with 38 attending (72 percent participation rate.) Some invitations were sent to more than one person in an agency to ensure that agency's representation. Four focus groups were held at the DC Armory classroom and nine individual phone interviews were made to accommodate those who were not able to attend the focus groups. Two consultants co-facilitated, with TMG staff support, each focus group session and individual calls, with the exception of two calls that were facilitated by one consultant with TMG support staff and one call facilitated by TMG staff.

Figure 7: Focus Group Participants by Type N=104



See Appendix D for the agenda and timeline of focus group sessions and individual interviews.

Service Analysis Themes

As highlighted in the literature review executive summary (**Error! Reference source not found.**), "Jails are able to contribute to reductions in future admission through reentry services." The DOC has a singular reentry program for "sentenced inmates who are within one hundred and eighty (180) days of release." This "may include misdemeanants, felons designated to serve the sentence in a DOC facility…pending release on a split sentence…and who will not be eligible for halfway house placement within 30 days."[89] DOC has a designated reentry program for

[89] Brochure of the DOC Reentry Program provided to TMG by the DOC on March 9, 2017.

inmates to assist them in providing programs and services toward a successful return to the community. The vision of the DOC reentry program is "successful prisoner reentry" as a major priority "and through strategic interventions, authentic care and concern, we seek to make a positive impact on the lives of every inmate who passes through our gates to ensure that they never return."[90] Inmates eligible and admitted into the DOC reentry program are not required to participate in other pre-release programs and services, while participation in particular programs and services does not require reentry participation. Each are independent, stand-alone functions of the DOC instead of a wraparound philosophy that encompasses the total needs of the inmates.

Criminogenic

Producing or leading to crime

Themes from the focus groups and individual interviews emerged that consistently indicated that while the DOC reentry program is important and helpful to access community-based information when one can be involved, it serves only a small segment of the population of returning citizens and is not yet ingrained as a system. According to the Transition from Jail to Community initiative, reentry "involves the development, implementation, and evaluation of a *model* for jail-to-community transition. (A reentry) model … entails systems change and collaborative relationships between jails and community partners, …. and aims to improve public safety and reintegration outcomes."[91] Reentry is greater than the program and services components, from entry into the facility, through incarceration, and into post-release support through pre-release staff and partners into the community. Thus, our analyses focus on the overall programs and services available to the pre-trial and sentenced inmate populations, not just reentry programming and services.

Success

Inmates, staff, stakeholders, service providers, and advocates were unified in identifying aspects of an inmate's ideal release from DC DOC custody.

- Participation in programs and services that meet the individual risk, needs, and characteristics of the inmate
- All information in hand, including identification, housing, employment, medical insurance and social benefits verification, health needs including medication, educational status, program certificates and references, and release case plan
- Connected to services inside the facility that seamlessly continue with mentors and support systems within the community
- A sense of motivation and hope towards continued success

Participants indicated strengths and challenges in the following aspects of the DOC's services and programs. Specific service analysis themes from the literature review are highlighted as tenets of a successful program philosophy that can reduce criminal behaviors by returning citizens.

[90] District of Columbia Department of Correction. *Reentry Strategic Plan* presentation. Washington DC. 2012-2013.
[91] National Institute of Corrections and Urban Institute. *Transition from Jail to Community Initiative.* 2007. http://www.urban.org/policy-centers/justice-policy-center/projects/transition-jail-community-tjc-initiative.

Foundations of Case Planning

A validated individualized assessment of every inmate at entry that identifies risk for reoffending, case plans that follow the inmate inside and out, and available and accessible evidence-based programs that meet the measured risks and needs of the assessed inmate population.[92]

To develop effective programs and services for the discrete population, research indicates that aligning the level of individualized risk with the level of intervention will produce the best outcome. Ensuring the right interventions are targeted toward inmates' higher risks and needs maximizes limited resources, focusing on the higher risk population that would produce a higher community benefit. Without knowing the population's composite criminogenic risks and needs of all they serve, correctional agencies may misuse, overuse, or underuse available programming and may even do more harm than good.[93]

Service providers noted some familiarity with a handful of existing consumer assessment tools used by the DOC and service providers, but there is not a consistent, standardized assessment tool that is validated, consistent, and gender-responsive on the criminogenic risk and needs assessment on every inmate at intake. Some contracted community programs that provide services within the jail use the Texas Christian University's correctional treatment assessment scales, the NorthPointe and COMPAS correctional assessments, and other tools based on their individual agency protocols and assessment practices, but only if the inmate is using that particular program and agency for services and only if the inmate is within their program eligibility guidelines. When employed by a particular agency, the assessment is used for an individual case plan and is maintained for the agency's service use only; it is not shared among other service or correctional staff as information on the inmates' risk and needs or used for broader program placement. The case plans vary in structure and guidance by each service provider.

Placement into DOC programs is based on eligibility and admission criteria, which screen many inmates out of available programs and services. Staff indicated sex offenders and higher classification inmates are not eligible for most programs and services. Yet, inmates reported lower-level offenders are often mixed with high-risk populations, with the main classification delineations based on whether pretrial or sentenced, or local (District) versus FBOP jurisdiction. These mixed classification housing units disallow programming for everyone in the unit if a small segment falls into a disallowed group (high-risk) in the same unit.

If their sentence is too short, generally under 30 days, or if they are pre-trial or without an identified release date, they are not eligible to participate in time-based programs. There was mixed information about participation in programs for FBOP inmates, with some stating they receive more services and initiate motivation to document participation that may affect a better housing placement, while some indicated they must wait until their release from DOC (either until placement into a FBOP facility elsewhere or onto probation or parole) to access outside services.

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[92]JRSA (2017) in Appendix G.

[93]Lowen, Christopher, "Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders." *National Center for State Courts.* 2004. http://www.ncsc.org/~/media/Microsites/Files/PJCC/H%20RiskPrinciple.ashx

Without a consistent assessment tool identifying the needs of the inmate populations, staff and inmates identify program and service needs through the inmate's self-report. Historical information is not available to staff or service providers to provide a glance at prior programming needs and experiences. Inmates, staff, and stakeholders pointed to a multitude of needs noted among the inmate's self-reporting, including housing, substance abuse, mental health care, education, and employment, along with needs to improve family support systems, a change in thinking patterns, and improving their own soft skills that would improve their success (communication skills were often mentioned.)

While 75 percent of inmates knew where they were going to live upon release, several remarked they would be returning to old neighborhoods with negative influences, lack of positive support, and safety concerns. High crime and high violence areas are often the only available and affordable for returning citizens and they are forbidden by probation or parole supervision requirements from the types of communities and environments that may be better suited for living successfully. Rules forbidding felons from Section 8 housing and other housing services may further prevent returners from finding a suitable place to live.

Both inmates and staff pointed to employment as a primary need among returning inmates and provided high praise for Project Empowerment (PE). The DOC partners with PE to implement a vibrant transitional employment program for job seekers who have multiple barriers to employment. Upon participation and completion of the pre-release PE program, inmates are provided with employment for up to six months post-release, relieving the stress and time of finding viable employment with verifiable references. A study found that PE is implementing evidence-based strategies consistent with programs that serve those with multiple barriers to employment opportunities. Due to this positive reputation, it seems to meet inmates' needs and skill development through a diverse set of programs and staff. Using assessment results would ensure that multiple risks and needs identified for that inmate could be met through one such program as Project Empowerment, such as coaching and support models to address cognitive behavioral needs.

To assess and work as a team toward an inmate's success, staff and service providers indicated that access to the Jail and Community Corrections System Booking Screen, which holds inmates' personal information, should be expanded. It could alert all correctional staff who have a need to know, based through their supervision and security role, to serious mental health or behavioral issues. The current limited access places them at a disadvantage for proper management and success. Some programs, such as Project Empowerment, keep their own records, but there is not an overarching, composite formal recordkeeping of the inmates' background information or program-related accomplishments that is shared among case planning and correctional staff.

The contracted healthcare provider reported its internal electronic health records have been improved, but the information is not shared or linked with correctional staff, to include release planning needs and resources. Sharing behavioral health information is still a challenge and disjointed among staff and providers, and it could be eased through a robust jail and case management information system. One improvement with the health records is an increase in inmates with mental health concerns receiving three to seven days of medication upon release, although it was noted this short-regimen many times did not cover the time it takes to get into the

initial behavioral health appointment. A realistic medication regimen at release in order to maintain continuity of care until their first community-based appointment is a critical first step.

Assessing all inmates at the point of entry into a correctional facility with a consistent tool managed through a dynamic, multi-faceted, and relational jail and case management system would provide consistent eligibility determinations based on their status in the judicial system, risks and needs to ensure all inmates are being reviewed for potential inclusion in pre-release services, modeling the importance of the inmate's success. develops an outline of the inmate's case plan, indicating needed programs and services. This helps meet the DOC population's distinct needs and provides a consistent pathway of goals toward release.

Ensuring eligibility criteria does not hinder access to programs that match the identified needs, reduces unnecessary programming, and mitigates the inmate's criminogenic factors that lead to recidivism. Research points to the importance of collecting static risk factors, to include age at first arrest and current age, gender, and criminal history.[94] Common criminogenic needs to be collected also include dynamic changing risk factors, such as social attitudes, peers, social behaviors, employment history, educational achievement, and family impacts. Regularly reviewing the assessment information gleaned from the population of the DOC for trends and changes through an integrated jail and case management information system promotes an efficient use of the right programs and services with the right dosage within the DOC to reduce recidivism.

Jail-based Programming: Access to Services

Wrap-around holistic pre-release services that consist of multi-disciplinary providers and correctional staff through centralized housing practices allow for a multitude of programs to meet the individual needs.[95]

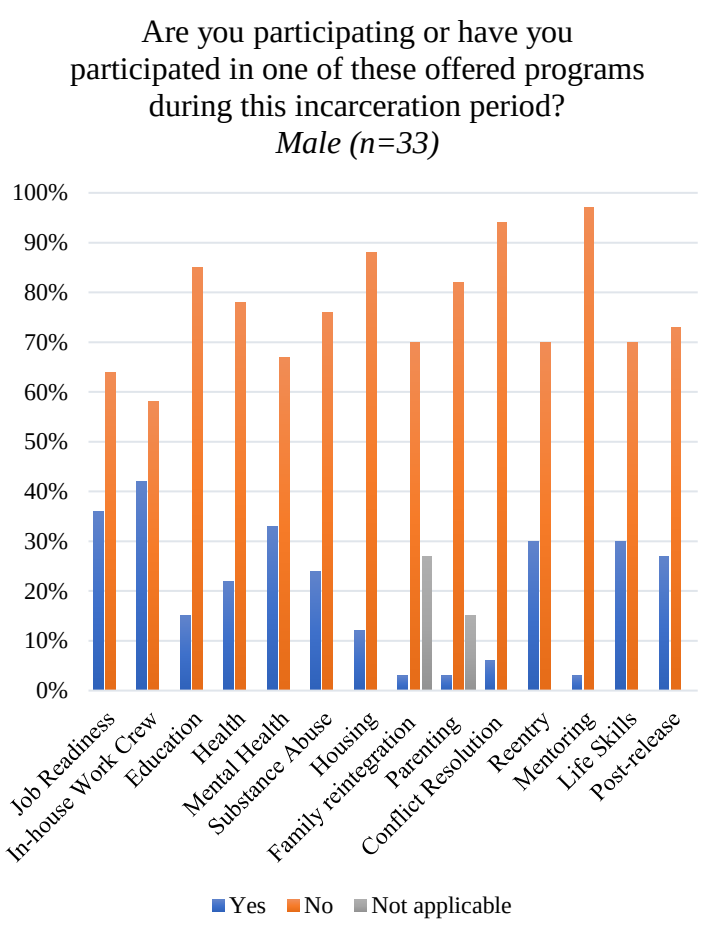
DOC has a variety of programs within its facilities and has identified and engaged relevant community service providers to assist in pre-release planning. Through the TurningPoint[96] questions asked of the inmates about program participation during their current incarceration, inmates reported the following:

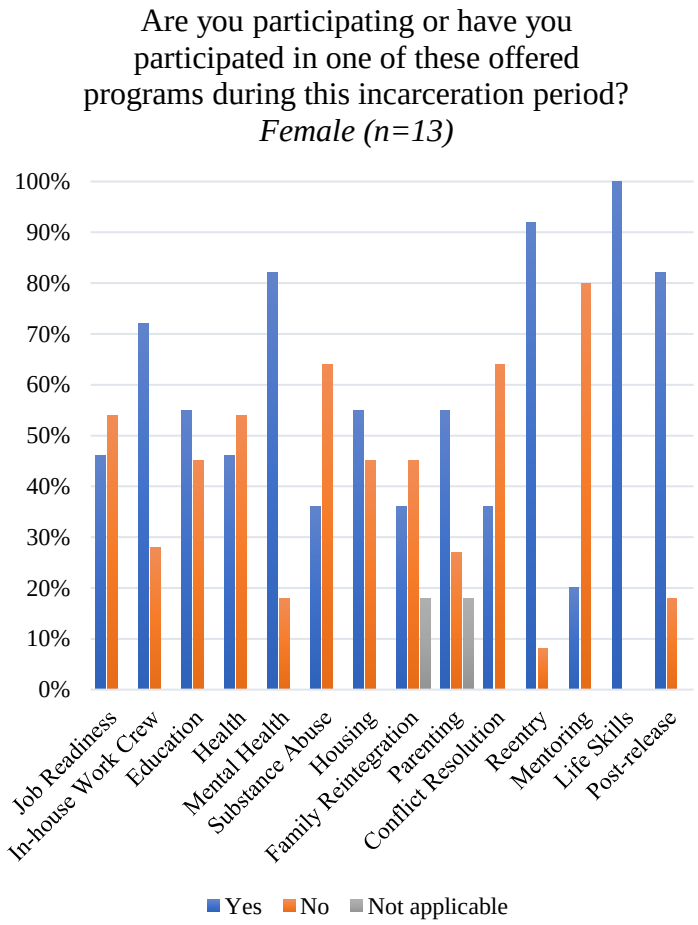
- Most programming was only available to sentenced or FBOP inmates due to their defined release date. Inmates without release dates are not placed into programs that have defined timeframes.
- Most inmates reported that they had not participated in many of the offered programs, although most participants were sentenced inmates (75 percent).
- Female inmates reported more participation in programs than their male counterparts.
- Male participants noted that some of the programs we identified in the quantitative questioning were not stand-alone programs but rather components of the job readiness or reentry programs (i.e., life skills programming is built in as a part of the substance abuse and job readiness program).

[94]"The Principles of Effective Interventions." *National Institute of Corrections.* (NIC) 2014. https://nicic.gov/theprinciplesofeffectiveinterventions.

[95]JRSA (2017) in Appendix G.

[96]See also Appendix E for additional results.





Nearly all participants expressed a desire for better access to a variety of programs while in custody.

Stakeholders, service providers, and advocates aligned their experience with programs similarly to inmates and staff experiences and advised that access to programs for inmates can vary based on the following factors:

- **Judicial Status**: Pre-trial inmates without a defined release date versus sentenced inmates who have a defined length of sentence to serve and a known release date.
- **Release Date Calculation:** there is a lengthy process for determining released dates for sentenced inmates, and inmates are not eligible to participate in programs until this date is calculated. The calculation involves sentenced credits by the DOC and the courts.
- **Length of Stay:** Those with lengths of stay fewer than 30 days or more than 180 days.
- **Program Admission Process:** Those who do have knowledge of the admission process to programs by inmates or criminal justice partners are more likely to participate.
- **Knowledge of Programs:** Inmates aware of the available pre-release programs and services and accompanying eligibility requirements are more likely to access these resources.

Two other opinions voiced by these groups included:

- Substance abuse treatment should be available for all DOC inmates and the referral process should start upon entry into the DOC through a system that identifies their criminogenic needs and risks; and
- Reentry servicees should be available from admission date and to all inmates, not just those housed in the reentry unit.

Substance abuse treatment: One structured treatment program is through the Residential Substance Abuse Treatment (RSAT) housing unit. The DOC has an extensive policy regarding RSAT eligibility, placement, and structure, but indicates "(r)eferrals are accepted from a variety of sources, including, but not limited to, correctional staff, medical/mental health staff, criminal justice system partners, case managers and self-referrals."[97] Inmates participating in RSAT indicated they were grateful for the substance abuse treatment program while in custody, with one inmate stating "it saved my life," but expressed a need for more structured content and time toward recovery issues while in custody. Inmates indicated approximately five to ten hours of programming weekly was available to them, resulting in a lot of idle time and a desire for much more intensive programming and treatment time. One drawback noted of RSAT was participants were unable to link to or participate in other programs while housed within RSAT units. Inmates expressed a desire for additional substance abuse education and treatment programs, not just RSAT alone as a concurrent tool alongside employment, housing, and other areas of need.

Work and employment: Inmates reported a few preparatory job skills programs available to them, if they were residing in the appropriate housing unit. But of the programs surveyed in the inmate focus groups, in-house work crews had the highest male inmate participation, with job readiness programs with the second highest male inmate participation rate. In-house work crews served several needs: the opportunity to do something with idle time, contact with other inmates, and some monetary value in exchange for their work. Inmates in the job readiness program unit had positive experiences developing soft skills, such as developing a resume, how to job search, and interview pointers. But, most voiced there are few hands-on employment programs to develop hard skills.

One program stood out as participants from all arenas indicated supportive employment programs have been the most helpful. Project Empowerment was consistently identified as the most helpful program. PE provided the supportive piece missing from many employment programs. PE "provides supportive services, adult basic education, job coaching, employability, life skills and limited vocational training, and job search assistance to District of Columbia residents living in areas with high unemployment or poverty levels."[98]

[97]The policy dated 2015 notes the previous CTF supervision by CCA, which ended its contract and oversight on January 31, 2017. DOC Policy # 6050.3B. https://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/PP%206050.3B%20%20Residential%20Substance%20Abuse%20Treatment%20Program%2011-17-15.pdf

[98]"About Project Empowerment." *Department of Employment Services.* https://does.dc.gov/page/about-project-empowerment

For those not participating in Project Empowerment, one of the challenges with helping them return to the community is job placement. Inmates indicated that having community-based "connections" was just as important as the type of programs and services offered. For example, inmates wanted to be able to use an agency or organization representative's name as a reference or to call upon for job or service leads. Inmates indicated that mentoring, apprenticeship, and practical skills training should be created and improved inside the facility. While training is provided on electrical and plumbing theory, they expressed a desire for hands-on, real-time application and experience to feel competent to put the theory into action.

Mental health: Inmates reported there was consistent availability of medication management services to obtain behavioral health medications. Yet, inmates and stakeholders repeatedly voiced a need a for additional therapeutic interventions, such as therapy for trauma-related incidents; the anxiety of managing grief, loss, and anger in a jail setting; and learning tools to motivate change. Many inmates were cognizant they would be returning to difficult environments with few tools available to them to direct change. Inmates also indicated that family stress, employment, income, lack of housing, loss of structure, and financial obligations as mental health challenges. Inmates would like to have concurrent therapeutic services in addition to programs that support workforce and substance abuse skills. A motivation to change was reported as a missing tool among the inmate population, and providing these therapeutic interventions would bolster their confidence to change.

One Inmate's Perspective

I wish that I could do an actual trade. Some people have more time, some people are coming out in 90 days. There are different sentences. Some people have been in here a long time. Some people like me, I got 60-90 days but I've been on the computer learning how to do plumbing. In jail, it would be helpful if I can get a program that's more hands on because you're not going to really learn anything if you're just in a book reading the basics of what to do and how to be a plumber. I still don't know. I have a certificate that says I read these skills, but you put a broken sink in front of me, I still don't know how to fix it.

Access: Inmates consistently reported they were not aware of available programming or how to ask about available programming, relying on word-of-mouth information inmate-to-inmate. For some that were aware of and may be participating in some programming, providers noted inmates did not understand how or why they were selected for a program. TMG is aware of significant efforts approximately five years ago to provide written resources to releasing inmates, but since that time eligibility and admission may have changed, service providers contact information and guidelines may have changed, and newly identified services may have been added into the community.

Correctional and reentry staff indicated the inmate handbook outlines available programs and services available during incarceration, but is not consistently provided to inmates at entry and is out of date. Inmates noted they would hear of the programs and services from another inmate's handbook, then find many of the programs and services were no longer available and eligibility criteria was not well defined or adhered to. A more current DOC reentry services guide was

provided to the project team detailing a wide number of community-based services available to inmates upon release. It was reported by DOC this release guide may be provided to inmates through the reentry program at release, but inmate participants reported eligibility barriers to participating in the formal reentry process, thus not having a pathway through reentry to obtain the release guide. This was seen during the informational sessions prior to the focus groups when inmates approached reentry staff asking how they may become eligible or receive information about community services. After a few questions, such as "are you sentenced?" "who (what court entity) sentenced you?" and "when are you scheduled to be released?" most inmates were advised they were not eligible or would not be in custody long enough to participate in the initial quarterly town hall introduction to reentry. They were then guided to speak with their housing unit case manager about other programs and services they may be eligible for based on their status and housing location.

The limited number of case managers and lack of regularly scheduled access to case managers was noted as barriers to addressing questions, services, and needs in a timely manner. Case managers' offices were not in the housing unit and there was not a regular daily or weekly schedule posted indicating when they would be available for inmates to discuss case and release planning. One inmate noted he had missed the case manager several times due to visitation. If he had known the case manager would be available, he would reschedule his visit to ensure he could meet with the case manager. Inmates reported sending requests to speak with a case manager, but response was either slow or not followed up. Inmates and staff noted a lack of communication between case managers and officers when officers were left to answer questions and find out availability of case managers to meet inmates' requests.

When inmates could meet with a case manager, inmates expressed that limited time with case managers and individuals trained to work with inmates and assess needs contributes to lack of positive reinforcement, impacting their motivation and heightening their hopelessness. Providers also reported training does not address the philosophical values of successful and effective release and

Program Highlight: RSAT

The Department of Corrections continues to operate a grant-funded therapeutic substance abuse program for both male and female inmates—the "Progress Towards Empowerment" Residential Substance Abuse Treatment Program. Inmates entering the program are either self-referred, referred by correctional staff, the United States Parole Commission, or the Public Defenders' Service. The program uses a co-occurring modified therapeutic service model with each participant's unique circumstances and progress dictating the duration of his or her stay in the program (90-day average). Inmates enrolled in RSAT move through progressive therapeutic phases with workshops on domestic violence, parenting, fatherhood, life skills, arts, behavior modification, vocational education, and health education included in the curriculum.

After completing the full program, RSAT graduates are transferred and placed bed-to-bed into an Addiction Prevention and Recovery Administration-funded aftercare program for up to six months. The agency negotiated a unique agreement with the US Parole Commission to grant parole to those who successfully complete the 90-day program and transition into community programming for a six-month period.

https://doc.dc.gov/page/substance-abuse-treatment-doc

reentry back into the community. Also, inmates indicated that a lack of consistent services by external providers impacts their self-esteem and frustration. Inmates indicated that external service providers frequently cancel at the last minute or are "no shows." Inmates related that they are made to feel less important or considered an afterthought by the very people who are responsible for providing positive reinforcement.

Criminal justice stakeholder and service providers indicated that they are, by default, based on the access they have, the primary vehicle to meet inmates' needs, not case managers or other staff. Inmates describe their experiences as having limited access to programs and case managers to access and meet their individual needs. There are several barriers and restrictions on who gets into programming, often reported as simply a result of who knows who, or who likes who. Pretrial inmates report having no access to services, despite how long they may be held in custody.

Individual programs are unit based and most programs are singularly offered for the inmate that is housed in that unit, if they are sentenced to enough time to participate. If they are pre-trial, inmates had little access to programs and services. Some indicated they would meet with a unit case manager to receive information on obtaining identification materials, but without firm release dates, there were logistical issues to navigate when they could obtain what service or assistance prior to their release. Sentenced inmates also indicated computing release dates was a lengthy process, sometimes finding out too close to release what the firm date is, disallowing them time to participate in some programs. This brought concern from inmates who indicated they had numerous needs and had to choose one program, be placed in a single program module, wait until they were within the eligibility timeframe, or miss the opportunity.

When case manager-inmate relationships do exist, they seem to be satisfying for those inmates. But, conversely, inmates reported that case managers are not often on the housing unit floors, have varied and unknown hours and schedules, and "have the ability" to get inmates into programs, but without their presence, it becomes harder. For example, some focus group participants reported no knowledge of substance abuse, housing, or family reintegration programs and services. Inmates repeatedly indicated program selection seemed "random," stating inmates sometimes don't necessarily have to do anything to access it, they are just told by different staff they are now assigned to complete that particular program.

Finally, deployment of staff and the training they receive are essential components to any correctional operation. At DOC, civilian and custody staff, along with a contingent of volunteers provide a variety of essential services. Their day-to-day operational responsibilities are augmented by community-based services providers. Uniform staff were consistent in stating inmates brought programming and services questions to them, absent a case manager. They were also consistent in stating that many times they did not have the information or knowledge to provide them. As noted above, providers reported training does not address the philosophical values of successful and effective release and reentry back into the community. Also, inmates indicated that a lack of consistent services by external providers impacts their self-esteem and frustration. Inmates indicated that external service providers frequently cancel at the last minute or are "no shows." Inmates related that they are made to feel less important or considered an afterthought by the very people who are responsible for providing positive reinforcement.

Aligning the inmate handbook with up-to-date programming information would provide accurate information and dispel myths and mystery about what programs and services are available to whom, increasing the likelihood of participation in programming upon entry to the jail. Incorrect word-of-mouth information and eligibility and admission criteria spreads quickly without a guiding document available to all inmates. An updated inmate handbook should also lay out the process for all inmates to consistently, across-the-board be informed of and understand how to access programs and services.

Additional training for staff, volunteers, and community providers on evidence-based practices to improve reentry success is warranted. For example, inmates relayed mixed experiences on incentivized positive reinforcement, an important evidence-based communication tool that supports success. Inmates recalled staff members who have been incredibly encouraging in that "(t)hey don't give up on you" and some who have been discouraging. Female inmates described experiencing positive reinforcement from staff more than the male inmates. But male inmates involved in Project Empowerment all noted good feedback from staff and helpful guidance on how to present themselves, how to improve communication skills, and the impact of body language.

Participants suggested additional support programs be available in the DOC in addition to offered programs. Individual and group therapy sessions that address trauma, anxieties, and feelings of loss were a missing desired resource. Peer support, coaching, mentoring, and other "groups like this," referring to the focus groups that provided a listening foundation for participants to express their perceptions, desires, and challenges.

Jail-based Services and Programs for Specific Populations

Develop correctional practices and programs that meet the individual identified characteristics of the population, meeting the specific higher risk needs of youthful offenders, gender-specific populations, and identified physical and behavioral health needs. [99]

Through assessment, jails can be responsive in considering the appropriate services to address the unique needs of inmates in their population. With over 3,000 jails in the United States, ranging from rural to urban areas, each jail has a population reflective of the community it serves.

Members of the women's focus group believed there were more male-centered programs and services available at DOC, though women indicated participating in more programming than male inmates. A lack of consistent information across the population may perpetuate this gender divide on available programming. Inmates reported that some programs are listed in the inmate handbook, but the list is not exhaustive or inclusive of specialized programs, many of the programs listed weren't available any more, or were not available to them based on their housing location. Inmates indicated additional and up-to-date program information was generally shared through word-of-mouth with other inmates. Women indicated programs geared toward their needs, including trauma and family reintegration, would address underlying needs that affect their successful return to the community.

[99]JRSA (2017) in Appendix G.

An area of agreement found from our diverse conversations is the need for cross training all participants, including uniform and non-uniform staff, service providers, volunteers, and inmates, on effective population-specific practices. Many non-inmate participants voiced an eagerness for all to speak the same language by sharing information of each other's roles, services, and what would improve an inmate's success upon release from the DOC. Staff indicated they receive some limited training on identifying unusual behaviors, but welcome more in-depth training on better supervision techniques to use with inmates with mental health disorders.

Correctional staff and program staff are not cross trained to assist each other as a unit management model would recommend to assist inmates across the board. Both correctional and program staff voiced a need for improved communication skills to interact with inmates with diverse needs and to communicate as a multi-disciplinary team for the success of the inmate. Current training is geared toward a non-descript hypothetical inmate without regard to a variety of traits and populations. A well-defined, integrated jail and case management information system could bridge this communication and information gap for the staff—uniform and non-uniform—that support pre-release services from assessed factors. As the need for validated assessment was previously identified, research shows "offender assessments are most reliable and valid when staff are formally trained to administer" the tool to best serve the inmate needs.

Jail-based Best Practices for Success

Research points to best correctional programming practices that promote success: cognitive behavioral interventions for inmates who have higher risks and needs, supporting family and social supports through the transition, multi-disciplinary collaboration between uniform and program staff, bringing the outside in, and providing effective programming to support employment, education, and substance abuse services as identified in the assessed characteristics and needs of the population.[100]

DOC provides a variety of facility-based programs from reentry services that may assist with pre-and post-release case planning, job readiness, education, connecting with community-based providers, obtaining identification, mentoring, court intervention, housing, substance abuse, and mental health. Some programs are voluntary, other programs are unit-based or court required, and some groups of inmates are automatically enrolled in programs like GED attainment.

Evidence-based training focuses on the knowledge of principles that reduce recidivism. Research and best practices indicate correctional agencies should develop approaches targeted at addressing unwanted behavior and supporting positive behavior.[101] Incentives and rewards are powerful motivational tools. This does not diminish the need for sanctions and is only a reminder that positive tools are effective tools. One such important principle is targeting cognitive-behavioral needs. Implementing effective cognitive-behavioral-based programs can produce a reduction in recidivism rates.[102] One cognitive-based barrier that arose from many of our conversations was that of an inmate's sense of hopelessness. The hopelessness led to reduced

[100]JRSA (2017) in Appendix G.
[101]NIC (2014), page 4.
[102]NIC (2014), page 5.

motivation, anger, and lack of goal-oriented development. One inmate recommended regularly continuing the focus groups as a positive avenue to express their feelings and be heard, stating the group was helpful as it was the most he had talked to others, including among inmates themselves.

Motivation is an important aspect of offender management, which can be influenced by corrections professionals' interactions with offenders. The focus groups explored interactions that are supportive of positive intrinsic motivation. There is an existing motivation and will among inmates that has yet to be capitalized on within DOC. Inmates, staff, and stakeholders identified peer mentors as a missing support source that may drive inmates' motivation toward success. Inmates have limited exposure to individuals who have successfully completed programs and reentered their communities without reincarceration, despite that those individuals do exist. There may be a missed opportunity by not promoting success stories, for the sake of the programs and those individuals who will enter them. Also, inmates report current staffing limitations do not allow for the type of interpersonal relationships required to assess and foster intrinsic motivation. Training for staff to recognize signs in inmates' behavior was an often-noted need. For instance, is an inmate behaving in such a way because he or she lacks intrinsic motivation, or is he or she communicating a different set of needs that staff and facilities are unable to provide?

Both inmates and staff had different views on how best to enhance and instill intrinsic motivation.

Offender-based Effective Evidence-based Practices

Evidence-based practices arise out of research-based, proven empirical knowledge.

1. Does agency policy require that offender interventions be based on the principles of evidence-based practices?
2. How are staff educated about the principles of evidence-based practices?
3. Are interventions regularly monitored and evaluated for outcome measures?
4. Does the agency employ a validated risk-assessment tool?
5. Does policy require that offenders be assessed early and on an ongoing basis for intervention needs?
6. Does release planning begin when the offender enters the institution or residential setting?
7. How are institutional interventions linked to community interventions to ensure continuity of treatment?
8. Are high-risk or high-need offenders prioritized for more intensive services?
9. Does your agency use a single, dynamic case management plan that follows the offender from the institution through his or her release into the community?

http://cepp.com/wp-content/uploads/2015/12/Successful-Offender-Reentry-Corrections-Policymakers-2.pdf

- Staff consistently cited inmates' lack of willingness to improve one's self, while inmates often cited a lack of staff knowledge, understanding, and training along with available program spaces to work toward their goals.
- While inmates indicated additional programming that met more than one need would be motivating and valuable in addressing a wide variety of barriers, correctional staff believe that

access to programs should be restricted and enhanced to ensure inmate accountability (i.e., file notes when inmates are late for class or programs). This is one way staff believes the agency can separate inmates with true interest from those who simply want to leave their cells.

Inmates indicated certificates or other concrete displays of their participation in programs would be motivating. Inmates noted it would be helpful for staff to provide references of individuals who can attest to their abilities. Inmates indicated these work certificates could be produced for potential employers during interviews or when applying for jobs. They expressed disappointment that their hard work ended without "something to show" for their participation.

Recommendations: Service and Programs

Assessment and Case Planning

Numerous evidence-based best practices in corrections are contingent on obtaining timely, relevant measures of offender risk and need at the individual and population levels.[103] The knowledge of the inmate population, individually and aggregately, is the foundation that drives how efficiently and effectively a facility provides the right services to the right population.

There is emerging research that indicates employment is not the panacea to reducing recidivism.[104] It's important to concurrently address cognitive behaviors that target thoughts, attitudes, and beliefs—some refer to as the softer skills—that impede the success of hard skills, such as successful employment along with incorporating gender-responsive practices. Thus, an objective assessment that focuses on all risks and needs would identify the totality of skills that would improve employment success.

Assessment and Case Planning Recommendations

- *Conduct a validated, consistent, gender-responsive criminogenic risk and needs assessment on every inmate at intake.*
- *Revise eligibility criteria policies to align inmates assessed risks and needs to develop appropriate services and programs.*
- *Revise the inmate handbook with up-to-date programming, eligibility, and admission criteria and provide to all inmates at entry.*
- *Tailor case planning and use of programs and services pathways to meet the varied statuses of inmates (e.g., pre-trial, sentenced, District, FBOP).*
- *Develop policies and processes to share assessment information with correctional staff and pertinent community partners invested in the successful release of the inmate, facility- and community-based.*
- *Regularly review composite assessed risks and needs to ensure the deployment of evidence-based services and programs meet the identified needs of the population, including therapy interventions, and peer support, coaching, and mentoring as recommended by inmates.*

[103] "Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention, page 3." *Crime and Justice Institute.* https://s3.amazonaws.com/static.nicic.gov/Library/019342.pdf.

[104] Office of Planning, Research and Evaluation. *More Than a Job: Final Results from the Evaluation of the Center for Employment Opportunities (CEO) Transitional Jobs Program.* New York, NY, January 2012. https://www.acf.hhs.gov/sites/default/files/opre/more_than_job.pdf

For example, Project Empowerment's success comes from a holistic, encompassing approach through the development of soft and hard skills. The District's Department of Employment Services' Project Empowerment Comparative Analysis Report notes "transitional employment programs can play a vital role in helping job seekers with multiple barriers to employment succeed in the job market. These programs combine time limited paid work experience, skills development training, job development, retention and supportive services to help individuals with barriers to succeed in the workforce."[105]

Unit Management Style of Supportive Supervision

The current system of program-based housing limits inmates' access to the wide variety of services they may need to be successful and fragments communication among staff who supervise in single-program units that house inmates with multi-faceted needs.

If an inmate is housed in the GED unit, he or she will receive intensive educational services but not have access to substance abuse education and treatment, employment endeavors, or life skills programs that are needed in concert to improve success. Unit management is the reverse of program-based housing. The cornerstone of unit management is the holistic approach administered by staff—uniform and non-uniform—who bring services and programs to address the majority of inmates' risks and needs on-site within the housing unit management community.

Inmates housed in the work readiness unit reported positive self-identified outcomes. They indicated they are paired with other inmates that have similar goals, producing a peer-to-peer reinforcement. They report these units are smaller, with vested staff who appear to motivate and provide a supportive environment, similar to the unit management style of supportive supervision.

Both security and case management staff pointed to a desire to work cohesively and collaboratively, to "be put in the same room and talk" about how they can help one another. There was a view that they are at "odds" too often, not understanding each other's needs and purpose, but noted they are highly supportive of a team environment. Both also pointed out the need for better information sharing, from inmate information to facility scheduling through a shared jail management system.

Staff believe a more team-based approach would build this cohesion and support one another to provide necessary services to inmates. For example, officers in the mental health unit believe they must fill in the gaps where case managers do not because they are understaffed, do not use proper management, or are insensitive to inmate needs.

Unit management is designed as a smaller housing unit community. One inmate with several incarcerations in the DOC remarked that the smaller units he had been housed in have fewer interpersonal problems than the larger units. This inmate stated that smaller units allow for

[105]District of Columbia Department of Employment Services. *Project Empowerment Comparative Analysis Report* Washington, DC, November 2015. https://does.dc.gov/sites/default/files/dc/sites/does/page_content/attachments/IMPAQ_Comparative%20Analysis_Final_110315_0.pdf

increased and improved communication with other inmates and staff. For example, larger units have lower staff supervision and inmates can "claim" areas as they would on the streets, such as the phones, and not allow others to use it. Smaller units "allow you to let your guard down" and get along with other inmates and staff without so much anger that builds during incarcerations

The benefits are echoed in the Office of Justice Programs' information resource on unit management:

- A multi-disciplinary staff comprised of uniform and non-uniform staff co-located within the singular housing unit and who are steady officers assigned to work with the inmates and services of that unit.
- The atmosphere of the unit in general is improved and specifically the environment is positively enhanced.
- Development and implementation of pre- to post-release community programs is enhanced,
- Staff morale is improved,
- Constructive, scheduled programs and activities for inmates is developed fostered through staff knowledge of the risks and needs
- Large institutions are broken-up into smaller more manageable units. [106]

Cross training correctional (uniform) and program (non-uniform) staff on the mission of each role, models and supports a unified vision of safety, security, and success of inmates from both roles.

Unit Team Management

Unit team management of housing units: The unit management concept is a holistic, unified approach. Immediate intake, assessment, and orientation of all inmates on the unit occurs for the unit team to have greater knowledge of the inmates. A variety of programs that meet the unit's needs come to the unit, providing a higher level of structured time onsite (in lieu of one program per unit, reducing inmate movement in and around the facility with a mix of classification concerns, and further reducing the need for additional staff movement outside of the unit.)

"According to the U.S. Bureau of Prisons, unit management is defined as a small, self-contained, inmate-living and staff office area, which operates semi-autonomously within the confines of the larger institution (U.S. Bureau of Prisons, 1977). The essential components are:

- A smaller number of inmates (50-120) who are assigned together permanently
- *A multi-disciplinary staff (unit manager, case manager(s), correctional counselor(s), and full- or part-time service providers and correctional officers whose offices are located within the inmate housing unit and who are permanently assigned to work with the inmates of that unit* (emphasis added)
- The assignment of an inmate to a unit based on age, prior record, specific behavior, specific behavior typologies, a need for a specific type of correctional program such as drug abuse counseling, or on a random-assignment basis *(assessment-driven).*[104]

[106] Office of Justice Programs National Criminal Justice Reference Services. *Corrections in a New Light: Developing a Prison System for a Democratic Society.* Houston, James and Dragan Stefanoviae. 1996.

Unit management supports the rising concept and implementation of community one-stop centers. Modeling a one-stop, pre-release center through a unified management approach aligns with reinforcing support systems that are critical to success in the community. Unit management through identified assessment of the inmate's risk and needs characteristics that feeds into a vibrant and living pre-release case plan can seamlessly follow the inmate into the community.[107]

Unit Management Recommendations

- *Develop a unit-management style of supervision in programming units that creates a multi-disciplinary collaborative approach among staff—uniform and non-uniform—and inmates.*
- *Structure and schedule regular access to case managers and service providers to communicate availability to inmates and staff.*
- *Hold regular unit management meetings with all staff to communicate and solve operational barriers and challenges facing staff and inmates.*
- *Develop policies that support the eligibility of inmates into unit management based on assessed risks and needs.*
- *Mirror availability of community-based programs for seamless transition into the community.*

Cross Training

Although staff noted the need for additional cross training, correctional officers indicated they do receive training on detecting unusual inmate behavior, along with de-escalation and stress management techniques and some mental health identification training, which is helpful in working with the inmate population. One stakeholder remarked training has progressed and evolved, particularly through the transition of CTF, formerly under the CCA, into the DOC earlier this year. Participants reflected that the new leadership "clearly articulates their (DOC) positive values", but the vision does not yet weave its way through all of the lines of staff. Staff sees their roles in security and safety realms, focusing on the present environment and behavior rather than primarily rehabilitative, focusing on the future effectiveness and success upon release.

Training for working with special inmate populations (e.g., mental health, sex offenders) is not adequate in the opinion of correctional staff. But both correctional staff and inmates agree that staff-staff and staff-inmate communication could be more targeted to the characteristics of the population and more professional and respectful. Correctional staff stated they felt they did not have information, knowledge, or available resources to assist inmates on reentry needs with a vision to be a parallel partner with program staff and better serve inmates.

[107]The District is in the early stages of conceptualizing a post-release pathway identified as a Portal of Entry. The Portal of Entry project is a Mayoral- and District-supported community-based one-stop center for returning citizens that will provide the post-release bridge toward a successful transition from incarceration into the community. Collaborative, intertwined systems, such as recommending linkages to the DOC management system's assessments and release plans are imperative to efficient delivery of information to support success, and community partners who have signed on their collaborative services.

As a robust assessment at the point of entry for all inmates is an initial recommendation, it should not rest alone with intake and booking staff. Training on how the assessment shapes supervision, treatment, and programs and services for housing unit staff will be critical.

According to the DOC training administrator, "A new DOC training academy is tentatively slated for early November 2017. It is located near Bladensburg and Queens Chapel Road, SE. The new space will have numerous benefits, including being a state-of-the art training environment. It will also have a gym, warehouse, and fleet space. The classrooms are much larger and we can host much larger staff and community gatherings. The projected color scheme is far more conducive for adult learners. And the overall environment is far more welcoming while promoting a very professional atmosphere."[108]

As noted above, cross training correctional (uniform) and program (non-uniform) staff on the mission of each role will ensure a unified vision of safety, security, and success of inmates from both roles.

Cross Training Recommendations

- *Incorporate supportive training on evidence-based practices to improve recidivism success, to include cognitive behavioral needs and support, motivation to change, and implementing positive reinforcement tools.*
- *Cross train all participants—including uniform and non-uniform staff, service providers, volunteers, and inmates—on effective population specific practices, still incorporating training based on their specialized roles and needs (i.e.: volunteers should receive additional training on correctional behaviors and evidence-based practices in addition to operational aspects)*
- *Review deployment of staff and the training received based on unit assignments and the risks and needs the unit serves*

Evaluation and Feedback

As recommended by the JRSA literature review, it will be critically important to establish a systematic method to determine if processes and practices produce the desired results of reducing recidivism and embark on positively evolving the program into a system through routine review.

Focus group and conversations elicited the following processes necessary for successful reentry:

- Inmates participating in programs and services that meet the individual needs and characteristics of the inmate.
- Identifying primary benefits to livelihood, such as improved housing, improved employment and educational endeavors, and improved familial supports.
- Releasing inmates with all information in hand including identification, housing, employment, medical insurance and social benefits verification, health needs including medication, and educational status.

[108] Communication from Raul Gradillas, Training Administrator, DC Department of Corrections, on June 29, 2017

- Releasing inmates with a shared release case plan that is communicated and connected to continuing services in the community.
- Providing tangible evidence of success (e.g., certificates of skill development, references validating improvement).
- Identify secondary benefits of success, including the degree of community engagement and support.
- A primary measure of success would be reducing recidivism rates.

Inmates also noted a need to receive feedback from peers. Inmates value hearing from successful returning citizens. Inmates cited one member of the Project Empowerment team that was particularly valuable because this person was a formerly incarcerated person. Inmates were more likely to listen and internalize guidance from this person because of his experience with the criminal justice system. Engaging formerly incarcerated service providers is particularly helpful in cultivating trust among inmates and engaging their participation in programming.

Inmates stated that although they are appreciative of community-based programs, they are less likely to encounter individuals who have experienced similar challenges upon their return to the community in these programs. Probation and parole release guidelines often prohibit association with other formerly incarcerated individuals, but inmates remarked these are the very individuals who can provide guidance on navigating post-release challenges. Inmates indicated that they have learned a great deal about helpful external services from other returning citizens, which one worked for them and why, and how to capitalize on the services offered based on the challenges and barriers they, too, encountered. Inmates recommended that such information be captured and tracked to be shared by returning citizens, creating reentry alumni groups or peer-to-peer networking opportunities for formerly incarcerated individuals to meet and discuss challenges and techniques for overcoming challenges unique to individuals with criminal records.

Evaluation and Feedback Recommendations

For departmental analysis:

- *Develop performance measures–inmate-, program-, and departmental-based that identify success and challenges, including a regular review of composite assessed risks and needs to ensure the deployment of evidence-based services and programs meet the identified needs of the population.*
- *Conduct exit surveys with randomly selected inmates at regularly scheduled intervals (i.e., quarterly or twice annually), to include program and service reviews and feedback along with operational concerns (i.e.: food issues raised) to provide a listening forum.*
- *Define a consistent recidivism rate.*

For returning citizens motivation:

- *Develop an inmate peer mentoring program.*
- *Share case plan with community partners to ensure continuity of care pre- to post-release.*

Through the focus groups, the inmates expressed interest in continuing to be heard on a variety of issues. Exit surveys may be a viable opportunity to receive evaluative feedback from the population which the department serves. For example, a survey with a random sampling of inmates at regularly scheduled intervals, (such as 50 inmates twice annually or quarterly), could be conducted by correctional or

administrative interns as an academic feedback project. The student could then present the information to the DOC policy team and use this as an opportunity to brainstorm ideas on addressing any concerns that arise. While each facility has unique circumstances to consider when operationalizing such endeavors, however, ensuring the inmate's voice is a part of the department's work is a powerful tool that could show a dedication that everyone, including staff, stakeholders, service providers, and advocates are at the table.

Collecting, analyzing, and sharing performance information is a significant indication of program effectiveness and success, as well as offender accountability.

Jail Management System

Both the qualitative and quantitative findings in this study highlight the need for a new jail management system. A "common deficiency of older jail systems is the limited ability to interface and exchange data with other systems that support law enforcement, prosecutors, courts, other justice agencies, and treatment providers."[109] The lack of a consistent, shared information base leads to a lack of knowledge that supports the inmate's success, as heard from uniform and service providers, and to repetitive, inefficient sharing of information and raises inaccuracies, as heard from service providers who conduct individual assessments by program with each inmate.

Jail Management System Recommendations

- *Develop a collaborative electronic management system and pre- and post-release policies to share appropriate inmate information among staff, providers, and community providers to target inmate success pre- and post-release.*
- *Revise the timing of calculating release dates for sentenced inmates to be calculated and forecasted earlier in the sentence to guide case planning schedules.*
- *Include formal recordkeeping of the inmates' program-related accomplishments that could also provide tangible proof of inmate program participation.*

A jail management system that encompasses both the uniform security aspects along with programming evaluative features would also address a common concern among all participants: information sharing difficulties. Uniform and non-uniform staff, along with stakeholders, service providers, and advocates, stated they work toward discrete goals, such as safety and security for uniform staff and release planning for non-uniform staff and community-based successful reintegration goals for stakeholders, service providers, and advocates that were difficult to share across their individual spheres. While uniform staff are present 24 hours a day, they shared an interest in having information and tools to address inmate's questions when non-uniform case management staff were not available. Conversely, non-uniform staff reported barriers that uniform staff had upon their programs, such as canceled schedules, staff not moving inmates to the designated scheduled program rooms, not knowing when an inmate has been moved out of a housing unit (to another housing unit or released from custody), and interrupting case management and programming activities for count and other unknown security reasons.

[109] National Institute of Corrections. *Running an Intelligent Jail: A Guide to the Development and Use of a Jail Information System.* Washington, DC, August 2013. https://s3.amazonaws.com/static.nicic.gov/Library/027446.pdf. Page 82-83.

Wrapped into these barriers are that providers are only able to help those with programming that have a release date. Community providers can't serve inmates pre-release and make the needed supportive connection if eligibility barriers preclude providers from identifying returning citizens while incarcerated. And, community partners voiced a concern that inmates receive only a warm handshake at release from the DOC. Post-release partners conduct assessments again, start over on programs and services, and reengage in support after release, duplicating services and time that may have occurred pre-release or starting too late after release with a cost-effective outcome.

Conclusion: Service and Programs

As noted and highlighted in the literature review's executive summary, "providing the right services to the right individuals can ease the transition of returning citizens. Jail-based reentry services reduce the chances of coming back to jail by targeting criminogenic needs and lessening the negative impact that incarceration may provide."[110] Reframing reentry from an isolated, admission- and eligibility-based programs and services into a philosophy that evolves through all staff and inmates can reduce recidivism through effective practices that support and guide their success. This service analysis focuses on the front-end programs and services provided by the DOC.

DOC has made strides in initiating programs and services available to their inmate population. Days of simply being a detention and holding facility are now behind jails with the desire to become a successful partner for returning citizens to our communities.

Effective Jail Management Systems

Successful jails recognize that an inmate's incarceration is an opportunity to address that person's criminogenic risk factors (that is, those factors that produce or tend to produce crime or criminality). These include substance abuse, criminal thinking, and lack of employment, education, or housing. As a result, inmates' access to rehabilitation programs is gaining importance in the field. As reentry initiatives are implemented and begin to take hold in local corrections plans, inmate programs are often initiated in the jail and then continued once inmates are released and reenter the community. This practice is an important component of good correctional policy and may reduce recidivism and save taxpayer dollars. Access to work assignments of lower-risk inmates also supports effective correctional policy—it keeps inmates busy, permits extra time off their sentence for good behavior, and gives participants some additional work experience.

https://s3.amazonaws.com/static.nicic.gov/Library/027446.pdf. *Page 6*

The next step is to incorporate a consistent tool that drives the planning and releasing programming and services. Through assessment and case planning, jails are now the proactive factor in guiding inmates towards meeting their risks and needs. One inmate quipped he didn't have a choice to participate in a particular jail program, but "I'm glad I did." Jails can be the guiding, driving force to support inmates' success upon release.

[110]JRSA (2017) in Appendix G.

Although outside of the scope of our review, inmates raised two issues we are noting for the DOC's review. The quality of food was noted by the inmates as poor, eliciting an escalating discussion and perception that the quality of food equated into how the department views and treats inmates.

Also, inmates described some negative interactions with staff. There were examples of staff being helpful and inmates understanding uniform staff focus on their arena through security-minded requirements, but inter-personal communication skills with inmates was an often-mentioned frustration. Inmates did not feel as if their needs were fully heard or understood by staff, being dismissed or directed to someone else.

Jails have a plethora of available tools and resources to develop an effective facility-based program and service model to reduce recidivism. The eight principles of effective intervention tool were developed "(t)o build learning organizations that reduce recidivism through systemic integration of evidence-based principles in collaboration with community and justice partners."[111] Their vision adopts a holistic approach of including a variety of partners to assist departments in developing successful offender programming strategies. Assessment tools lay the foundation of directing case plans into effective, responsive programs, with communication and training features to equate successful transitions into reduced recidivism. The National Institute of Corrections' Transition from Jail to Community model highlights the need for interdependence collaboration among criminal justice partners. "For many inmates being released, no organization or individual is responsible for their supervision or treatment in the community."[112]

[111] NIC (2014)
[112]"Transition from Jail to Community(TJC)." *National Institute of Corrections.* 2012. https://nicic.gov/jailtransition

CHAPTER IV: RECOMMENDATIONS AND CONCLUSION

The following combine the chapter specific JRSA and TMG recommendations. Based on the findings of this study, and relying upon the extant literature, we believe implementing some or all of the following recommendations will move DOC further in its effort to align jail reentry services with evidence-based practices. Please note there are a number of reentry related efforts currently underway in the District of Columbia. However, as this project was a discrete effort, the recommendations below do not consider that other initiatives may be in the process of implementing policies and practices which address these recommendations.

Recommendations

The following combine the chapter specific JRSA and TMG recommendations. Based on the findings of this study, and relying upon the extant literature, we believe implementing some or all of the following recommendations will move DOC further in their effort to align jail reentry services with evidence-based practices.

Assessment and Case Planning

- Conduct a validated, consistent, gender-responsive criminogenic risk and needs assessment on every inmate at intake.
- If conducting a full assessment on intake is not feasible, implement the Proxy Risk Assessment as prescreen for higher risk individuals to receive full assessment and/or among medium and high risk as a flag for in-reach by community providers.
- Retain Proxy Risk Assessment data in DOC data system for those who cycle in and out of the jail repeatedly, so that information is readily available and can be utilized to triage and cumulatively treat the offender, without repeatedly collecting static information.
- DOC currently uses the Northpointe COMPAS Assessment tool with at least some of those in custody. We recommend that DOC explore the possibility of conducting the COMPAS assessment tool facility wide.
- Revise eligibility criteria policies to align inmates assessed risks and needs to develop appropriate services and programs.
- Revise the inmate handbook with up-to-date programming, eligibility, and admission criteria and provide to all inmates at entry.
- Tailor case planning and use of programs and services pathways to meet the varied statuses of inmates (e.g., pre-trial, sentenced, District, FBOP) risk levels, lengths of stay, gender, and ages.
- Develop policies and processes to share assessment information with correctional and programming staff and pertinent community partners invested in the successful release of the inmate, facility- and community-based. One option is use COMPAS assessment data as the foundation of reentry case plans. Share case plans and/or COMPAS data with community based providers engaging returning citizens to ensure continuity of care pre- to post-release.
- Regularly review composite assessed risks and needs to ensure the deployment of evidence-based services and programs meet the identified needs of the population, including therapy interventions, and peer support, coaching, and mentoring as recommended by inmates.

Research and Evaluation

- Develop performance measures that are inmate-, program-, and departmental-based that identify success and challenges, including a regular review of composite assessed risks and needs to ensure the deployment of evidence-based services and programs meet the identified needs of the population.
- Conduct exit surveys with randomly selected inmates at regularly scheduled intervals (i.e., quarterly or twice annually), to include program and service reviews and feedback along with operational concerns (i.e.: food issues raised) to provide a listening forum.
- Invest in building reports from the COMPAS database to easily extract the data for research and evaluation purposes.
- Measures from the COMPAS data could be used as control variables in recidivism analysis and DOC program evaluation. Control variables are used to account for factors that could otherwise explain the outcome. For example, older offenders are less likely to recidivate, thus one would want to "control" for age in the analytic model.
- Define a consistent measure of recidivism.

New Jail Management System

- Develop a collaborative electronic management system and pre- and post-release policies to share appropriate inmate information among staff, providers, and community providers to target inmate success pre- and post-release.
- Revise the timing of calculating release dates for sentenced inmates to be calculated and forecasted earlier in the sentence to guide case planning schedules.
- Include formal recordkeeping of the inmates' program-related accomplishments that could also provide tangible proof of inmate program participation and measures of "dosage".
- Track all program participation, as well as process measures (e.g., number of applications for program participation, and screening if applicants met eligibility criteria and if not, why not).
- Program Milestones and Completion rates should be maintained – including the number who completed interim steps in program, and completed any program overall.

Unit Management

- Develop a unit-management style of supervision in programming units that creates a multi-disciplinary collaborative approach among staff—uniform and non-uniform—and inmates.
- Structure and schedule regular access to case managers and service providers to communicate availability to inmates and staff.
- Hold regular unit management meetings with all staff to communicate and solve operational barriers and challenges facing staff and inmates.
- Develop policies that support the eligibility of inmates into unit management based on assessed risks and needs.
- Mirror the availability of community-based programs for seamless transition into the community

Cross Training

- Incorporate supportive training on evidence-based practices to improve recidivism success, to include cognitive behavioral needs and support, motivation to change, and implementing positive reinforcement tools.
- Cross train all participants—including uniform and non-uniform staff, service providers, volunteers, and inmates—on effective population specific practices, still incorporating training based on their specialized roles and needs (i.e.: volunteers should receive additional training on correctional behaviors and evidence-based practices in addition to operational aspects)
- Review deployment of staff and the training received based on unit assignments and the risks and needs the unit serves

Recommendations Regarding Specific Populations

- **FBOP/DOC**: **DOC Transfers to FBOP** – Consider Support Programs. A foundational tenant of successful reentry programs is that reentry begins on Day 1 of incarceration. Utilize community based programs such as mediation and mentoring to help inmates maintain family connections and/or to other supportive individuals during their time at FBOP. Use assessment data to develop a plan with the inmate to target areas that can be addressed while incarcerated at FBOP.
- **FBOP/DOC**: **FBOP Inmates to Return Early** – Consider Higher Risk Candidates. Recommend including FBOP inmates who have an infraction history while housed at FBOP and/or high security level at release. Conduct needs assessment and develop a reentry plan to address key issues prior to release.
- **Opportunity for More Halfway House Placements**. As HWH participants and DOC custodial populations are very similar, space permitting, DOC may to consider greater utilization of HWH for sentenced populations.

Establish DOC Reentry Strategy Workgroup

- Include DOC Staff, both uniform and non-uniform; key agency stakeholders; and representatives from community based service providers.
- Once a strategy is developed, a workgroup should continue to meet to provide a venue to ensure ongoing and effective communication between agency and community based providers.
- Periodic reviews of the strategic plan would allow for revisions on an ongoing basis to respond to changing trends and concerns
- **Recommended Resources for Strategic Plan Development:**
  - **Jail Reentry Planning from The Urban Institute:**
    - Life After Lockup: Improving Reentry from Jail to the Community details five critical strategies by creating six "Tracks" by length of stay and level of need (p. 83-84) and recommends actions along a continuum based on the needs, risk factors, and history of the detainees.
      Available: https://www.ncjrs.gov/pdffiles1/bja/220095.pdf
    - The Jail Administrator's Toolkit for Reentry which provides practitioner oriented information and examples of successful programs.
      Available: https://www.ncjrs.gov/pdffiles1/bja/222041.pdf

- **Strategic Planning: Center for Effective Public Policy Coaching Packets (2007)**. This series was developed based on prison (and not jail) reentry, but provides a step-by-step approach and checklists to implement a reentry system. Topics include: "Implementing Evidence Based Practices"; "Measuring the Impact of Reentry Efforts"; "Engaging Offenders' Family in Reentry"; "Shaping Offender Behavior"; and "Building Offenders' Community Assets through Mentoring".
  Available: http://cepp.com/expertise/reentry/products-and-resources/

Conclusion

As noted in the project's literature review's executive summary, "providing the right services to the right individuals can ease the transition of returning citizens. Jail-based reentry services reduce the chances of coming back to jail by targeting criminogenic needs and lessening the negative impact that incarceration may provide."[113] Reframing reentry from an isolated, admission- and eligibility-based programs and services into a philosophy that evolves through all staff and inmates can reduce recidivism through effective practices that support and guide their success.

[113]JRSA (2017) in Appendix G.

Appendix A: Federal Bureau of Prisons - Examples of Infractions by Seriousness Level

Level 100 – Greatest Severity: Killing; sexual or physical assault; setting fire that poses a threat to life; rioting; encouraging others to riot; refusing urine sample or breathalyzer; the introduction, making, use and/or possession of narcotics, alcohol or other substances; use of telephone for illegal purpose;

Level 200 – High Severity: Escape from work detail; fighting; threatening bodily harm; engaging in sexual acts; sexual assault, including non-consensual touching without force or threat of force; wearing a disguise or mask; engaging or encouraging group demonstration; encouraging work stoppage; bribing staff; giving money or receiving money for purpose of introducing contraband; destroying, altering, or damaging government property; stealing or possession of stolen property; demonstrating, practicing or using martial arts, boxing, wrestling; being in unauthorized area with person of opposite sex without staff permission; tattooing; refusing to participate in required physical test or examination unrelated to testing for drug abuse;

Level 300 – Medium Severity: Indecent exposure; possession of money or currency without authorization, or in excess of amount authorized; loaning of property or anything of value for profit or increased return; refusing to work or to accept program assignment; refusing to obey an order of any staff member; insolence towards a staff member; participating unauthorized meeting or gathering; failing to stand count or interfering with taking of count; destroying government property with value of $100 or less; being unsanitary or untidy; smoking where prohibited; cheating on a GED exam; communicating gang affiliation; circulating a petition;

Level 400 – Low Severity: Using abusive or obscene language; Malingering, feigning illness; unauthorized physical contact (e.g., kissing, embracing); conduct with a visitor in violation of Bureau regulations.

Appendix B: Type of FBOP Community Facility for Inmates Released to DC in FY2015

ATLANTA CCM	CAT CCCS	2
BALTIMORE CCM	CBR ADMIN	4
BALTIMORE CCM	CBR CCCS	77
BALTIMORE CCM	CBR HCONS	8
BALTIMORE CCM	CBR JAILS	4
CHICAGO CCM	CCH HCONS	1
DIST OF COLUMBIA CCM	CDC ADMIN	2
DIST OF COLUMBIA CCM	CDC CCCS	637
DIST OF COLUMBIA CCM	CDC HCONS	206
DIST OF COLUMBIA CCM	CDC JAILS	401
DIST OF COLUMBIA CCM	CDC JUVS	2
DETROIT CCM	CDT JAILS	1
KANSAS CITY CCM	CKC HCONS	1
NEW YORK CCM	CNK HCONS	2
ORLANDO CCM	COR CCCS	1
PHILADELPHIA CCM	CPA HCONS	1
PHOENIX CCM	CPH CCCS	1
RALEIGH CCM	CRL CCCS	7
RALEIGH CCM	CRL HCONS	2
RALEIGH CCM	CRL JAILS	131
RALEIGH CCM	DSC ADMIN	1
Total		**1640**

Key:
CCCS = Halfway House
ADMIN = Administrative
HCONS = Home Confinement
JAILS = Jails
JUVS = Juvenile

Source: Figure provided by Office of Research and Evaluation, February 23, 2017.

Appendix C: Focus Group Protocols

Inmate Protocol

Note: This protocol helps guide the language and flow of the focus groups. Do not read directly from the protocol, but instead practice before you are on-site to figure out the best way to convey this information in a way that is conversational. The goal of the focus group is to get your thoughts and ideas about programming and services inmates receive or may need while incarcerated to help them successfully re-enter back into the community. Build rapport before discussing some of the more sensitive questions for best results. It is not expected that you will be able to ask every question on this protocol due to time constraints, but the open discussion may answer or apply to other questions that you may or may not get to. Rather, use judgement to determine the best use of time.

Interviewer notes are in this font.

Questions and discussions for the groups are in this font.

Setting the Agenda (15 minutes)

- *Welcome participants and introduce TMG and the team in the room.*
    - Welcome! And thank you for coming to our focus group.
    - *Introduce yourself, TMG, and purpose*
        - The Moss Group, Inc. is a company out of Washington, D.C. that was subcontracted with Justice and Research Statistics Association to bring together this group. The purpose of the focus group today is to get your thoughts and ideas about programming and services you receive or may need while you are incarcerated to help improve you to successfully reenter back into the community.
        - *Be sure to define reentry: Incarcerated inmates that are released to the community.*
        - At the end of our groups, we'll be writing a short report for JRSA highlighting areas of strengths, challenges, barriers, and recommendations from you to assist returning citizens.
    - *Introduce the agenda*
        - How many of you have participated in a focus group before? Basically, it is a "group interview" where we ask questions and you freely and honestly give your responses. There are no right or wrong answers. There does not need to be group consensus. So, you don't have to agree with the person sitting next to you.
        - We have some questions to start with that we will use our Turning Point clickers for your yes or no answers. Remember, there are no right or wrong answers. Just answer how the question may apply to you or not.
        - Then, we will have a group discussion on a few questions that ask about your jail experiences that focus on your release.
        - We want to be sure we have all your ideas so we will be taking notes [introduce note taker]. However, all of your responses, answers, and information are anonymous and your name will not be associated with any

specific comments. Your ideas will be summarized with many others we are talking to this week.

- You may be wondering how you were selected: We asked jail staff to identify inmates that would be available this week for the focus groups. From that list, we randomly selected names to come speak with us.
- *Group agreements:*
  - One person speaks at a time
  - Everyone listens
  - Participate: we value your individual input
  - Celebrate diversity and be open to potentially differing opinions and ideas
  - No use of disrespectful language or profanity
  - What other agreements would you like to include?
- We treat what we hear as anonymous, but it is not confidential in certain cases. That means:
  - We will report out on the themes we hear overall, but no statement will be associated with a particular individual so any statement you make will be anonymous. That said, if you tell us you're going to hurt yourself or someone else, or if you tell us of a reportable incident, do know we should report that for everyone's safety.
  - *Explain that we will not write down the names of who is saying what, remember we are just looking for themes.*
- We have allowed about an hour and a half together but I will give you my card in case you want to email or call me later with any other ideas that emerge. Do you have any questions? Let's get started with our first set of questions!

Survey of Quantitative Values (15 minutes)

- Are you male or female?
  - Male
  - Female
- What is your age group?
  - 18-19 years of age
  - 20-29
  - 30-39
  - 40-49
  - 50 or older
- Have you been sentenced?
  - Yes
  - No
- Have you been incarcerated somewhere before?
  - Yes
  - No
- Do you know where you will live when you release?
  - Yes
  - No

- Is it a safe place to live?
  - Yes
  - No
- Is it a stable place to live?
  - Yes
  - No
- Do you know where you will get medical care when you are released?
  - Yes
  - No
- Do you know where you will get mental health care when you are released?
  - Yes
  - No
  - Does not apply to me
- What will you do for employment?
  - I have full-time employment
  - I have part-time employment
  - I am looking for employment
  - I am unable to work.
  - I don't need to work.
- Are you participating in the following programs while in jail?
- Job Readiness Preparation
  1. Yes
  2. No
  - Inmate work squad
    1. Yes
    2. No
  - Education (GED, HSD, other)
    1. Yes
    2. No
  - Physical health
    1. Yes
    2. No
  - Substance Abuse
    1. Yes
    2. No
  - Behavioral Health
    1. Yes
    2. No
  - Housing
    1. Yes
    2. No
  - Family reintegration and parenting
    1. Yes
    2. No

- Court intervention (probation, parole, other)
    1. Yes
    2. No
- Identification (ID, DL, birth certificate, social security card)
    1. Yes
    2. No
- Conflict resolution Mentoring
    1. Yes
    2. No
- Life skills
    1. Yes
    2. No
- Women services programming (trauma-focus, etc.)
    1. Yes
    2. No
- Post-release case planning
    1. Yes
    2. No
- Connect with post-release community-based provider
    1. Yes
    2. No

- On a scale of 0-5 with 5 being the most prepared, how prepared do you feel for success in the community?
    1. Not prepared at all
    2. Feel a little prepared, but could a lot more assistance
    3. About half prepared
    4. Somewhat prepared
    5. Full prepared

Focus Group of Qualitative Questions (45 minutes)

- ** What do you need to be successful after release? How would you describe "successful"?*
- ** What are you experiencing? Describe the "typical" problems you're encountering.*
- ** What programs or services in the facility help you in preparing to go back to the community?*
- ** What is the process for making a release plan? Do you work with staff in the jail? Who? People from the community? Who?*
- ** If you could pinpoint one thing, person, or program that you think is most helpful in helping you be ready for release, what would it be?*
- ** What programs or services in jail do you wish were available to help you prepare to go back to the community?*
- ** Do you know where you can get help with these things in the community?*
- Are there programs in jail that are required? Do they help? Would you get in trouble if you didn't attend? Are there things you get, rewards, extra time out in rec, etc. if you do attend? f
- In your view, what are the biggest things and issues that people face when they are released?
- Where can you go for help when you get out?

Open Discussion, Q&A (10 minutes)
Do you have additional things to mention about your reentry we haven't discussed? What other questions would you ask someone to check on how they are doing?

Wrap Up (5 minutes)
Thank them for participating and remind them of your contact information if they would like to provide additional information. Ensure you collect all supplies and materials from the participants (I.E. Turning Point clickers, pens.)

Post Session (5 minutes)
Ensure you collect all supplies, materials, and equipment you brought in, and save and reset Turning Point sessions, if applicable.

Stakeholders, Service Providers, and Advocates Protocol

Note: This protocol helps guide the language and flow of the focus groups. Do not read directly from the protocol, but instead practice before you are on-site to figure out the best way to convey this information in a way that is conversational. Build rapport before discussing some of the more sensitive questions for best results. It is not expected that you will be able to ask every question on this protocol due to time constraints, but the open discussion may answer or apply to other questions that you may or may not get to. Feel free to ask probing and follow up questions as you glean information from the participants.

Interviewer notes are in this font.

Questions and discussions for the groups are in this font.

Conversation: _____
Notetaker: _____
Date and Time: _____

Setting the Agenda (10 minutes)

- *Welcome participants and introduce TMG and the team in the room.*
  - Welcome! And thank you for participating in our conversation today.
  - *Introduce yourself, TMG, and purpose*
    - The Moss Group, Inc. is a criminal justice agency based in the District that is subcontracted with Justice Research and Statistics Association to bring together this conversation. The purpose of our discussion group today is to get your thoughts and ideas about programming and services incarcerated persons receive to help improve their successful reentry back into the community.
    - *If need be, reentry is defined as incarcerated inmates that are released to the community, focusing on the District community.*
    - At the end of our conversation, we'll be formulating a short report for JRSA synthesizing and highlighting areas of strengths, challenges, barriers, and recommendations to assist returning citizens.
  - *Introduce the agenda*
    - We want to be sure we have all your ideas so we will be taking notes [introduce note taker]. However, all of your responses, answers, and

information will be summarized with other stakeholders, advocates, partners, staff, and inmates we have been speaking to about the study.

- You may be wondering how you were selected. We asked the DC Criminal Justice Coordinating Council for recommendations of pertinent stakeholders within the DC community regarding returning citizens, and gleaned program and service information from focus groups held in March with inmates and staff.
- *Group agreements:*
  - Every participate: we value your individual input and want to hear all of your voices and information
  - Celebrate diversity and be open to potentially differing opinions and ideas
  - What other agreements would you like to include?
- We treat what we hear as anonymous, but it is not confidential in certain cases. That means:
  - We will report out on the themes we hear overall, but no statement will be associated with a particular individual so any statement you make will be anonymous.
  - *Explain that we will not write down the names of who is saying what, remember we are just looking for themes.*
- We have allowed about an hour and a half (*two hours for stakeholders Monday May 22)* together but we will give our contact information in case you want to follow up later with any other ideas that emerge. Do you have any questions?
- Let's get started.

Focus Group of Qualitative Questions (45 - 60 minutes)
The following questions are similar and parallel to the questions asked of inmates and staff (uniform and non-uniform). After each question, facilitator asks clarifying questions:

- What is your experience and information about reentry endeavors in the jail?
- How would you describe a successful release of inmates returning to the community? What does this look like? What does it entail?
- What have you experienced from the inmate population and from community stakeholders about release planning? What are some of the successes you've encountered? What are some of the typical problems you're hearing from returning citizens? From correctional partners?
- What programs or services in the facility do you see that prepare inmates effectively and successfully to return to the community?
- *(Advocates and service providers):* How is the process for developing release plans occurring currently? Who is involved: staff in the jail? People from the community?
- What programs or services in jail would you identify that should be expanded or available to help inmates return to the community?
- How are inmates provided information and access to community resources and services from the jail? What are the gaps in bridging the transition from jail to the community?
- In your view, what are the biggest concerns and issues that people face when they are released? What are the biggest concerns for the community regarding returning citizens? What is occurring in the community to serve inmates effectively? What is missing in the community to serve inmates effectively?

The following questions are in addition to the questions above asked of inmates and staff (uniform and non-uniform) for stakeholders, advocates, and providers focusing on the principles of effective correctional interventions[114]*:*

- Evidence-based practices have validated the importance of identifying the varied needs inmates have that are barriers to success. How are needs assessed currently in the DOC, or how should they be assessed and identified? What particular inmate needs should the DOC prioritize towards success?
- The DOC has numerous providers offering a cadre of services to various inmates in the facility. How should programs and services be vetted for effectiveness and appropriateness?
- Enhancing motivation and providing positive reinforcement are other critical effective practices. How do you see DOC being effective in these practices? How do you see this integrated into reentry services in a correctional environment?
- How would you quantify success?
    - What would be your two or three top critical data points or outcomes that would be goals of successful reentry into the community?

Open Discussion, Q and A (15 -30 minutes)
Do you have additional things to mention about reentry we haven't discussed? What other questions would you ask to inmates to provide a holistic review and recommendations for reentry? Stakeholders? DOC leaders and staff? Community advocates, providers, and partners?

Wrap Up (5 minutes)
Thank them for participating and remind them of your contact information if they would like to provide additional information.

Post Session (5 minutes)
Ensure you collect all supplies, materials, and equipment you brought in.

Observations

_____
_____
_____

Participant Questions

_____
_____
_____

Debrief Notes

_____
_____
_____

[114] https://nicic.gov/theprinciplesofeffectiveinterventions

Appendix D: Agenda (Timeline of Activities)

Wednesday March 8, 2017
8:30 a.m. – 10:00 a.m. CDF inmates – men
10:30 a.m. – 12:00 p.m. CDF inmates – men
1:00 p.m. – 2:30 p.m. CTF inmates – men
2:45 p.m. – 4:00 p.m. CTF inmates – women

Thursday March 9, 2017
8:30 a.m. – 10:00 a.m. CTF and CDF correctional (uniform) staff
10:30 a.m. – 12:00 p.m. CTF and CDF programming (non-uniform) staff
1:00 p.m. – 2:30 p.m. CDF inmates - men
2:45 p.m. – 4:00 p.m. CDF inmates - men

Monday May 1, 2017
1:00 p.m. – 2:00 p.m. Individual stakeholder call
2:15 p.m. – 3:15 p.m. Individual stakeholder call

Monday May 22, 2017
8:30 a.m. – 10:30 a.m. Stakeholder focus group
11:00 a.m. – 12:30 p.m. Service providers and volunteers focus group
2:00 p.m. – 3:30 p.m. Advocacy focus group (group one of two)

Tuesday May 23, 2017
9:00 a.m. – 10:30 a.m. Advocacy focus group (group two of two)
3:15 p.m. – 4:15 p.m. Individual stakeholder call
4:15 p.m. – 5:00 p.m. Individual stakeholder call

Tuesday May 30, 2017
11:00 a.m. – 12:00 p.m. Individual stakeholder call

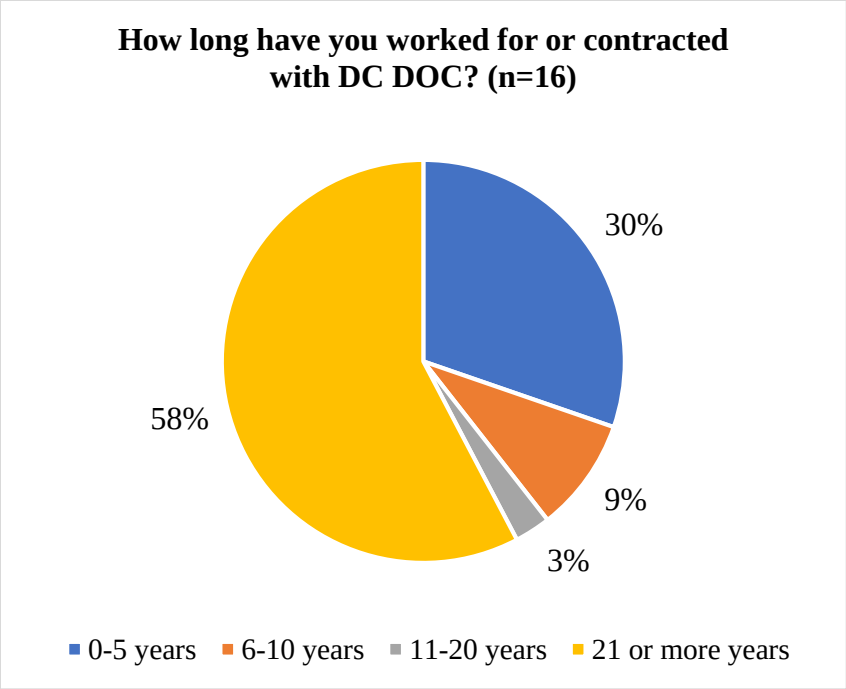
Monday June 5, 2017
4:15 p.m. – 4:45 p.m. Individual stakeholder call

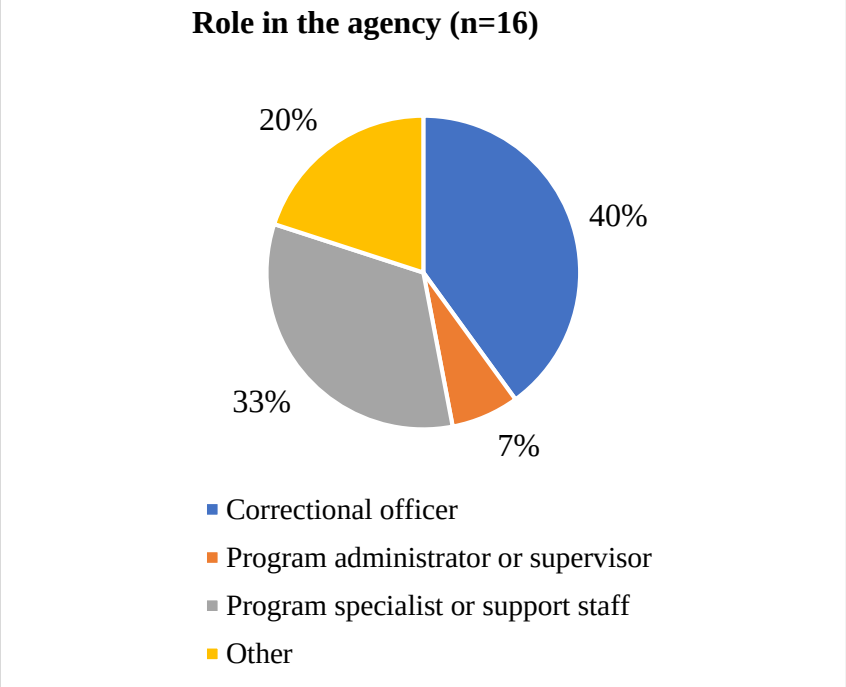
Thursday June 29, 2017
1:00 p.m. – 1:45 p.m. Individual stakeholder call

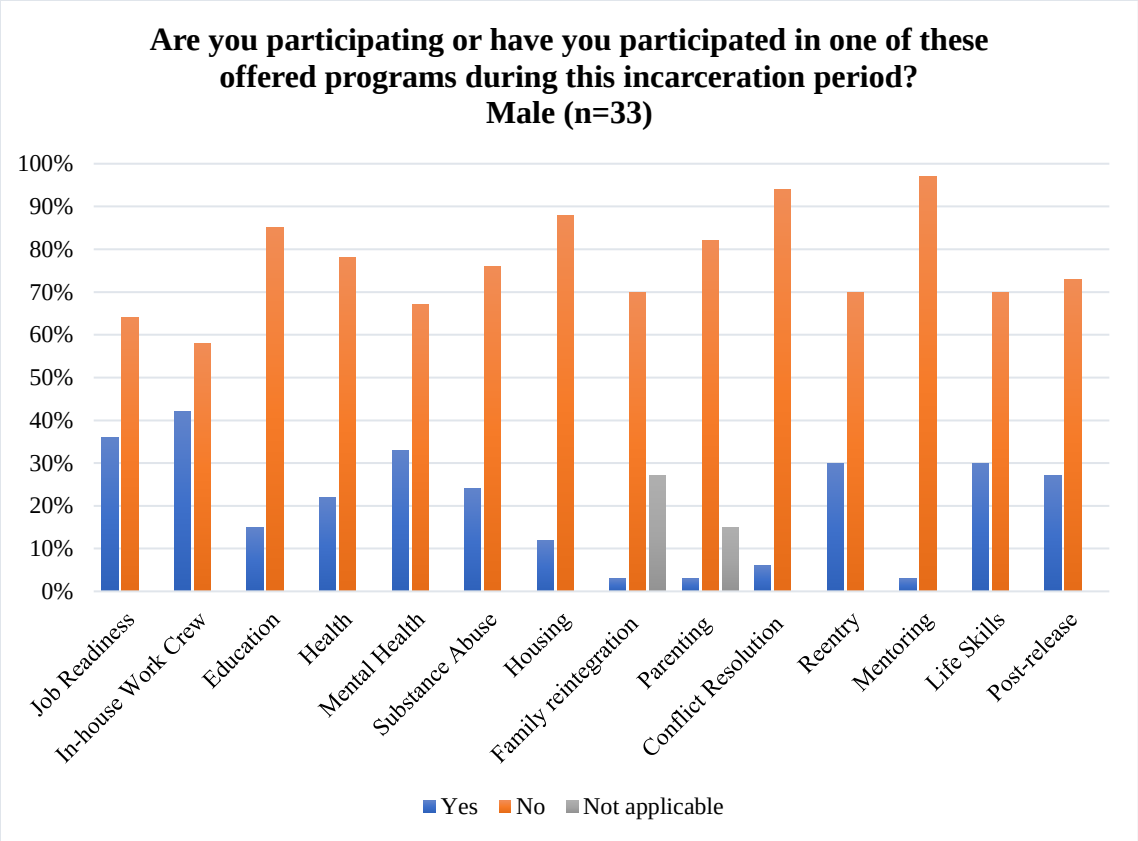
Wednesday July 5, 2017
11:00 a.m. – 11:30 a.m. Individual stakeholder call

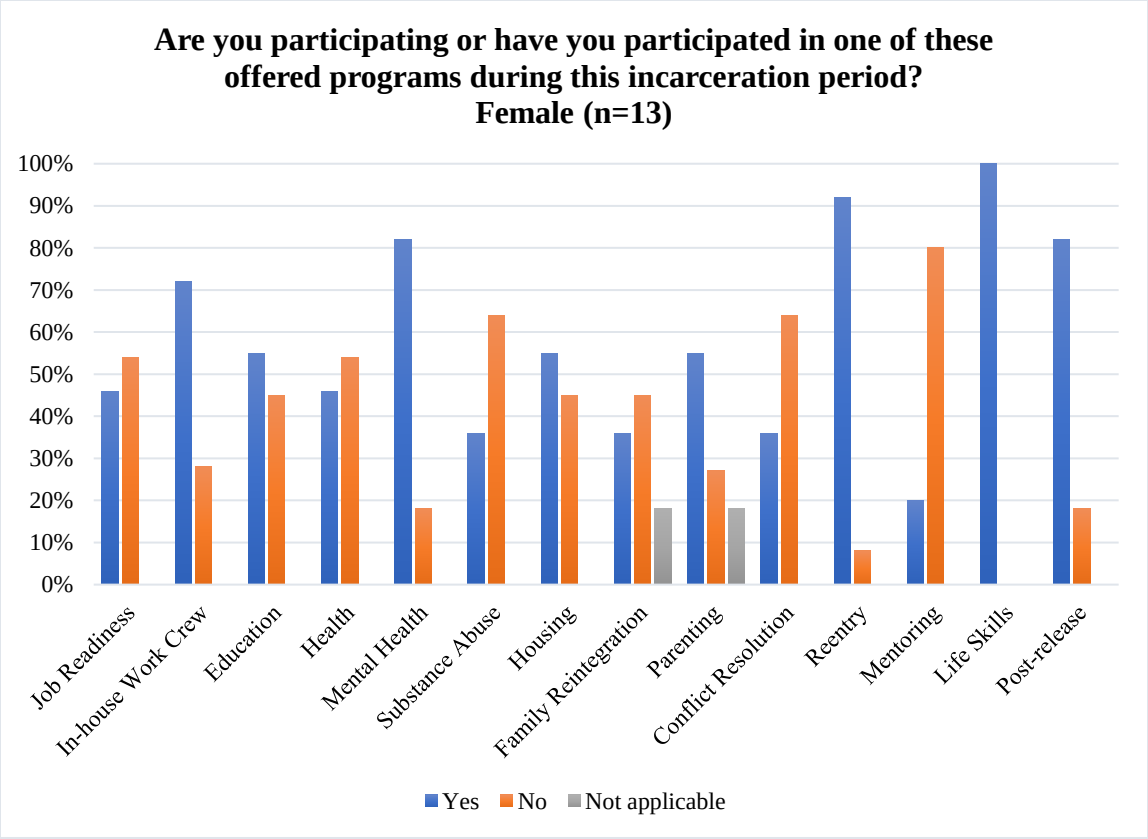
Thursday July 13, 2017
11:00 a.m. – 11:30 a.m. Individual stakeholder call

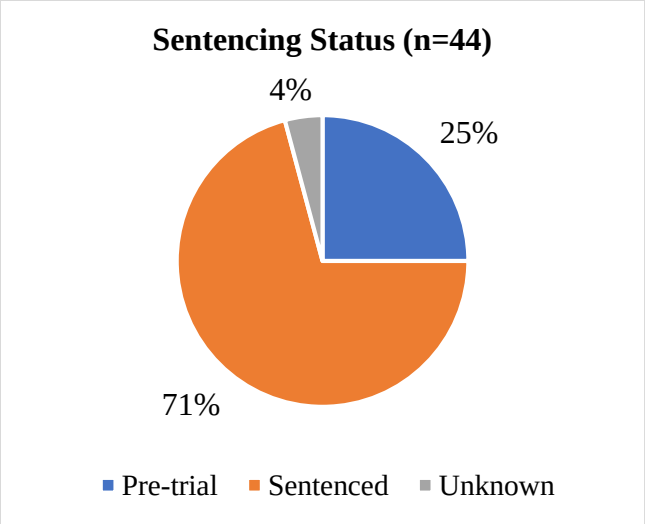
Appendix E: TurningPoint Technologies® Responses

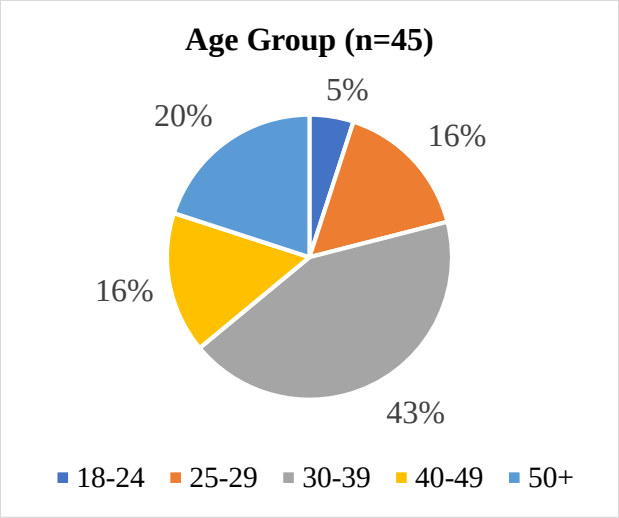


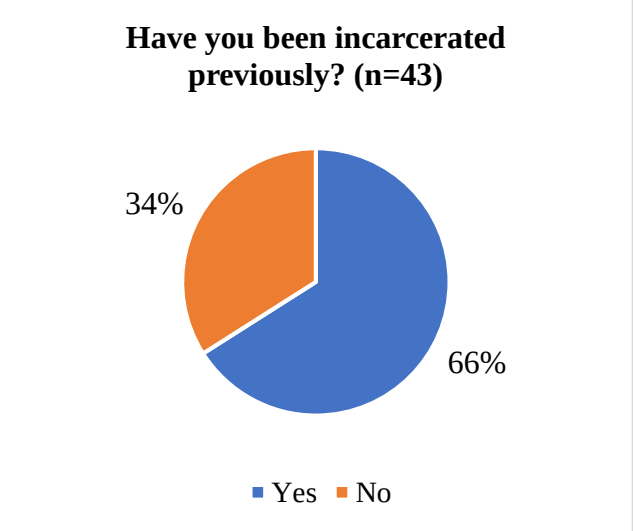


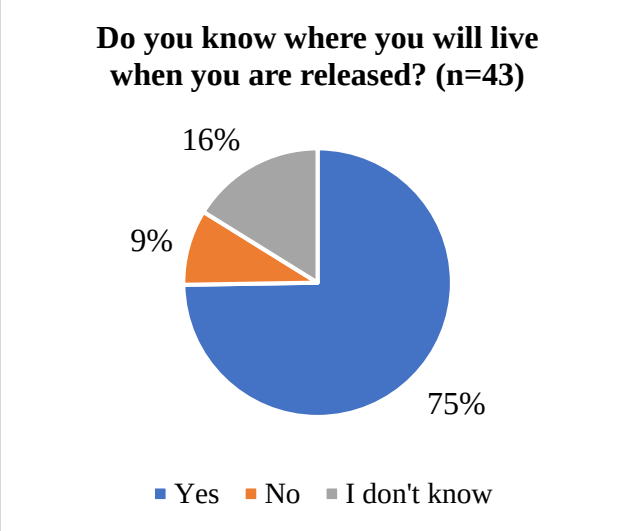

Are you participating or have you participated in one of these offered programs during this incarceration period?
Male (n=33)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Job Readiness
In-house Work Crew
Education
Health
Mental Health
Substance Abuse
Housing
Family reintegration
Parenting
Conflict Resolution
Reentry
Mentoring
Life Skills
Post-release
Yes
No
Not applicable

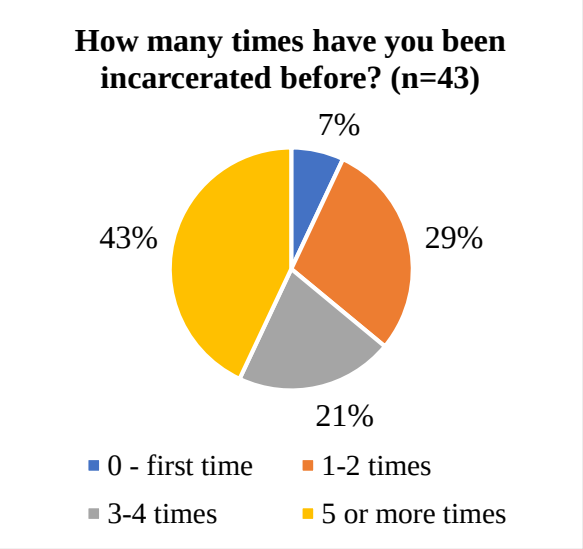

Are you participating or have you participated in one of these offered programs during this incarceration period?
Female (n=13)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Job Readiness
In-house Work Crew
Education
Health
Mental Health
Substance Abuse
Housing
Family Reintegration
Parenting
Conflict Resolution
Reentry
Mentoring
Life Skills
Post-release
Yes
No
Not applicable

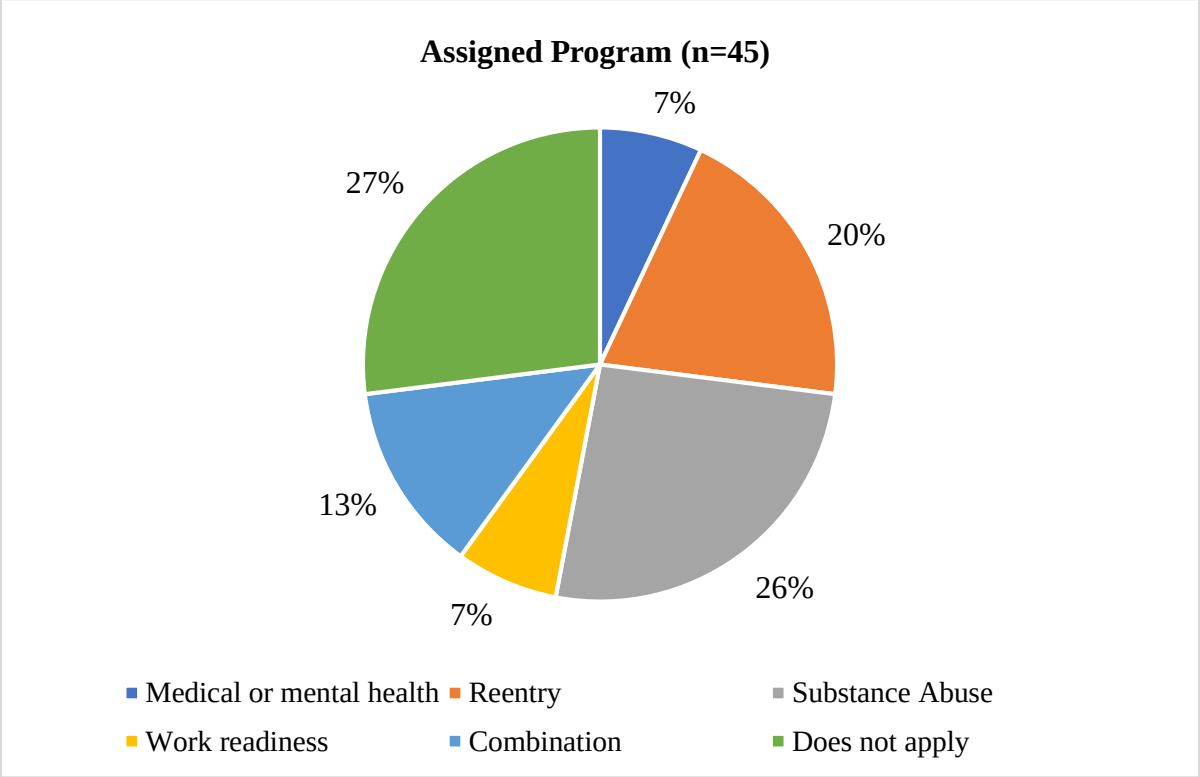

Sentencing Status (n=44)
4%
25%
71%
Pre-trial
Sentenced
Unknown


Age Group (n=45)
5%
20%
16%
16%
43%
18-24
25-29
30-39
40-49
50+


Have you been incarcerated previously? (n=43)
34%
66%
Yes
No


Do you know where you will live when you are released? (n=43)
16%
9%
75%
Yes
No
I don't know


How many times have you been incarcerated before? (n=43)
7%
43%
29%
21%
0 - first time
1-2 times
3-4 times
5 or more times


Assigned Program (n=45)
7%
20%
26%
7%
13%
27%
Medical or mental health
Reentry
Substance Abuse
Work readiness
Combination
Does not apply

Appendix F: Contributing Agencies

Data was provided by the following agencies:

- District of Columbia Department of Corrections
- Pretrial Services Agency for the District of Columbia
- Federal Bureau of Prisons
- Department of Behavioral Health for the District of Columbia

Qualitative discussion participation by the following agencies:

- Washington DC Department of Corrections (DOC) uniform and non-uniformed staff
- DOC inmates
- Office of the Deputy Mayor of Public Safety
- DC Department of Youth and Rehabilitation Services (DYRS)
- Washington DC Court Services and Offender Services Agency (CSOSA)
- Chief of Staff US Parole Commission
- Washington DC Public Defender Service
- Federal Bureau of Prisons (Retired)
- Office of Victim Services and Justice Grants (OVSJG)
- Washington DC Corrections Information Council (CIC)
- ACLU-DC
- America Works
- Catholic Charities Welcome Home Reentry Program
- Community Connections
- Community and Family Life Services
- Council for Court Excellence
- CURE International
- Drug Policy Alliance
- DC Washington Lawyers Committee
- DC Jail and Prison Advocacy Project, University Legal Services
- Jubilee Housing
- Gatekeeper Connection
- Interagency Counsel on Homeless
- Justice Policy Institute
- Lawyers for Youth
- Metropolitan Police Department
- National Reentry Network on Returning Citizens
- Pretrial Services (Retired)
- The Sentencing Project
- United Methodist of Women
- Unity Healthcare

Appendix G: Custodial Population Study Literature Review

Deliberative To

District of Columbia Criminal Justice Coordinating Council

Literature Review

District of Columbia Custodial Population Study: Seeking Alignment between Evidence Based Practices and Jail Based Reentry Services

Justice Research and Statistics Association

Anat Kimchi
Ajima Olaghere
Shawn M. Flower

February 2017

The District of Columbia Custodial Population Study is funded by the District of Columbia Criminal Justice Coordinating Council (CJCC). The opinions, findings, and conclusions or recommendations expressed in this product are those of the contributors and do not necessarily represent the official position or policies of the District of Columbia Criminal Justice Coordinating Council.

Table of Contents

Table of Tables

Table of Figures

Executive Summary

Whether we consider reentry a program, philosophy or process, what remains constant is institutionalizing a basic understanding of the number and complexity of needs returning citizens have upon reentering society. Equally important are the necessary services that need to be appropriately matched on an individual basis to meet these needs. Over the course of a year, over 10,000 people are admitted and released from the District of Columbia Department of Corrections. During fiscal year 2016, the majority of those released from DOC leave within 90 days with 76% of men and 90% of women were released within 3 months. Of those, 18% of men and 24% of women were held from 1 week to 1 month, and 40% of men and 47% of women were released within 1 week of intake into DOC.[115] An additional 2,000 Bureau of Prison inmates are returned to the community every year.[116]

Methodology for Literature Search

This literature review examined references relevant to reentry-related correctional models, programs, and practices across academic on-line databases, institutional and organizational websites, and recent conference materials. This review summarizes 118 publications, which included a mix of academic and non-academic sources ranging from peer-reviewed journal articles, technical reports, conference presentations and publications, to information gathered from the National Institute of Justice's website (CrimeSolutions.gov). The review found a dearth of studies relating specifically to jail reentry practices, as much of the research on reentry is focused on individuals returning from prison. The search and synthesis of literature was primarily focused on recent publications, 2006 to present, in an effort to summarize information no more than 10 years old.

Reviewed literature included outcome and process evaluations. Outcome evaluations measure the effectiveness of programs on achieving the desired goal, while process evaluations examine whether programs were implemented as designed. No single study or evaluation informs the following discussion of evidence-based models, strategies, and practices; instead, this summary provides an overview of successful components of reentry from both jail and prison that emerged repeatedly in the literature.

Summary of Findings

Jails are able to contribute to reductions in future admissions through reentry services. Despite facing the challenge of servicing a diverse and high needs population with rapid inmate turnover, jails are at an advantage as they are located near the communities to which individuals will return. Consequently, jail reentry programs are better situated to draw upon community resources and coordinate with community providers, thus easing the reentry process. Communities greatly benefit from jail reentry programs through reductions in crime and investments in human capital.

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[115] DC Department of Corrections Facts and Figures October 2016, page 25 http://doc.dc.gov/sites/default/files/dc/sites/doc/publication/attachments/DC%20Department%20of%20Corrections%20Facts%20and%20Figures%20October%202016_0.pdf

[116] Criminal Justice Coordinating Council InfoGraphic: Justice System Involved Individuals https://cjcc.dc.gov/sites/default/files/dc/sites/cjcc/page_content/attachments/Fall%202016%20InfoG%20Justice%20System%20Involved.pdf

Further, small reductions in recidivism rates are necessary for public agencies to break-even in their investment in publicly funded, jail-based reentry programs. This goal can be accomplished through cost effective evidence-based reentry practices.

The findings below highlight specific suggestions[117], noted as essential for reentry programming as identified in the literature, and thus important for jail-based reentry. These findings are collapsed into six specific domains to highlight broad areas in which lessons about jail-based reentry planning, both philosophical and pragmatic can be drawn. Overall, these findings are representative of actionable statements for the District's decision-makers and stakeholders to evaluate in the context of their own reentry strategy.

Foundations of Reentry Planning

- The first step to any reentry effort is using a validated risk assessment tool for identifying individual risk level for reoffending upon return to the community.
- A comprehensive assessment of dynamic criminogenic needs (e.g., housing, employment, substance misuse, family relations, etc.) identifies areas of focus for reentry programming for medium and high risk offenders.
- Case managers develop individualized reentry plans using the risk and needs assessments that address services and programming administered in-jail, at release, and during the subsequent transitional period within the community.
- Programs should be tailored to individuals' characteristics and the communities to which they will return.
- Sound reentry programming consists of the right evidence-based services tailored to individual needs, as well as the appropriate intensity and duration of services.

Jail-Based Reentry for Specific Populations

- The literature supports gender-specific reentry programming for women.
- Young adult offenders (those from 18 to 24 years old) are often at higher risk for criminal justice involvement. However, there is a lack of evidence based reentry programs or policies that focus on this population. Currently Federal funding is seeking to close this knowledge gap.
- Addressing individuals' physical health needs and supporting uninterrupted continuity of care can assist in the general reentry process.
- Individualized reentry plans should address mental illness needs, and specialized reentry services administered in a designated location are beneficial for mentally ill populations.

Jail-Based Reentry Programming (program evaluation findings)

[117]This literature review is part of the District of Columbia Custodial Population study and is intended to provide a summary of the extant empirical evidence related to reentry. In the near future, a custodial population report will comprehensively describe the flow of criminal justice involved individuals into and out of DC DOC facilities and will explain variations in custody populations. Thereafter, a services analysis report will summarize information obtained during focus groups and stakeholder interviews conducted by The Moss Group. A final report will compile the information and apply selected lessons outlined in this document to specifically address issues identified throughout the project.

- Wraparound services both before release through post-release is the most successful reentry strategy.
- Collaboration between corrections and community partners is critical for continuity of care. Communication also can help facilitate referrals for services, maximize existing resources, and identify service gaps.
- Staff turnover can cause substantial disruption in reentry processes, and therefore recordkeeping and ongoing routine and formal training on program operations and procedures is crucial to maintaining fidelity.
- A reentry specific housing pod or general housing unit on the same floor as a jail's reentry center allows for efficient administration of services.
- Maintaining a close relationship and teamwork philosophy among community service providers, community supervision providers, and jail case management staff is essential for improving reentry programming.

Best Practices for Reentry Applicable to Jail-Based Reentry

- Use of cognitive behavioral interventions for moderate and high risk offenders helps target criminogenic dysfunctional beliefs, thoughts, and patterns of behavior.
- Promoting family involvement and knowledge of services is an important component of reentry strategies to help offenders establish a continuum of social support ready in the community.
- Close working relationships, effective communication, and information sharing between jail staff and community providers are essential for continuity of care.
- A common and effective strategy is jail "in-reach" programs, where jails partner with community agencies to provide services and meet with clients in jail before release.
- Education- and employment-based programs and services can reduce recidivism and increase employment outcomes in the community.
- Substance abuse services and therapeutic communities effectively address needs faced by a large portion of the inmate population.

Jail-based Reentry Planning: Lessons from Halfway Housing and Federal Programs

- Halfway houses based on the risk-needs model have the potential to promote successful reentry.
- The Federal Bureau of Prisons (FBOP) has a reentry preparation program and utilizes Reentry Residency Centers (RRCs) and home confinement for federal prisoners returning home. However, evaluations of those programs would not be comparable to DC prison population because while the DC prisoner serves their time in a federal facility, they are more similar to state prisoners than to other federal prisoners. This is due in part to the types of charges (e.g., more than half of federal prisoners serve time for a drug offense, while more than half of state prisoners serve time for a violent offense). Thus, DC prisoners released from federal prison are in a unique situation and there is a lack of comparable research exploring evidence based practices for this specific population. Therefore, a need exists for improved reentry services for the returning federal prison population.

Conclusion

Almost every individual who enters jail will return to the community, and the majority will do so rather quickly. This review of the literature demonstrates that providing the right services to the right individuals can ease the transition of returning citizens. Jail-based reentry services reduce the chances of coming back to jail by targeting criminogenic needs and lessening the negative impact that incarceration may produce. While this review found studies specifically relating to jail reentry evaluation to be limited, this does not impede the creation of successful reentry programs based on evidence-based principles and strategies. Ideal programming would utilize the principles and strategies summarized above in a unique and tailored design specific to the population including their risks, needs, and overarching goals. The individualized aspect of reentry services, including incorporation and maximization of existing community resources, was a consistent theme in the literature. While this type of strategy calls for a more creative and integrative approach than standard "cookbook" replications of a successful program, the potential for programming designed in this manner is much greater.

Although jails typically are unable to provide the entire duration of services that would be appropriate to impact participants, they have the advantage of being in close physical proximity to the communities to which individuals will return. Strong partnerships and communication with community providers play a critical role in effective reentry strategies to promote wrap-around services and ensure continuity of care. An efficient and immediate assessment of the risks and needs of individuals who enter jail is necessary to create the individualized reentry plan that begins inside the facility and extends after release. In support of that effort, this review provides recommendations for the types of services, practices, and strategies that have been found most effective and relevant in criminal justice-involved populations. Specifically, support was found for services targeting education and employment, substance abuse, mental health, cognitive behavioral programming, and promoting family involvement. Furthermore, addressing population-specific needs through gender-specific programming, specialized services, and attention to both mental and physical illness is also beneficial. Centralizing reentry services in a 'reentry center' and separate reentry housing unit maximizes the impact of these services. In addition, based on our review of process and implementation evaluations, the role of quality assurance and fidelity in the overall effectiveness of reentry strategies cannot be overstated.

Overall, the shorter lengths of stay in jail facilities should guide planning for most programs and services. Physical and mental health programming and services, discharge planning and activities, as well as other types of programs should be developed and implemented with continuity of care after release as a key consideration. Although jails have little control over the number or type of population and the duration of stay, jails are able to contribute to reductions in future admissions through facility-based reentry services and a smooth and efficient transition to community-based services upon release. Cost effective, evidence-driven, jail-based reentry practices can help accomplish this goal, by ensuring that individuals are better positioned for success upon release.

Introduction

Jail facilities house a diverse population of individuals who have been sentenced, are still awaiting trial, or have violated supervision, with time served ranging from short stays to extended periods. Individuals range in their levels of dangerousness or vulnerability, and have varying degrees of medical, mental health, substance abuse, family, financial, and literacy needs (Martin & Katsampes, 2007). While there are roughly 11.7 million jail admissions in a typical year, these numbers do not represent unique annual admissions (Minton & Golinelli, 2014). In Chicago, 21% of the people admitted to jail between 2007 and 2011 accounted for 50% of all admissions (Olson & Huddle, 2013). In New York City, over 400 people were admitted to jail 18 times or more within a five year period, accounting for more than 10,000 jail admissions and collectively spending over 300,000 days in jail (Behavioral Health and Criminal Justice, 2015). The majority of these individuals who cycle in and out of jail had a substance use disorder (99.4%), were charged with a misdemeanor or probation violation (over 85%), and were more likely to have a serious mental illness (21%) than the general inmate population (Behavioral Health and Criminal Justice, 2015).

Individuals who enter jail often have varied and complex needs. They are less likely to have completed high school (Harlow, 2003), more likely to have housing needs, more likely to have a history of abusing drugs or alcohol (Subramanian, Delaney, Roberts, Fishman, & McGarry, 2015), and are four to six times more likely to suffer from a mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009) than the general population. Even a few days in jail may exacerbate the existing problems these individuals face by reducing economic viability, worsening health, increasing the likelihood of repeat incarceration, and promoting criminal behavior (Subramanian et al., 2015). Periods of incarceration may also impact future earning potential, decreasing employment and wages (Western & Pettit, 2010) through disruptions in the accumulation of human capital and as a direct result of employers' use of a criminal record as a signal of work-readiness (Raphael, 2010). The impact of these economic complexities may extend to the individuals' families and communities. Families experience financial strain through the loss of income and subsequently lose housing, particularly when the incarcerated individual is the primary provider, along with the additional costs of incarceration such as collect telephone calls. The aggregation of these consequences in communities with high rates of incarceration can lead to further destabilization (Subramanian et al., 2015).

Although jails have little control over the number or type of individuals admitted and the duration of their stay (Martin & Katsampes, 2007), jails are able to contribute to reductions in future admissions through facility-based reentry services and continuity of care upon release. Despite facing the challenge of servicing a diverse and high needs population with rapid turnover, jails are at an advantage as they are located near the communities to which individuals will return. As such, jail reentry programs are well situated to draw upon community resources and coordinate with community providers, easing the reentry process (Subramanian et al., 2015). These communities greatly benefit from jail reentry programs through reductions in crime and investment in human capital. Further, as a report by the Vera Institute of Justice summarizes, "the only way localities can safely reduce the costs incurred by jail incarceration is to limit the number of people who enter and stay in jails" (Hendrichson, Rinaldi, & Delaney, 2015, p. 24). Cost effective, evidence-driven, jail-based reentry practices can help accomplish this goal.

Cost Effectiveness of Jail-Based Reentry

Notably, only small reductions in recidivism rates are necessary for public agencies to break-even in their investment in publicly funded jail-based reentry programs, regardless of the cost of corrections and the offender population. An Urban Institute study by Roman and Chalfin (2006) examined how much of a reduction in crime is necessary to offset the costs of jail-based reentry programs. According to Roman and Chalfin (2006), only a 0.52-0.83% (less than 1%) reduction in recidivism rate would recoup costs incurred by communities and government agencies implementing a low-cost reentry program (the "break-even point").

For example, based on crime patterns in Philadelphia, and considering both the costs and benefits of reentry services to society, Roman and Chalfin (2006) found that a low-cost reentry program (Hamden County) pays for itself with a .67% reduction in recidivism, while a reduction of .93% in recidivism is necessary in a high-cost reentry program (Montgomery County). For contracted reentry services, a 4.14% reduction in recidivism is the break-even point as these programs were more costly than government run reentry programs. Researchers calculated estimates using crime trends in Philadelphia and three fictional jurisdictions (Table 27), and found that when one considers both costs and benefits for both the community and government agencies, the recidivism rate break-even point for publicly administered programs is most often less than 1%. For contract-based reentry services, the recidivism break-even range is 3 to 5%. When the benefits to community are removed from the calculation, and only the costs for police, courts, and corrections are included, the recidivism break-even point ranges from 1 to 5% for publically administered programs. The recidivism break-even point for contract-based reentry services is higher, ranging from 7 to 23%.

Table 27: Break-even Recidivism Rates by Correction and Reentry Services Costs*

	High Corrections Costs ($137/day)	Medium Corrections Costs ($78/day)	Low Correction Costs ($40/day)
(Costs and Benefits to Community and Government Agencies)			
Low cost reentry services	.52 - .58%	.62 - .71%	.71 - .83%
High cost reentry services	.71 - .80%	.86 - .98%	.98 - 1.15%
Contract reentry services	3.19 - 3.57%	3.82 - 4.37%	4.37 - 5.12%
(Costs to Government Agencies – Police, Courts, and Corrections)			
Low cost reentry services	1.25 - 1.27%	2.07 - 2.12%	3.58 - 3.74%
High cost reentry services	1.72 - 1.74%	2.84 - 2.97%	4.92 - 5.13%
Contract reentry services	7.66 - 7.77%	12.68 - 12.99%	21.96 - 22.91%

*Based on findings of Roman and Chalfin (2006)

The costs of programming can quickly balance out with reductions in recidivism if a jurisdiction properly allocates resources to the needs of the population being served through well-planned assessment and implementation.

Foundations of Reentry Planning and Continuity of Care: Risk, Need, & Responsivity
Overview of RNR Model and Target Clientele

Effective reentry practices that would reduce the number of readmissions and help offenders successfully return to the community are based on the Risk-Needs-Responsivity (RNR) model as pioneered by psychologists James Bonta, Don Andrews, and Paul Gendreau (Jonson & Cullen, 2015). The *risk* component refers to the idea that interventions and programs must match individuals' risk level for reoffending when returned to the community. Accordingly, the first step to any reentry effort is an evidence based risk assessment tool to assess an individual's risk level the moment the person enters the facility.[118] Given limited resources and a diverse jail population with rapid turnover, it is important and necessary to initially identify those who would benefit the most from reentry planning resources. The *Transition from Jail to Community (TJC) model* (Figure 8), developed by the National Institute of Corrections (NIC) in partnership with the Urban Institute, highlights screening as a first step in the triage approach to assess offender risk based on three principles:

1. Risk screening should be done using a valid and reliable tool designed to measure risk to reoffend in the community.

2. Screening is intended for the entire jail population and should occur at booking or as close to initial entry to the jail system as possible.

3. Screening should be used to categorize the jail population by risk level, with different intervention tracks for each level (Christensen, Jannetta, Willison, 2012 p. 3).

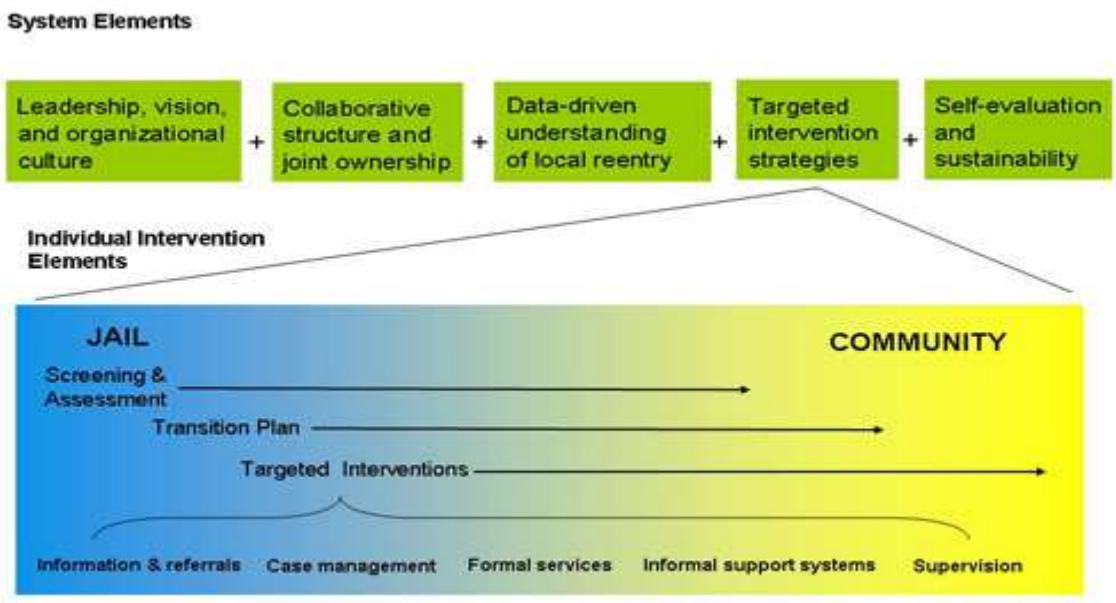

Figure 8. Transition from Jail to Community Model (Janetta, Willison, & Kurs, 2016)

[118] This differs from a pretrial risk assessment which is often used to determine detention recommendations prior to a jail admission.

Validity and reliability refer to the tool's ability to accurately and consistently measure risk of reoffending. Initial screenings at admission to the jail facility should also be quick and simple to administer so that every individual is successfully screened beyond security level classifications. Various assessments are available, and those with the highest predictive validity tend to be based on similar factors. The TJC model suggests the use of the Proxy Triage Risk Screener (Proxy) which uses an individual's current age, age of first arrest, and number of prior arrests to divide individuals into high-, medium-, and low-risk categories (Christensen, Jannetta, & Willison, 2012).[119] Another initial screening tool is the Service Priority Indicator (SPI) which targets those with the highest risk of readmission by identifying four risk factors for recidivism and assigning a score to each: (1) age at jail admission, (2) current charge, (3) number of prior admissions, and (4) recent admissions (Wei & Parsons, 2012).

The initial screening serves to determine who should be given more comprehensive assessments and eligibility for programming. Where allowed, the screening information can be shared with community providers, particularly when high-risk inmates are released before receiving needed interventions (Christensen et al., 2012). As a general rule, more intensive reentry programming should be fitted for moderate and high risk offenders (Andrews & Bonta, 2010; Lowenkamp, Latessa, & Holsinger, 2006). This is a critical concept because inappropriate programs for low-risk offenders may *increase* recidivism (Andrews & Bonta, 2010; Lowenkamp et al., 2006; Lowenkamp, Pealer, Smith, & Latessa, 2006; Lowenkamp, Latessa, & Smith, 2006). Imposing excessive restrictions and requirements on a low-risk individual may actually interfere with prosocial activities and community involvement and therefore unnecessarily thwart successful reentry (Lowenkamp & Latessa, 2004). For example, assigning low-risk individuals to unnecessary programming with high-risk offenders directly increases the time they spend with more criminogenic individuals without providing any benefit. Facilities should focus resources on the higher risk offenders, as it helps both those who receive those resources as well as those who are lower risk and may have negative outcomes due to unnecessary intervention. Another key factor is that the information from the initial screening should be stored and be readily available to identify individuals who cycle in and out of jail (Sandwick, Tamis, Parsons, & Arauz-Cuadra, 2013).

The second component of the RNR model concerns the *needs* principle, which states that programs that aim to reduce readmissions must target factors that are *dynamic* and significantly influence criminal behavior; these dynamic factors are known as *criminogenic needs* (Andrews & Bonta, 2010). The dynamic needs that contribute most to an individual's chance of recidivating include antisocial thoughts and beliefs, antisocial temperament such as poor decision-making skills, difficulties with impulse control, anger management problems, and antisocial peers. Other dynamic criminogenic needs that should be addressed to increase an individual's chance of successful reentry from jail include: family/marital stress, substance misuse and disorders, employment instability, problems with educational attainment and engagement, and a lack of prosocial leisure activities (Andrews & Bonta, 2010; Gendreau, Little & Goggin, 1996). Assessment of criminogenic needs is the second step in the triage approach, and requires a more comprehensive assessment**.** The TJC model recommends using an actuarial needs assessment that is valid and reliable, and also conducting the assessment on individuals

[119]The Proxy is a public domain instrument and can be administered in less than a minute. For more details see Bogue, Woodward, & Joplin, 2005.

scoring as medium or high risk on initial screenings. These needs assessments can then be used to appropriately plan, manage, and treat each individual (Christensen et al., 2012).

The needs assessment is essential to developing appropriate programming that best utilizes available resources and maximizes an individual's chance of successful reentry. One example is the Level of Services Inventory-Revised (LSI-R), a well-established assessment that evaluates individuals' needs across ten domains that increase the risk for recidivism. The LSI-R domains include: (1) criminal history, (2) education/employment, (3) financial, (4) family/marital, (5) accommodation, (6) leisure, recreation, (7) companions, (8) alcohol/drug problems, (9) emotional/personal, and (10) attitudes/orientation. This 54-item assessment tool is completed by trained assessors who interview the individual (Andrews & Bonta, 2000).

A critical component of the risk/needs assessment in general is to ensure appropriate use of these assessments. Miller and Maloney (2013) found 12.4% of practitioners report completing assessments carelessly, putting forth minimum effort, and manipulating information to correspond to subjective opinions. Inaccurate assessments due to practitioner noncompliance or lack of proper training will lead to incorrect program and supervision decisions, possibly resulting in increases rather than decreases in recidivism (Lowenkamp, Latessa, & Holsinger, 2004). Therefore, fidelity must be monitored during implementation of any risk/needs assessment tool.

The last component of the RNR model is the *responsivity* principle which adds that programs should be both evidence-based (general responsivity) and tailored to individuals (specific responsivity) (Andrews & Bonta, 2010). Tailoring programs to individuals' characteristics is critical for effective reentry practices. Individual characteristics that should be taken into account in programming include culture, age, cognitive/development functioning, motivation to change (Andrews & Bonta, 2010), and mental health status (Skeem, Steadman, & Manchak, 2015). Evidence suggests that matching treatment modalities and counselors to individual offender types is also effective (Petersilia, 2011).[120] This all goes to the point of being responsive to general offender needs, as well as addressing the specific issues of each individual.

Case Planning: Promoting Continuity of Care

Once an individual's needs are identified through appropriate assessments, case managers can then develop individualized reentry case plans**.** As the TJC model notes, "case plans are the primary vehicle for matching assessed criminogenic needs to available interventions" (Christensen et al., 2012, p. 9). Case managers represent a critical component of reentry planning

[120] A full review of these factors is beyond the scope of this literature review. A growing literature addressing the importance of cultural competency for assessment, supervision, and programing is emerging, especially for Hispanics and American Indians (See Kane, Bechtel, Revicki, McLaughlin, & McCall, 2011; available at: https://www.bja.gov/Publications/CRJ_Role_of_Responsivity.pdf). Cognitive function refers to the intelligence, thinking style (e.g. concrete-oriented thinking), learning style, verbal skills, and problem-solving skills of the individual. Many factors that are not criminogenic fall under the responsivity category. For example, individuals with poor verbal skills may benefit more from behavioral focused treatment, and those with higher anxiety and depression levels may not do as well in group settings. The relationship between counselors and clients and staff characteristics is also important to the responsivity principle, and staff who are warm and committed generally tend to be associated with better outcomes.

(Solomon, Osborne, LoBuglio, Mellow, & Mukamal, 2008) and should establish rapport with clients and be trained in the components of the reentry process from assessment administration to making appropriate referrals (Warwick, Dodd, & Neusterer, 2012). Case management can involve case managers both from within the jail and in the community. TJC's principles offer useful guidance:

1. Case management services are provided to clients who have been screened as medium or high risk to reoffend.
2. Clients receive a comprehensive case plan that builds upon needs assessment by specifying interventions that address the client's identified criminogenic needs.
3. A single case plan is used by all agencies interacting with the client, including the jail, probation, and community-based service providers, and the case plan follows the client into the community upon release from jail.
4. Jail staff coordinates with staff from community-based organizations to ensure that clients are referred to the appropriate programs and services (Warwick et al., 2012, p. 3).

Given the short lengths of stay in jail, case plans need to reflect continuity of care as a priority, combining programs that begin inside jail and continue once individuals are released (Jonnson & Cullen, 2015). As such, the TJC model advises that each case plan should include: (1) an in-jail component to prepare for release, (2) interventions targeting immediate post-release needs, and (3) programs targeting the longer-term transitional period in the community. Given that reentry plans require a multitude of services and agencies, case plans need to be constructed in a clear, informative, and organized manner, with a specified timeline, an outline of needs to be addressed, and identification of agencies responsible for providing each service. (Warwick, Dodd, & Neusterer, 2012). Engaging inmates in the case management process through motivational interviewing and developing SMART (Small, Measurable, Attainable, Realistic and Timely) goals to establish what offenders need to accomplish in the institution was also shown to be effective (Duwe, 2012).[121]

Jail and reentry staff can work with community providers to develop and implement reentry plans to appropriately match inmates' risk level and needs (Parsons, 2014). Evidence supports including an offender's community supervision agent as early in the process as possible (Duwe, 2012; Willison, Bieler, & Kim, 2014). Case management may mean the difference between delaying offenses and desistance. While based on a prison population, a rigorous impact evaluation of 1,697 adult males in twelve programs[122] funded under the Serious and Violent Offender Reentry Initiative (SVORI) with a five year follow-up period found that having a reentry plan delayed risk of initial rearrests, and meeting with case managers reduced post-release rearrests during the initial 56 months post-release (Visher, Lattimore, Barrack, & Tueller, 2016).

[121]The study utilized a prison sample in Minnesota who began the Minnesota Comprehensive Offender Reentry Plan (MCORP) program at least two month prior to release, and had at least 6 months of community supervision remaining (n=175) compared to a control group (n=94).

[122]The programs were for serious and/or violent male offenders, 35 years or younger in Iowa, Indiana, Kansas, Maine, Maryland, Missouri, Nevada, Ohio, Oklahoma, Pennsylvania, South Carolina, and Washington.

Furthermore, *The Jail Administrator's Toolkit for Reentry* developed six ideal reentry tracks and recommended actions based on identified risk factors, needs, and length of stay (Mellow, Mukamal, LoBuglio, Solomon, & Osborne, 2008). Higher track levels include the services provided to those in the tracks below it (Table 28).[123] These recommended actions, from providing individuals with a list of service providers, contact information, and governmental benefits to scheduling appointments for services prior to release provides a preliminary roadmap of activities for case management to execute.

[123]The Baltimore City Jail Reentry Strategies Project (Flower, 2013) provides an example of this plan based on level of risk and length of stay for individuals. The final report can be found at http://choiceresearchassoc.com/documents/final_jail_reentry_strategies_report_09_01_2013.pdf

Table 28: Jail-Based Reentry Tracks and Recommended Level of Services*

Track	Target Population	Interactions w/ Reentry Staff	Recommended Actions for Reentry Services	Scope of Recommended Reentry Services
1	Low needs and/or Very short stays	No interaction	Resource information (A)	) *Resource information*: Provide individuals with a list of service providers, contact information, governmental benefits, and applications. This package can also include "harm reduction and personal care kit" with information on health insurance, clinics, HIV/STD testing sites, personal health record plan, and condoms.) *Reentry plans*: Written copies of the reentry plan, described earlier, should be signed and provided to inmates. Community service providers/supervisors should also receive written copy of reentry plans to promote continuity of care.) *Appointments for services*: Appointments should be scheduled prior to release and the name of the service provider, time/date, address, and phone number be provided to inmates in writing. Populations requiring drug treatment or HIV aftercare should be receiving this service.) *Coordination and collaboration of services back to community*: Individuals in this level should be receiving a higher level of reentry planning and support, and have contact with community service providers before release. The Jail Administrator's Toolkit for Reentry highly recommends this service for individuals with serious mental health needs.) *Extended care placement or supporting houses*: Individuals, such as those within a geriatric population, who are unable to do two or more activities of daily living should be transferred to a nursing home or assisted living facility
2	Medium needs and/or longer stays	1 interaction	Resource information Reentry plan (B)	
3	High needs and/or longer stays	1 interaction	Resource information Reentry plan Appointments for services (C)	
4	High risk and needs and/or longer stays	Multiple interactions	Resource information Reentry plan Appointments for services Coordination and collaboration of services back to community (D)	
5	High needs/problems with activities of daily living[124]	Level of care assessment & determination of housing placement	Resource information Reentry plan Appointments for services Coordination and collaboration of services back to community Extended care placement or supporting houses (E)	
6	Inmates from track 2-5	Multiple sessions	Resource information Reentry plan Appointments for services Coordination and collaboration of services back to community Reentry programs[125]	

* From Mellow, Mukamal, LoBuglio, Solomon, & Osborne, 2008

[124] Activities of daily living include: bathing, dressing/undressing, toileting, transferring, eating, and mobility.

[125] *Reentry programming:* Formal reentry programs targeting needs in jail should be appropriately provided to medium and high risk inmates in the other tracks.

Continuity of care also applies to basic needs that must be met as one leaves a facility and should be part of the reentry plan. These include transportation, food, clothing, and personal identification (La Vigne, Davies, Palmer, & Halberstadt, 2008). Coordinated transportation is important both for leaving the institution, and in the following days for individuals to access services and employment. Public transportation subsidies and partnerships with local authorities to use release identification as a temporary bus pass assist in ensuring releasees are able to attend meetings and appointments. State-issued photo identification cards are necessary to access many basic needs such as proving employment eligibility and obtaining benefits. When individuals do not have a state issued identification card upon release, institutions can provide easily exchangeable identification cards (La Vigne et al., 2008). For example, the Montgomery County Department of Correction and Rehabilitation partners with the Maryland Motor Vehicle Administration to provide a temporary identification called, "Community Reentry ID" that also serves as a 60-day bus pass and library card (Solomon et al, 2008).

Quality Assurance in Case Planning and Reentry Programming

1. Program Dosage and Duration

The best practices and programming utilized in successful reentry strategies are all contingent on appropriate implementation, duration, and staff training. Applying a medical framework to reentry practice and needs -- too little intervention will give little to no benefit, while too much may not work or have harmful effects. A dosage framework explains the findings described earlier -- that inappropriate programming can be detrimental to low risk offenders. The dosage conceptual model provided below is based on findings of effective treatment durations of programming for various risk levels (Table 29). Note this model suggests that offenders of different risk levels can receive the same intervention, but the *intensity* of the intervention should vary according to level of risk. The model also reinforces partnership with the community, as most individuals will not stay in jail long enough to receive the entire duration of services. Therefore, continuity of care is critical for maximizing reentry efforts (Carter & Sankovitz, 2014). While these are ideal standards (and based primarily on those returning from prison), reviews of the literature suggest that effective programs tend to be intensive, lasting an average of six months, and occupying 40-70% of an offender's time (Petersilia, 2011).

Table 29: Dosage Conceptual Model*

Risk Level	Dosage Target	Ideal Duration
Moderate Risk	100 hours	12 months supervision 12 months services
Moderate/High Risk	200 hours	18 months supervision 15 months services
High Risk	300 hours	24 months supervision 18 months services

*From Carter & Sankovitz, 2014

2. Critical Timing

Given individuals' short length of stay in jails, it is important for jails to efficiently assess risks and needs and begin case management as early as possible. Jails can provide a component of reentry programming inside the institution, but also must prepare individuals for the moment of release. The first 24 hours and initial days after release are critical (Solomon et al., 2008) and individuals remain in the riskiest time period through the first days and weeks out (National Research Council, 2008). Therefore, any delays in assessment, case planning, or program implementation will increase an individual's risk of reoffending once in the community.

The TJC Initiative supports a "hub and spoke" model for handoff to the community, working through a primary community-based partner to connect returning individuals to services and resources in the community. This approach has two main advantages: (a) efficient communication: it is easier for individuals to only deal with one primary coordinator, and that entity is also able to track the referrals and service utilization after release; and (b) the hub can connect individuals to services and programs that are not met by the primary partner organization. TJC notes that many times probation is the most convenient primary community-handoff partner and therefore it is important for jails to develop a collaborative relationship with probation offices. The earlier jails can foster a relationship between individuals and reentry partners in the community, the greater the likelihood of individuals engaging in post-release services (Jannetta, Willison, & Kurs, 2016). Timing the initiation of the engagement and planning process is a key to success.

3. Program Implementation, Staff Roles, and Training

The risk-needs-responsivity principles should also serve as a guide for program implementation. Performance metrics should be designed to ensure adherence to the principles of effective intervention. Programs lacking treatment fidelity have no effect on recidivism (Jonson & Cullen, 2015). Appropriate and routine staff training on core practices, program operations, and procedures is an important component of successful reentry strategies to ensure that the right services are delivered with fidelity to program participants (Warwick, Dodd, & Neusterer, 2012; Willison, Bieler, & Kim, 2014). All jail staff engaged in reentry planning should have clearly defined roles and expectations, and the training program should involve treatment staff, as well as correctional officers and management (Kerle, 2003).

Findings from Phase 2 of implementation of the TJC Initiative support four components of a collaborative team for implementation that can include both new and preexisting groups. Leadership for such an initiative, according to their findings, should include an executive-level criminal justice leadership body, a core team, a group of community partners, and working groups across stakeholders. In addition to this oversight and collaboration, self-evaluation is important in the implementation of reentry efforts, as routine data analysis can identify gaps and support the sustainability of the programming (Jannetta, Willison, & Kurs, 2016). Problems in implementation and pre-service assessments (e.g., the appropriateness of the assessment used or the target population of the program) are more highly correlated with recidivism than program and staff characteristics such as the program type or treatment target or the staff education and experience (Lowenkamp, Latessa, & Smith, 2006; Visher, Lattimore, Barrack, & Tueller, 2016).

4. Lack of Access to Services

In addition to being true to the intent of a program, problems in implementation can also include a lack of service delivery, as evaluations find that a substantial portion of program participants do not receive the basic services that characterize the core components of the program (Lattimore & Visher, 2013).[126] Effective programming is built on services that target criminogenic needs, and participation in programs without access to such services substantially reduces the program's ability to demonstrate effective results – a program must have enough space to provide all services to all those who need them. U.S. Deputy Attorney General Sally Yates notes that a significant problem affecting programming and treatment in correctional facilities are long waiting lists for participation (The Hamilton Project, 2016). Many individuals are unable to access evidence-based programs during their stay in prison or jail because they are released before a spot opens.

Dosage and duration, timing of engagement, program fidelity, and program capacity all contribute to a well-functioning facility-based reentry strategy. It is also important to address the reentry programming needs of specific populations in order to find success – particularly by gender, and for those with physical and/or mental health challenges.

Reentry for Specific Populations

Gender-Specific Reentry

Gender-specific reentry programming has been established as an effective framework for reentry practices and programs (Office of Justice Programs, n. d.(c)) for women. The percentage of women in jail has been consistently increasing over the past 15 years (Minton & Zeng, 2015). Women enter the criminal justice system differently than men, and also desist from future offending differently (Belknap, 2007; Blanchette & Brown, 2006; Bloom, Owen, & Covington, 2005, 2006; Herrschaft, Veysey, Tubman-Carbone, & Christian, 2009 as cited in Gobeil, Blanchette, & Stewart, 2016; Scroggins & Malley, 2010). In terms of offense patterns, women in jail are less likely to be charged with violent offenses than men, and more likely to be charged with property or drug-related offense than men (James, 2004).[127] In terms of reentry, women identify the primary problems they expect to face upon release to include challenges related to securing stable housing, access to substance abuse treatment, inadequate income, unemployment, access to educational opportunities, and strained relationships with their children (Freudenberg, Daniels, Crum, Perkins, & Richie, 2005).

While many of the needs identified by women overlap with needs identified by men, some generally affect women more, or manifest differently. In particular, women are more likely to have traumatic histories of physical and sexual abuse. Furthermore, the remnants of traumatic

[126]Intent-to-treat evaluations of the 12 SVORI reentry programs with 1,697 adult male offenders found that employment was a primary focus of many of the reentry programs, but only 27% of SVORI participants received any of the eight specific employment related services.

[127]While this 2004 publication is over a decade old, it was the most recent information available on the offense patterns of women *in jail*. A report from Bureau of Justice Statistics focused on state and Federal prisoners in 2014 indicated that women continue to be more likely than men to be incarcerated for property and drug-related offenses. https://www.bjs.gov/content/pub/pdf/p14.pdf

histories among women coexist with similar complicating factors such as substance abuse, mental illness, and physical health, all of which affect reentry outcomes differently for men and women (Mallik-Kane & Visher, 2008). Women are also disproportionately disadvantaged in terms of employment prospects, being both underemployed and unemployed, and are restricted from several suitable occupations that provide both flexible hours and living wages (e.g. caregiving and service industries) (Flower, 2010). Women also tend to be the primary caretakers of their children, which add additional challenges and obligations (Richardson & Flower, 2014).

A recent meta-analysis focusing on 18 high quality studies[128] found that gender-informed interventions were much more effective than gender-neutral programming (Gobeil, Blanchette, & Stewart, 2016). Effective gender-specific reentry strategies tend to take a holistic approach through therapeutic communities and/or cognitive behavioral therapy to address women's psychological and physical well-being, and programs to enhance parenting skills (Office of Justice Programs, n.d.(c)). Operating within a therapeutic community is especially effective for gender-specific substance abuse treatment (Gobeil, Blanchette, & Stewart, 2016). Research also supports providing services to women such as food and shelter, clothing, transportation, legal assistance, literacy, parental training, family therapy, medical care, childcare, assertiveness training, psychological assessment, and family planning (Shively & Ricciardelli, 2016).

Young Adult Offenders

One of the most consistent findings in the criminological literature is what is referred to as the "age-crime curve" (Hirschi & Gottfredson, 1983).[129] The age-crime curve illustrates that the peak age for criminal offending is in late adolescent (ages 15 to 19), and then declining through the mid-20s. While there are variations in this pattern (e.g., those committing minor offenses generally cease prior to reaching majority), it remains that young adult offenders, defined as those from the ages from 18 to 24, are disproportionately represented in the criminal justice system.[130] This is part due to the fact that young adults have not fully developmentally matured and thus may not "have full control over their behavior" (Loeber, Farrington, and Petechuk, 2013, p. 2) and are less likely to be employed or engaged in educational pursuits (The Council of State Governments (CSG) Justice Centers, 2015). Given these factors, young adult offenders have specific needs; however, there is a lack of evidence based programs or practices focused on this group. For example, while cognitive behavioral approaches are considered one of the most effective practices for medium and high risk offenders (Mellow, Christensen, Warwick, & Willison, 2011; Visher, Lattimore, Barrack, & Tueller, 2016; Willison, Bieler, & Kim, 2014) there have been no studies that explicitly examine the impact of these programs among young adult offenders. It is likely that practices which are effective with either younger or older adult offenders may need to be revised to accommodate the maturational issues of this specific population. The Federal government is currently funding projects to address these issues (Justice

[128]"High quality studies" refers to studies where an attempt was made to account for initial differences between treatment and comparison groups.

[129]See https://www.nij.gov/topics/crime/Pages/delinquency-to-adult-offending.aspx#reports

[130]See The Council of State Governments (CSG) Justice Center November 2015 publication for a detailed discussion on young adult offenders. https://csgjusticecenter.org/wp-content/uploads/2015/11/Transitional-Age-Brief.pdf

Policy Institute, 2016), and reentry practices for this population will likely evolve once more is known.

Physical Health

Incarcerated populations are much more susceptible to poor health conditions and increased risk of death, and the majority of returning prisoners (8 in 10 men and 9 in 10 women) have chronic health conditions which require medical care. While the most common physical conditions include asthma, high blood pressure, and diabetes (Mallik-Kane & Visher, 2008), 21% of prisoners and 14% of jail inmates have communicable diseases such as hepatitis C, tuberculosis, and STDs (excluding HIV or AIDS) compared to 5% of the general population (Maruschak, Berzofsky, & Unangst, 2015). In the first few weeks following release from correctional institutions, deaths are more than 12 times the average general population (National Research Council, 2008). In addition, people living with HIV/AIDS are disproportionately represented in the jail population. Inmates are three times more likely to be infected with HIV/AIDS than the general population (Maruschak, Berzofsky, & Unangst, 2015) and the homeless population, and those with substance abuse problems, are at greater risk for poor treatment and care. Research suggests that targeting basic needs such as housing and substance misuse increases the likelihood of engagement in HIV treatment (Zelenev et al., 2013). The experience of jail incarceration is also associated with a higher burden of physical health problems such as hypertension, arthritis, asthma, cervical cancer (for women), and hepatitis compared to the general population (Bingswanger, 2010). Additionally, those with physical health conditions are more likely to have trouble reentering the community, particularly with respect to obtaining stable housing and employment (Mallik-Kane & Visher, 2008).

Automating medical records and clinical care processes are the most common way to embed best practices and ensure that individuals are getting the proper services in a timely matter. For example, the District of Columbia has developed a best practice protocol to screen inmates for gonorrhea and chlamydia at booking with a urine test. Electronic medical record (EMR) software systems with automated clinical decision support can provide guidance and warnings of adverse effects. Linking the EMR system to the jail locator system benefits providers and officials by knowing where patients are and their custody status (Sheehan, 2008).

The Affordable Care Act (ACA) enabled many returning citizens to be eligible for Medicaid by expanding eligibility to all adults with incomes up to 133 percent of the Federal Poverty Level (Howard et al., 2016). Before the passage of ACA, the majority of returning citizens were uninsured. Although Federal law generally prohibits billing Medicaid for services received while incarcerated, it allows individuals to apply for enrollment during this time (Howard et al., 2016). Table 30 below summarizes coverage eligibility under the Affordable Care Act for justice-involved populations.

Table 30: Eligibility for Health Insurance Coverage under the ACA*

Status	Marketplace	Medicaid
Pretrial (not detained)	Yes	Yes
Pretrial (detained)	Yes (depending on specific plan requirement)	No (unless receiving inpatient treatment outside jail)[131]
Sentenced (not detained)	Yes	Yes
Sentenced and incarcerated	No	No (unless receiving inpatient treatment outside jail)

*From Gilmore, 2014

Once released, individuals on parole, probation, on home confinement, or in halfway houses (but not in federal Residential Reentry Centers[132]) are all immediately eligible for Medicaid coverage and services. As Medicaid coverage allows access to physical and behavioral health services for the reentering population, uninterrupted continuity of health care can be achieved if individuals are already enrolled in Medicaid at the moment of release (Howard et al., 2016). Jails can also work with community-based organizations[133] that assist in enrolling detainees or inmates while in jail to ensure that they are covered as soon as they leave the facility.

Mental Illness

As a result of the deinstitutionalization movement in the 1960s-1970s, there is a lack of sufficient mental health services and institutions, and some experts suggest that jails have become "de facto mental hospitals" (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Individuals with mental illnesses represent a high proportion of jail populations; 45% of people in federal prison and 64% of people in jail report symptoms of a mental health disorder[134] (James & Glaze, 2006). Mentally ill men and women are even more likely to have problems accessing services, difficulties finding housing and employment, and are also less likely to receive family support after release (Mallik-Kane & Visher, 2008). A recent study evaluating data from 2001-2009 on 44 states and the District of Columbia found that in 35 of the 44 states and DC, an increase in mental health care spending would reduce the jail population and subsequently jail expenditures (Yoon & Luck, 2016).

[131]Individuals are prohibited from receiving Medicaid benefits if they are in detention. One exception applies to individuals who are transported outside of the jail to receive inpatient services in a medical institution (e.g. hospital) for at least 24 hours.

[132]The Department of Justice, Bureau of Prisons (BOP) retains responsibility for payment of health care services rendered to individuals in Residential Reentry Centers. All other halfway house residents are eligible for coverage as long as they have 'freedom of movement and association' and (a) are not restricted in working outside the facility, (b) can use community resources (e.g. grocery stores, education, etc.) freely, and (c) can seek health care treatment in the community (Wachino, 2016).

[133]Assisters and certified application counselors are individuals who are federally qualified to help with enrollment, are typically from community health centers and social service agencies, and are funded by federal or state grants (Gilmore, 2014).

[134]This is compared to1 in 5 adults (18.5%) of the general population who experience mental illness. http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Research suggests that effective interventions for mentally ill individuals in the justice system utilize a person-place framework. This framework combines individual and environmental factors and addresses the standard risk factors, (i.e., those factors that impact mentally ill individuals and the broader offender population as a whole), as well as unique manifestations of criminogenic needs specific to populations with mental illness. For example, persons with mental illness face additional challenges in obtaining employment beyond those faced by the general offender population through discrimination and stigma (Epperson et al., 2014).In addition to symptoms of mental illness and criminogenic needs, person-level factors that should be addressed include addiction and behavioral patterns and exposure to trauma. Place-level factors include social and environmental disadvantage, and stress (Epperson et al., 2014). A recent evaluation by Skeem et al. (2015) suggests that mental illness considerations best fit the responsivity principle in the risk-needs-responsivity model. This is an important distinction as the risk principle only focuses on risk to the community in terms of public safety, thereby excluding low-risk individuals from services or more comprehensive evaluations. As such, a focus on individuals with mental health issues, irrespective of their low risk status, is necessary to ensure their persistent mental health needs are addressed.

One way to address this issue is to incorporate use of the "Assess, Plan, Identify, Coordinate" model (APIC).[135] The APIC model for jail transition to community is based on the importance of working partnerships between community service organizations and jails, specifically for those with mental illness (Table 31). The model calls for fast-track assessments for individuals spending less than 72 hours in jail to ensure that their basic needs are identified and they are linked to resources and identification of co-occurring mental health disorders. As mental illness exacerbates the common problems faced by the jail population, individuals with mental health illnesses should receive special care in addressing their specific needs including: coordinating treatment and behavioral health services, medication and medical care, and practical services such as addressing housing needs, income support, food and clothing, transportation, and childcare. As with the case management strategies described for the general jail population, wraparound care and coordination is necessary to ease the transition and avoid gaps in service provision (Osher, Steadman, & Barr, 2003).

[135]The APIC model is supported by the Substance Abuse and Mental health Services Administration (SAMHSA) as a best practice approach in reentry (see http://www.samhsa.gov/sites/default/files/topics/criminal_juvenile_justice/reentry-resources-for-consumers-providers-communities-states.pdf)

Table 31: APIC model*

Assess	Assess inmate's clinical and social needs, and public safety risks
Plan	Plan for the treatment and services required to address the inmate's needs
Identify	Identify required community and correctional programs responsible for post release services
Coordinate	Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services

*Adapted from Osher, Steadman, & Barr, 2003

Individuals with mental illness are also especially susceptible to homelessness (Mallik-Kane & Visher, 2008).The Jail In-Reach Project is a special program targeting homeless and mentally ill individuals who cycle in and out of jail that integrates the APIC model. It is based on six principles to reduce rates of re-arrest: (1) continuity of care and an established relationship with a personal physician; (2) a whole person perspective/patient-centered approach; (3) coordination and provision of immediate services; (4) integrated care of physical and behavioral health treatment and evidence-based practice of critical time intervention to establish long-term connections to services beginning in jail; (5) health information technologies for communications and quality assurance; and (6) access to care through close proximity to jail and the community. An evaluation of 207 participants in the pilot Jail In-Reach Project (both males and females) found that the program reduced the total average annual bookings per person into the county jail by 57.1%, with a similar magnitude of reductions in number of charges. The program also reduced the average days in jail per person per year by 28.4%. (Held, Brown, Frost, Hickey, & Buck, 2012).

Dosage and duration, timing of engagement, program fidelity, and program capacity all contribute to a well-functioning facility-based reentry strategy. Additionally, targeting special populations and individualized needs are good ways to ensure the greatest impact of resources focused on facility-based reentry. In addition to these planning aspects, the characteristics of programs must also reflect the most current knowledge to be impactful.

Best Practices in Reentry Programming

Overview

Several evidence-based practices are consistently noted in the literature as most effective to incorporate in facility-based reentry programming, including housing inmates in specialized units prior to release, implementing behavior modification programs, family engagement, and establishing working relationships among jail staff and community partners. It is important to note that due to the lack of research in this area specific to jails, most of the literature summarized is based on prison and not jail populations. Therefore, if implemented in jail settings, these programs and/or practices may need to be modified and subsequently evaluated to fit the plant limitations and/or needs of a jail population.

The literature on facility-based reentry, which primarily relies on prison studies, finds substantial support for separate housing facilities for reentry participants to increase the effectiveness of reentry programming (Jonson & Cullen, 2015). Housing individuals separately from the general population in prerelease centers (Seiter & Kadela, 2003) or therapeutic communities (Office of Justice Programs, n.d.(d)) has been shown to be effective at reducing recidivism. Separate housing facilities provide a location where all individuals participate with a common goal, and can easily receive required services. This evidence-based practice is effective for both genders, for adults,[136] and in particular for substance abusers in reducing crime for multiple offense types. Within a therapeutic community setting in a facility, residents are first introduced to the community, assigned community-related work, and taught the rules and routines. Once in the community, residents participate in appropriate in-jail programming, discharge planning, and receive referrals to reentry services in the community (Office of Justice Programs, n.d.(d)).

Another practice with strong support is cognitive behavioral interventions for moderate and high risk offenders. This lines up well with the responsivity principle of focusing programming on medium and high risk individuals. Cognitive behavioral therapies target criminogenic dysfunctional beliefs, thoughts, and patterns of behavior (National Academy of Sciences, 2008). These interventions are delivered by professionals or group facilitators who receive special training, can be delivered as part of a program or as a standalone intervention, and are effective with both genders. An example of this type of program, "Thinking for a Change" (T4C), was developed by the National Institute of Corrections and designed for high-risk offenders. The program is implemented through three components: (1) cognitive self-change, (2) social skills, and (3) problem-solving. The program consists of 25 one to two hour lessons in small groups of 8-12 offenders (Figure 9) and incorporates cognitive skills training, role playing, and anger management. Individuals are also given assignments to complete between sessions (National Institute of Corrections, 2016; Office of Justice Programs, n.d.(a)).

[136]Incarceration-based therapeutic communities have been determined effective for ages 18+, but not effective for juveniles by CrimeSolutions.gov ((Office of Justice Programs, n. d. (e)).

1: Introduction	6: Thinking Controls Our Behavior	11: Understanding the Feelings of Others	16: Introduction to Problem Solving	21: Think of Choices and Consequences
2: Active Listening	7: Pay Attention to Our Thinking	12: Making a Complaint	17: Stop and Think	22: Make a Plan
3: Asking Questions	8: Recognize Risk	13: Apologizing	18: State the Problem	23: Do and Evaluate
4: Giving Feedback	9: Use New Thinking	14: Responding to Anger	19: Set a Goal and Gather Information	24: Problem Solving Practice
5: Knowing Your Feelings	10: Thinking Check-in	15: Negotiating	20: Practice Problem Solving Skills 1, 2 and 3	25: Next Steps

Figure 9: Lessons in Thinking for a Change. Retrieved from http://info.nicic.gov/t4c40/

Promoting family involvement and knowledge of services is another important component of reentry strategies to help offenders establish a continuum of social support in the community (McGarry et al., 2013). A study evaluating the effects of prison visitation on recidivism for 16,420 offenders between 2003 and 2007 found that visitation during incarceration significantly reduced the risk of recidivism and reconviction, regardless of length of stay, and had the greatest impact for visits closest to release dates (Duwe & Clark, 2013). The study suggests the effects of visitation on recidivism operate through the enhancement of social ties by strengthening social support (Duwe & Clark, 2013). Although those in jail generally do not have contact visits, promoting any type of contact with social supports outside the jail is supported in the publication, *Life After lockup- Improving Reentry from Jail to the Community* (Solomon, et al., 2008).

Making facilities "visitor friendly," promoting family visits, and involving families in the development of and participation in the reentry plan aids transition from jail to community and promotes the prosocial support provided by families (Duwe & Clark, 2013; Solomon et al., 2008). Social networks, and specifically family ties and maintenance of good and stable marriages, lead to less offending (National Academy of Sciences, 2008) and aid in employment and accommodation needs after release (McGarry et al., 2013). In addition, since family conflicts immediately following release were shown to increase both drug use and the likelihood of subsequent criminal activity (Mowen & Visher, 2015), reentry plans should incorporate family mediations accordingly. An evaluation of 282 individuals participating in the Community Mediation Maryland (CMM) Reentry Mediation program between 2008 and 2014 found that participation in mediation[137] significantly reduced recidivism on all measures[138] (Flower, 2014).

Finally, close working relationships, effective communication, and information sharing between jail staff and community providers are critical for continuity of care**.** A jail's proximity to the community in which most individuals will return suggests that communities can be involved in the reentry process even before an individual's release date. Common and effective strategies are jail "in-reach" programs, where jails partner with community agencies to provide services and meet with clients in jail before release (Warwick, Dodd, & Neusterer, 2012), much like the Jail In-Reach Project (Held, Brown, Frost, Hickey, & Buck, 2012) cited earlier. *Life after Lockup: Improving Reentry from Jail to the Community* (Solomon et al., 2008) provides several effective examples of in-reach programs:

- *Community health centers:* local health centers can come into the jail to treat chronically ill patients, set up community appointments after release, and establish patient-doctor relationships to promote continuity of health care.
- *Workforce development in jail:* One-Stop Career Centers/American Job Centers inside jail offer a variety of resources to help individuals start searching for jobs while incarcerated. In addition, employment services specialists can work in the jail in

[137]The majority of mediations (85%) were with family (parents, children, siblings) and/or spouse or partner.

[138]The probability of arrest was reduced by 13%: The mediation group had 45% probability of arrest compared to a 58% for a matched-control group (created through propensity score matching). More results available at http://choiceresearchassoc.com/documents/cmm_recidivism_2014.pdf?patientinform-links=yes&legid=spcjp;0887403412466671v1

prerelease classes, job fairs, provide employment related services, and provide community case management after release.

- *Faith community mentoring:* local religious centers can establish mentoring relationships that begin in jail and continue after release.
- *Peer mentors:* ex-offenders, recovering addicts, and program alumni can provide successful examples and offer hope and support to facilitate changes. [139]

These best practices indicate the value in housing reentry populations separately, providing cognitive programming, involving family and other connections, and connecting jail and community program staff to provide continuity. In addition to these general areas of need, there are some well-established criminogenic needs, including education/employment, substance misuse and use disorders, and emotional/personal/attitudes and orientation, that have been investigated more specifically.

Program Clients

Specific Criminogenic Needs

Programs that target high risk offenders and their criminogenic needs tend to be most effective in achieving the overarching goal of reentry – reducing the likelihood that individuals will recidivate and return to jail (Jonson & Cullen, 2015).

1. Education/Employment

   A review of rigorous evaluation studies concluded that vocational and work programs can be effective in both reducing recidivism and improving job readiness skills, particularly with finding and retaining employment after release (Seiter & Kadela, 2003). These programs are also promising approaches for reducing institutional problem behavior by decreasing idle time, and maintaining facility operations by creating jobs for inmates in institutional maintenance tasks (Office of Justice Programs, n. d. (b)). Employment-centered reentry programs provide avenues for individuals to signal that they are different from other offenders with the same risk and improve their job prospects through voluntary enrollment, active participation, and successful completion of these programs (Bushway & Apel, 2012). Jail can play an important role in targeting employment, as research demonstrates that employment programs while in custody are more effective at reducing crime than noncustodial programs (Office of Justice Programs, n.d.(b)).

   Specific evaluations of employment programs have had mixed results, but most evaluations do not include both process and outcome measures[140] to identify whether the program was

[139]Implementation of mentorship programs should be approached thoughtfully as clients may be resistant to having someone 'tell them what to do' (Wiegand, 2016). Program participants generally support staff and mentors to whom they can relate (Lindquist, Willison, Rossman, Walters, & Lattimore, 2015), but the framing of program descriptions should be considered carefully (Wiegand, 2016).

[140]Process measures focus on whether the intervention was implemented as intended. Outcome measures address the impact of the program. Ideally, evaluations would incorporate both process and outcome as the information can be used to identify program areas that need to be addressed, and in explaining less than desired outcomes.

ineffective or if the program was not implemented as intended. For example, ineffective programs may not be delivering the right amount of services over an appropriate length of time. Programs that were short in duration and of low intensity were found to be ineffective in impacting recidivism, employment, or earnings (Wiegand & Sussell, 2016).

However, jail based employment programs may be effective if in the form of (a) inmate work programs, which concentrate on production and experience, and/or (b) vocational programs, which focus more on education and training (Kerle, 2003). A review of jail operations suggests that jail industries can be promising if they are better tailored to the job market (Kerle, 2003) and are therefore able to prepare individuals for employment after release.

Most recently, innovative approaches utilizing specialized American Job Centers (AJC formerly known as CareerOneStop) as an in-reach program have been implemented to provide opportunities for offenders to prepare for employment before release to ease the reentry transition. These centers provide a centralized location where offenders can access employment-related services and training, information, and apply for jobs with the goal of attaining employment or educational placement at release. Although current evidence on employment programs comes primarily from prison studies, Mathematica Policy Research, along with Social Policy Research Associates, is currently evaluating the implementation of 20 jail-based programs under the Linking to Employment Activities Pre-Release (LEAP) initiative funded by the U.S. Department Labor. A primary focus of these programs is strong community partnerships with local workforces as well as services to increase support and services upon release, thereby smoothing the "hand-off" component from jail-based AJCs to community-based AJCs. Preliminary publications from this initiative identify practical issues in implementation of these centers:

- Job center staff should have (a) criminal justice experience, (b) workforce experience, (c) interpersonal skills, and (d) group facilitation skills (Clark, 2016).
- Ongoing communication and support between staff can smooth the differing goals of workforce staff, whose aim is to help clients find and maintain employment, and correctional staff who have more of a custodial focus (Lewis-Charp, 2016).
- Internet use for job search activities and applications must be adapted to comply with security restrictions in jails through limited accessible websites (Betesh, 2016).
- The location and scheduling of workforce development services require coordination to maximize access to services while not conflicting with other programming and security concerns (Henderson-Frakes, 2016).

Partnering with local workforce organizations can also include raising awareness of appropriate risk assessments in hiring practices of offenders. A criminal record can create additional barriers to employment through licensure and certification restrictions in approximately 350 occupations (Clark, 2004). Employers often have inaccurate perceptions about the validity of a criminal record in predicting continued engagement in criminal activity or the work-readiness of individuals (Harris & Keller, 2005; The Hamilton Project, 2016; Siwach, Bushway, & Kurlychek, 2016).

Evaluations of educational programs have generally shown consistently favorable results in reducing crime and increasing job placement outcomes. While most of this evidence is from evaluations of prison programs (Taliaferro, Pham, & Cielinski, 2016), jails are also positioned to provide education services (The Hamilton Project, 2016). While jails may have shorter amounts of time to deliver educational programming than prison facilities, if continuity of education is provided, jails have the opportunity to begin the process and follow that by linking clients to community education providers upon release. Table 32 below summarizes the type of programs that have shown promising outcomes (Office of Justice Programs, n.d.(g)); Taliaferro, Pham, & Cielinski, 2016).

Table 32: Correctional Education Programs*

Adult Education	Adult basic education: core skills in social studies, science, mathematics, reading, and writing for adults below the 9th grade skill level Adult secondary education/General Education Development (GED): mathematics, reading, writing, and other education at or above a 9th grade skill level, including High School Equivalency test preparation English as a second language (ESL) courses
Adult Postsecondary Education (PSE)	College level instruction that may provide college credit through partnerships with postsecondary institutions for individuals to earn credits towards an associates, bachelors, or graduate degree
Career and Technical Education	Education and skills training as a specified program that lead to an industry recognized credential or certification. Can be offered with college credit or as a non-credit course
Special Education	Courses and services for individuals with learning disabilities or other special needs

*adapted from Taliaferro, Pham, & Cielinski, (2016)

A meta-analysis of the literature found that participants of correctional education programs had 43% lower odds of recidivating and 13% higher odds of employment after release (Davis, Bozick, Steele, Saunders, & Miles, 2013). The review of the literature also suggests that computer-assisted instruction may assist in more reading and math learning in the same amount of instructional time (Davis et al., 2013). Furthermore, an intensive multisite impact evaluation of adult males in the 12 SVORI programs found that educational programs were associated with fewer post-release arrests than in matched comparison groups (Visher, Lattimore, Barrack, & Tueller, 2016).[141] The literature on employment and education reentry

[141]When compared to a matched comparison group, those participating in educational programs are expected to decrease post release arrests by 9.6% (p=.02).

programming shows promise for the implementation of inmate work, vocational training, and educational programs in jails to reduce recidivism and increase employment in the community.

2. Substance Abuse

Given that a large component of the jail population suffers from drug or alcohol addiction, especially those that cycle in and out, programs targeting substance abuse are both necessary and important. Sixty-six percent of jail inmates report regular alcohol use and 68.7 percent report regular illicit drug use (James, 2004), and those with mental health problems are more likely to suffer from substance dependence or misuse (James & Glaze, 2006).[142] In addition, drug rehabilitation programs are consistently found to be effective (Seiter & Kadela, 2003; National Research Council, 2008). In-jail substance abuse treatment programs have shown significant reductions in rearrests ranging between 5 and 25 percent, compared to untreated inmates (Peters & Matthews, 2002 as cited in Center for Substance Abuse Treatment, 2005). The National Institute of Drug Abuse (2014) lists a range of principles for managing drug abuse treatment for criminal justice populations. These principles emphasize recognizing drug addiction as a disease that affects the brain and therefore behavior. As such, treatment of addiction should be integrated and target factors associated with criminal behavior, facilitate treatment compliance and prosocial behavior with sanctions and rewards, and incorporate a medication regimen. Additionally, the principles underscore the importance of understanding recovery as a long-term process that first requires an initial assessment and careful monitoring and management over time. In particular, treatment must be long enough to produce stable behavioral changes and fitted to the needs of an individual. A corresponding plan for treatment is needed to ensure not only the longevity of necessary treatment, but also continuity of care as people return to the community. The treatment planning process should also extend to correctional supervision in the community, and encompass supervision requirements to inform treatment providers. Finally, treatment planning should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

Separate incarceration-based therapeutic communities have been shown to be especially effective for alcohol and drug offenders to focus on recovery and lifestyle changes (National Registry of Evidence-based Programs and Practices (NREPP), 2013; Office of Justice Programs, n.d.(d)). Motivational Interviewing (MI), a client-centered psychological treatment approach is also successful at promoting individuals' motivation to change and reducing drug and substance abuse. MI is typically administered before another treatment and is a brief intervention based on the basic principles of "expressing empathy, develop discrepancy, rolling with resistance, and developing self-efficacy," and is given through one to four one-hour sessions (Office of Justice Programs, n.d.(f)). A 2011 Campbell Collaboration meta-analysis found overall support for MI compared to no treatment control groups, but did not find significant differences between MI and other types of substance abuse treatments (Smedslund, Berg, Hammerstrom, Steiro, Leiknes, Dahl, & Karlsen, 2011).

[142] 76% of jail inmates with mental health problems have substance dependence or abuse versus 53% of jail inmates without mental health problems (James & Glaze, 2006).

Table 33 depicts a three level treatment approach by SAMSHA for jail-based substance abuse programming by an individual's length of stay. The intensity and duration of a person's treatment regimen increases the longer the individual remains in the facility. This also allows for an opportunity to increase the breadth of issues that can be addressed. Each treatment tier builds on the services provided in the levels below it, and includes other non-substance abuse specific treatments (Center for Substance Abuse Treatment, 2005). For example, an individual in the facility for 8 weeks would receive all the services under Level 1 (including Motivational Interviewing, information on available resources, community linkage and psychotropic medications) as well as some of Level II services (e.g., 12-step programs, problem solving and/or social skills training) depending on availability of programming slots within the 8 week timeframe.

Table 33: Levels of Intervention and Treatment Components*

Level 1: Brief Treatment Jail Stay: 1-4 Weeks	Level II: Short-Term Treatment Jail Stay: 4-12 Weeks		Level III: Long-Term Treatment Jail Stay:3 Months or More
Motivational Interviewing	Relapse Prevention	Communication Skills	Employment Counseling
Orientation to Treatment/ Treatment Planning, and Substance Abuse Education	12-step Programs	Dealing with Domestic Violence	Therapeutic Community
Information on Available Community Resources	Basic Cognitive Skills	Anger Management	Family Mapping and Social Networks
			Following through on 12 Steps
Facilitating Access to Community Services	Identity and Culture	Problem Solving	Continued Stabilization
Community Linkage and Transition Services	Strengths Building	Social Skills Training	Cultural Factors
Psychotropic Medications: Education and Compliance			Criminal Thinking

*Adapted from the Center for Substance Abuse Treatment, 2005 for more information see http://store.samhsa.gov/shin/content//SMA13-4056/SMA13-4056.pdf

Although no single type of intervention has emerged as most effective, overall, there is overwhelming support for substance abuse treatment in jail for reducing recidivism.

3. Emotional/Personal/Attitudes/Orientation:

One of the most salient and consistent findings in criminal justice research is that attitudes matter for successful reentry (LoBuglio, 2016). Specifically, anti-social attitudes that are supportive of crime are one of the strongest criminogenic needs (Andrews & Bonta, 2010;

National Research Council, 2008). Cognitive behavioral interventions, described earlier in this review, are one of the most common and highly regarded evidence-based practices that directly target changes in emotional and attitude orientation. Another example is Moral Reconation Therapy (MRT), a cognitive behavioral modality that uses a personality-based multistage approach to target moral reasoning. MRT can be administered using prescribed homework assignments and group exercises for one or two weekly meetings over three to six months. While most appropriate for those staying longer than 3 months, it can be considered for in-reach to allow for community continuation of programming post-release. The program comprises 16 steps that focus on the following treatment issues (NREPP, 2008):

a. Confrontation of beliefs, attitudes, and behaviors
b. Assessment of current relationships
c. Reinforcement of positive behavior and habits
d. Positive identity formation
e. Enhancement of self-concept
f. Decrease in hedonism and development of frustration tolerance
g. Development of higher stagers of moral reasoning

Evidence suggests the use of MRT in rural jail settings as a reentry program combined with addressing medical, mental health, and substance abuse corresponds with completion of the program and decreased recidivism and probation violations at a one year follow up compared to matched offenders from the same facility (Miller & Miller, 2010[143]; Miller & Miller, 2015[144]). For adult male serious violent offenders under the age of 35, services focused on individual change such as anger management, changing criminal attitudes, and thinking. Researchers found these were beneficial to delay rearrest in the 12 SVORI programs discussed earlier in this review (Visher, Lattimore, Barrack, & Tueller, 2016). Research also supports interventions targeting criminogenic attitudes and orientation. Cognitive behavioral therapy has considerable support in the reentry literature, and although much of the research has focused on prison populations there is growing evidence for its success in jail populations (Mellow, Christensen, Warwick, & Willison, 2011; Willison, Bieler, & Kim, 2014). Other types of cognitive behavioral modalities show promising results as well (National Registry of Evidence-based Programs and Practices, 2008).

The specific programming areas that have an evidence base include those addressing education and employment, substance abuse, and cognition around emotions and attitude. This, coupled with housing, family involvement, and community linkages can lead to successful facility-based programming.

[143]Miller & Miller's (2010) original quasi-experimental study of the Auglaize County Transition Program (n=145) found that program participants had lower rearrests (12.3%) compared to the matched offender group from the same facility (82% recidivism). The favorable results were not contingent upon successful completion of the program.

[144]Miller & Miller's (2015) study found that the second cohort (2011-2013) of the Auglaize County Transition Program participants (n=62) had lower recidivism (29%) after one year versus 15 matched offenders from the same facility (73.3% recidivism). Program completion had a significant effect on recidivism, but participation did not.

Example of Risk-Needs Program

Larger scale evaluations and studies of the successes and challenges of reentry programs can provide useful recommendations and demonstrate how the services and practices can be incorporated into existing practices. Two such efforts – the Allegheny County Jail Collaborative Reentry Project and the Second Chance Act Adult Offender Reentry Demonstration Programs – are detailed below.

Allegheny County Jail Collaborative Reentry Program

The Urban Institute conducted a 12-month process and outcome evaluation in 2012 of two Allegheny County Jail reentry programs (N=798) (Willison, Bieler, & Kim, 2014). Allegheny County is the second most populous county in Pennsylvania, but has lower jail incarceration rates (per 100,000 county residents) than Washington DC (288.9 and 433.3, respectively[145]). This evaluation is particularly notable due to its analytic rigor[146], multiple data sources[147], and inclusion of both a fidelity assessment and impact analysis. These two Allegheny County Jail Collaborative Reentry Programs were designed to embody risk-needs principles and a strong partnership with the community. The positive outcomes can be attributed to the success of the need-based service delivery in jail, appropriate case management, and emphasis on prerelease contact between clients and key supports. Program participants in the Reentry 1, the voluntary program (n=215), had a probability of arrest of 10% compared to 34% for the comparison group (n=189), a statistically significant difference. Similarly, participants in Reentry 2, which required mandatory participation as a condition of supervision (n=249), were also less likely to be arrested than the comparison group (n=145), but the results were slightly above significant levels (p=.056)[148]. Key components of the program were the establishment of a reentry team and a focus on evidence based practices.

1. Establishment of a Reentry Team

   The reentry team comprised of: (1) reentry probation officers, (2) reentry specialists for case management, (3) jail reentry administrators overseeing prerelease reentry services, (4) jail reentry coordinators, (5) family support specialists, (6) and community service coordinators. The targeted population is identified through a universal proxy screening and a risk/needs assessment, the LSI-R.[149] Individual Offender Supervision Plans (OSPs) were then developed by the case management team based on the results of the LSI-R and client input. Participants

[145]Jail Incarceration Trends from Vera Institute of Justice http://trends.vera.org/incarceration-rates?geography=states

[146]A matched weighted comparison sample was drawn from administrative records using propensity score matching. A quasi-experimental design evaluated the impact of these programs on recidivism.

[147]The evaluation included data from stakeholder interviews, client and family member focus groups, casefile review, and three databases (Adult Probation Case Management System, Common Pleas Case Management System, and Reentry1 databases) for official records, services received, and dates in the program and jail.

[148]Differences that are statistically significant include a "p-level" indicator (e.g., at p<.001). This notation means that the findings are highly unlikely (e.g., for p<.001 - less than a 1 out of 100 chance or p<.05 less than 5 out of 100 chances) to be the result of chance or coincidence.

[149]In this evaluation, 92% of Reentry 1 and 95% of Reentry 2 scored as medium-high risk for recidivism indicating that the programs targeted the intended clients. 97% of Reentry 1 and 86% of Reentry 2 participants had recorded risk/needs assessments.

in the reentry programs were housed in the jail's reentry pod, a housing unit located on the same floor as the jail's Reentry Center, for easier administration of services.

2. Cognitive Behavioral Therapy and Other Needs-Based Services

A cognitive behavioral intervention, "Thinking for a Change" (T4C), was a core component of the programming[150] and individuals met regularly with their case managers to track their progress and develop a transition plan. Other services were provided according to an individual's needs and included: education classes and peer tutoring, apprenticeship and job readiness programs, gender specific as well as family-based substance abuse programs, and classes and coaching support promoting healthy family functioning. Sixty days prior to release, clients connected with the community service coordinators in addition to the reentry probation officers to track progress and facilitate the transition between jail and community. Following release (up to 9-12 months), the community service coordinator and probation officer teams worked with the client and their families to coordinate services, assist with basic needs, and provide family support while maintaining supervision.

3. Key Recommendations

The evaluation of the Allegheny County Jail Collaborative Reentry Program produced recommended strategies to improve reentry programming (Willison, Bieler, & Kim, 2014). The evaluation stressed the need for maintaining a close working relationship and teamwork approach between probation officers and jail case management staff and to continue probation prerelease contact**.** Other recommendations focused on program participants and their families and emphasized the need to educate family members on the services and programs that are available, apprenticeship opportunities, housing options, and transportation assistance. In terms of program implementation, the evaluation stressed the development of a quality assurance plan, tracking service utilization and dosage, and performance metrics.[151] Finally, standardized reentry training for correctional staff is crucial (Willison, Bieler, & Kim, 2014).[152]

Second Chance Act Adult Offender Reentry Demonstration Programs

Since 2009, the U.S. Department of Justice Bureau of Justice Assistance (BJA) has awarded funds to programs serving justice-involved adults returning from state and Federal prisons and local jails. In 2011, BJA funded 22 adult offender reentry demonstration projects. After initial evaluability assessment visits in 2013, RTI International and the Urban Institute conducted the

[150]68% of Reentry 1 participants received T4C intervention.

[151]Performance metrics track both long-term outcomes (i.e. recidivism, employment, etc.) and intermediate outcomes (i.e. disciplinary incidents in reentry pod).

[152]The evaluation found that staff consistently identified a need for more formal training around operations and procedures.

first round of process evaluations of seven of 22[153] Second Chance Act Adult Offender Reentry Demonstration Programs in 2014. In addition, 218 criminal justice and human services stakeholders (such as jail administrators and staff, probation chiefs and officers, executive directors, case managers, counselors) completed a survey across the seven sites (Lindquist, Willison, Rossman, Walters, & Lattimore, 2015). Table 34 below summarizes the program models and target population of each site in the evaluation.

[153]Seven of the 22 sites were used for this evaluation. The jail reentry programs included California's Women's Reentry Achievement Program (WRAP), Massachusetts's Boston Reentry Initiative (BRI), New Jersey's Community Reintegration Program (CRP), and Pennsylvania's ChancesR. The other programs in this evaluation were Connecticut's New Haven Reentry Initiative (NHRI), Florida's Regional and State Transitional Ex-Offender Reentry Initiative (RESTORE), and Minnesota's High Risk Recidivism Reduction Project.

Table 34: SCA Program Location, Target Population, and Program Models*

Program Location	Target Population	Basic Program Components
California: Solano County	Medium-high risk Female offenders **Jail**	Intensive pre- and post-release case management, **gender-specific cognitive-based therapies, peer mentoring**, transitional housing, employment assistance, parenting, and assistance with basic needs
Connecticut: Department of Corrections	Medium-high risk Male and female offenders 4 DOC facilities	A "reentry workbook" program; referrals to the facilities' job centers; pre-release reentry planning with community case managers; a **furlough component** for male offenders; **dual supervision** with parole officer/case manager and community advocate; and 120 days post-release services
Florida: Palm Beach County	Moderate-high risk Male and female offenders 1 DOC facility	**Pre-release services at the reentry center provided by counselors, followed by post-release continued support and services provided by community case managers**. Services include education; employment assistance; transitional housing; parenting, life skills, cognitive behavioral change, victim impact; substance abuse and mental health; family reunification; and assistance with basic needs
Massachusetts: Boston	Histories of violent or firearm offenses and gang associations returning to one of Boston's high-crime hotspot areas Male offenders **Jail**	**Panel meeting** to introduce the program to and invite eligible offenders; **case management support and advocacy** (throughout incarceration, transition to the community, and after release); a two-week **job skills** course (before release); assistance with employment, education, basic needs, and health care; and referrals to community services
Minnesota: Department of Corrections	Release violators with at least 150 days of supervised release in the community Male offenders	Individualized transition planning and pre-release case management from a **reentry coordinat**or, handoff from pre- to post-release case management through a **reentry team meeting**; post-release case management and services **offered at a community hub**
New Jersey: Hudson County	Diagnosed mental health, substance use, or co-occurring disorders Male and female offenders **Jail**	90-day in-jail substance abuse treatment in a gender-specific **therapeutic community** with focus on **cognitive behavioral programming**; pre-release case management and transition planning; post-release case management, linkage to public benefits, and services delivered by **intensive outpatient/day treatment and supported housing providers**
Pennsylvania: Beaver County	Medium-high needs for mental health or co-occurring services Male and female offenders **Jail**	Cognitive-based treatment groups, **highly structured vocational/educational services, transition planning, and case management and reentry sponsorship (mentoring) that begins in jail** and continues in the community

*From Lindquist, Willison, Rossman, Walters, & Lattimore, 2015. Emphasis on practices included in original publication

The lessons for effective practices and recommendations to target implementation challenges from the evaluation visits and survey responses are summarized below[154] (Lindquist, Willison, Rossman, Walters, & Lattimore, 2015):

1. Wraparound Services from Before to After Release

   Key lessons identified after implementation to improve programming focused on increased efforts for pre-release engagement with community-based service providers, followed by immediate post-release support, and intensive case management. Pre-release contact was especially important to let participants know before returning to the community what benefits they were entitled to receive, and starting the application process shortened the waiting time in the community for services such as temporary assistance for needy families, food stamps, Medicaid, and emergency assistance.

2. Organization and Staffing

   To enhance collaboration between corrections and community partners, centralizing and overseeing the referral process helps balance referrals among various organizations to best utilize existing resources in the community and identify service gaps. Additionally, to facilitate recordkeeping and manage staff turnover, recordkeeping and formalizing program policies and procedures, such as the creation of flowcharts conveying staff responsibilities and reporting structure, are necessary to combat disruptions caused by high staff turnover. Finally, identifying and elevating role models such as staff and volunteers who have criminal histories or have family members with criminal histories provide both empathetic support and serve as examples of successful life changes. Peer mentors and graduates who return as speakers can help individuals remain engaged in programming and be positive models to emulate. For example, in Connecticut former offenders take on the role of community reentry advocates and meet with inmates before release during program orientation and in the community. In California, graduates of the program return to the graduation ceremonies as speakers, and in Florida a few former clients return to the facility one year after their release to talk about their experience with the program (Lindquist, Willison, Rossman, Walters, & Lattimore, 2015).

These lessons for effective practices in reentry offer examples of best practices for implementing effective jail-based reentry programs. This provides a bridge between the large body of knowledge available on prison-based programming and the dearth of studies regarding jail-based reentry. The lessons also highlight the possibility of applying the same concepts to different facility types, as many of the recommendations and lessons learned emphasize common practices relevant to each facility type. These include, but are not limited to: treatment and reentry planning, reentry-specific case management, and the provision of a multitude of services, e.g., therapeutic communities, cognitive behavioral therapy, employment and housing assistance, and education.

[154]Ongoing evaluations are planned to include a retrospective outcome study, a prospective outcome study, and a cost study. The findings in this report are from the process evaluation visits in 2014 and the web-based survey (response rate 71%). Additional reports that provide a more comprehensive examination of the sites' programs are not yet available.

The Transition to the Community through Halfway Houses

Continuity of care has been identified as an important component of reentry practices. Many individuals enter halfway houses (also known as community correction centers and residential reentry centers) upon release. Halfway houses ideally ease the transition between incarceration and community living by meeting individuals' housing needs and providing access to community-based resources such as employment and therapy. Due to the variability in halfway house style, services, and facilities, research has been inconclusive regarding their potential for both positive and negative outcomes. Evaluations have suggested that halfway houses can be effective in easing the transition from prison to community by reducing the frequency and severity of future crimes (Seiter & Kadela, 2003). However, evaluation findings have also ranged from showing no difference in rearrest or reconviction, (Hamilton & Campbell, 2014)[155] to higher recidivism rates than those paroled to the street (Bell et al, 2013).[156] The differences in effectiveness of halfway houses may be attributed to inappropriate administration of services and target clientele as specified by the risk-need principle (Lowenkamp, Latessa, & Holsinger, 2006). Investigations of halfway house parolees and halfway house probationers matched to comparable offenders demonstrate the differential effects of halfway houses by risk level. Consistent with the risk principle of the risk-needs-responsivity model, higher risk offenders showed more benefits from halfway houses, and as long as offenders were moderate to high risk a decrease in recidivism was observed in a sample of 6,090 including matched parolee and matched probationer pairs (Latessa, Brusman Lovins, & Smith, 2010). However, halfway houses serving low-risk offenders generally increase rearrests and reincarceration (Lowenkamp & Latessa, 2002; Latessa, Brusman Lovins, & Smith, 2010).

In addition, halfway house program integrity, specifically program implementation and pre-service client assessments, is directly related to their effectiveness, with significant differences in recidivism measures found to be related to program assessment scores (Lowenkamp, Latessa, & Smith, 2006). A recent evaluation of offenders released from prison from 2006-2008 to one of 12 work-release halfway houses compared to a matched group of offenders released directly from prison found that when assignment to halfway house is based on a risk assessment, staff providing referrals for a variety of services, and social learning and cognitive behavioral programs are provided by the halfway house, the propensity for revocation and return to prison declines by almost 30% (Routh & Hamilton, 2015).

Halfway houses show promising results if they follow the same basic principles laid out in this review. Although their potential is great for supporting the continuation of programs and wraparound care, a lack of adherence to the risk, needs, and responsivity model can have criminogenic effects, reducing individuals' chances of success in the community after release.

[155]Hamilton & Campbell (2014) evaluated offenders released to 18 halfway houses in New Jersey compared to one-to-one matched sample (n=6,599) and found no significant differences in rearrest or reconviction.

[156]The Pennsylvania Department of Corrections Recidivism Report investigated differences in rearrest for those paroled to the street and those paroled to 38 privately run and 14 state run halfway houses. After controlling for important differences, only about a quarter of the halfway houses had lower recidivism rates than those paroled to the street and the majority had higher recidivism rates. On average, across the three release years, the recidivism rates of those who were released to halfway houses were about 5 percent higher than those released to the streets (Bell et al., 2013).

Federal Programs

This document concludes with a brief discussion of federal reentry, because in the District of Columbia (DC) most felons are incarcerated within the Federal Bureau of Prisons. The federal prison population makes up about one eighth of the total prison and jail population in the United States (slightly less than 200,000 inmates) (Hunt & Dumville, 2016). Federal prisoners differ from state prisoners as more than half are serving time for a drug offense and 6 percent for a violent offense, compared to state prisoners where more than half are serving time for a violent offense and only 16 percent for a drug offense (Carson, 2015). While the median length of imprisonment is 37 months for federal offenders, about one-eighth receives sentences over 10 years. In addition, almost all federal offenders have supervised release imposed after incarceration,[157] with over 40% given three years of supervised release, and about 20% more having five to nine years of supervised release. Federal offenders also tend to have lower recidivism rates compared to cohorts of state prisoners, with 16.6% rearrested in the first year, and 49.3% rearrested within eight years (Hunt & Dumville, 2016). Although federal offenders overall tend to appear as less serious offenders than state prisoners, given that most felons in DC are incarcerated in the federal system, the DC federal prison population may be more similar to other state prisoners. DC prisoners released from federal prison are in a unique situation and there is a lack of comparable research exploring evidence based practices for this specific population. While below we review several federal programs shown to reduce recidivism, a need remains for evaluating reentry services for DC prisoners returning from federal custody.

A recent review of the Federal Bureau of Prisons' implementation of the Release Preparation Program (RPP) suggests that improvements are necessary in current reentry efforts. While the RPP is mandatory for all institutions and all inmates, there were differences in how BOP institutions implemented the program. The RPP consist of classes, instruction, and assistance in (1) health and nutrition, (2) employment, (3) personal finance and consumer skills, (4) information and community resources, (5) release requirements and procedures, and (6) personal growth and development. The main weaknesses identified by the Office of the Inspector General (OIG) (2016) include:

- Low levels of Release Preparation Program completion; less than a third of inmates who should be participating in RPP actually complete the program. Few incentives exist for inmates to participate in programming and inmates do not face repercussions if they fail to complete the programming or choose not to participate.

- Institutions are unable to ensure that their RPP meets inmate needs – a nationwide RPP curriculum or centralized framework does not currently exist and there is no systematic method to identify inmate needs.

- Lack of effective coordination with agencies relating to release needs; currently institutions contact agencies on a local level which causes a delay in inmate access to reentry services. The Bureau of Prison is not utilizing its relationship with other federal

[157] In a cohort of 25,431 federal offenders who reentered the community in 2005, only 121 had no period of supervised release (Hunt & Dumville, 2016).

agencies such as the U.S. Department of Health and Human Services and Veterans Affairs for formal coordination of services.

- A recidivism analysis, as required by the Second Chance Act of 2007, has not been completed yet.

While the conclusions of the OIG are concerning, there are several programs offered in the federal prison system that are effective at reducing recidivism. For example, the Federal Prison Industries/UNICOR program provides inmates with work experience that was found to be effective for both reducing recidivism and increasing the likelihood of obtaining employment for male inmates. This was a quasi-experimental evaluation of 4,868 prisoners in UNICOR who were matched to a comparison group, which found that participation in UNICOR reduced the chances of recidivism for males by 24% over an eight to 12 year follow up period. Furthermore, the treatment group had a 7% higher employment rate than the control group at the end of a one year period follow up (Saylor & Gaes, as cited in What Works in Reentry Clearinghouse, 2016). UNICOR has undergone several improvements recently including updating certification programs to make participants more marketable. However, evaluations of UNICOR suggest the need for gender-specific programming, as no differences in recidivism have been found for female participants (Richmond, 2014). Another effective program is the federal Residential Drug Abuse Program (RDAP), a voluntary in-prison program based on the therapeutic community model. Evaluations reveal that RDAP may reduce recidivism rates by 25 percent (Pellisier et al., as cited in What Works in Reentry Clearinghouse, 2016; The Hamilton Project, 2016). Like UNICOR, this program has been more effective for males than females, again suggesting the need for gender-specific programming (Pellisier et al., as cited in What Works in Reentry Clearinghouse, 2016). One concern is that both programs are unable to reach inmates who may benefit due to long waiting lists. Demand for these programs is much higher than available space in the programs due to funding limitations (The Hamilton Project, 2016).

Conclusion

Almost every individual who enters jail will return the community, and the majority will do so rather quickly. This review of literature demonstrates that providing the right services to the right individuals can ease the transition of returning citizens. Reentry services reduce the chances of coming back to jail by targeting criminogenic needs and lessening the negative impact that incarceration may produce. While this review found studies specifically relating to jail reentry evaluation to be limited, this does not impede the creation of successful reentry programs based on evidence-based principles and strategies. Ideal programming would utilize the principles and strategies summarized above in a unique and tailored design specific the risks, needs, and overarching goals of the specific jail population. The individualized aspect of reentry services, including incorporation and maximization of existing community resources, was a consistent theme in the literature. While this type of strategy calls for a more creative and integrative

approach than standard "cookbook" replications of a successful program, the potential for programming designed in this manner is much greater.[158]

While jails typically are unable to provide the entire duration of services inside their facilities that would be appropriate to impact participants, jails have an advantage in their physical proximity to the communities to which individuals will return. Strong partnerships and communication with community providers play a critical role in effective reentry strategies to promote wrap-around services and ensure continuity of care. An efficient and immediate assessment of the risks and needs of individuals who enter jail is necessary to create the individualized reentry plan that begins inside the facility and extends after release. This review also provided recommendations for the types of services, practices, and strategies that have been found most effective and relevant in criminal justice-involved populations. Specifically, support was found for services targeting education and employment, substance abuse, cognitive behavioral programming, and promoting family involvement. Furthermore, addressing population-specific needs through gender-specific programming, specialized services, and attention to both mental and physical illness is also beneficial. Centralizing reentry services in a 'reentry center' and separate reentry housing maximizes the impact of these services. Based on a review of process and implementation evaluations, this review has recognized the important role of quality assurance and fidelity in the overall effectiveness of reentry strategies.

[158]Replications of existing effective programming can result in poor outcomes due to implementations that copy programming tailored to a specific location and population without careful consideration of implementation fidelity.

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