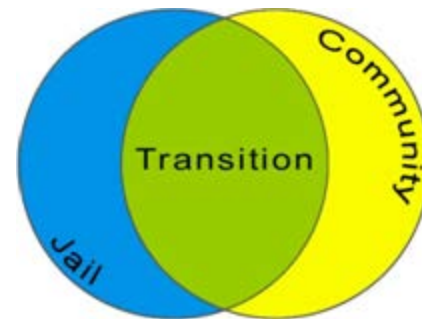


CASE MANAGEMENT STRATEGIES FOR SUCCESSFUL JAIL REENTRY



From the perspective of a transition initiative, perhaps the most important factor distinguishing jail reentry from prisoner reentry is length of stay. While prisoners may be incarcerated for months or years, allowing programming staff ample time to prepare them for the transition, individuals housed in jails typically stay for just days or weeks, making the community handoff process even more crucial. Reducing recidivism and improving reentry outcomes require that jails, community-based organizations, and supervision agencies work together to meet the needs of the returning population, both while incarcerated and upon release. To do so, it is imperative that jurisdictions use an effective case management process that includes a strong community handoff component, particularly at the moment of release, and that ensures continuity of care between in-jail and community-based programs and services.

This brief presents the Transition from Jail to Community (TJC) initiative's approach to case planning and community handoff. In the following sections, we discuss the role of case planning in the TJC model, case plan content and structure, the referral process, the importance of continuity of care between the jail and community, interagency information-sharing, and the role community supervision agencies can play in case management and handoff. Throughout the brief, we draw upon the implementation experiences of six TJC learning sites, all of which implemented elements of the TJC case management process to varying degrees and were continuing to work toward a more seamless and integrated process at the close of the TJC technical assistance period.

Due to the complexity and difficulties inherent in creating a unified system of case management and community handoff for jail clients, jurisdictions should be aware that the implementation of the TJC case management approach is a time-consuming and intensive process requiring the involvement of multiple agencies. This brief intends to provide concrete examples and strategies from the TJC sites so other jurisdictions can learn from the TJC case management approach—recognizing, however, that each jurisdiction is unique and will be confronted with different challenges and opportunities, depending partly on the availability of local resources. Additional information about implementation of case management, as well as tools and examples from the TJC initiative, are available in module 7 of the TJC Online Learning Toolkit, at <http://www.urban.org/projects/tjc/Toolkit/module7/index.html>.

The Transition from Jail to Community (TJC) Initiative

The National Institute of Corrections (NIC) partnered with the Urban Institute (UI) in 2007 to launch TJC in order to address the unique challenges of jail reentry and thereby improve public safety and enhance the success of individuals returning to the community from local jails. The TJC team worked to achieve these objectives by developing, implementing, and evaluating a comprehensive jail-to-community transition model (see box 1 on page 2). The TJC model represents a systems approach to jail-to-community transition, in which jails and communities jointly “own” local reentry. Jail stays are too short and

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The National Institute of Corrections (NIC) partnered with the Urban Institute (UI) in 2007 to launch the Transition from Jail to Community (TJC) initiative with the goal of improving public safety and reintegration outcomes.

TJC involves the development, implementation, and evaluation of a model for jail to community transition. The TJC model is not a discrete program; it is a new way of doing business that entails systems change and the development of collaborative relationships between jail and community partners. The TJC approach is being implemented in six jurisdictions and technical assistance products will be created for communities across the country.

More information is available at www.jailtransition.com.

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the issues present in jail populations are too difficult for either the jail or the community to achieve success alone.

The TJC model is intended to be adaptable so it can be applied in a wide variety of jurisdictions with diverse jail populations. Implementation of the TJC model began in Douglas County, Kansas, and Denver, Colorado, in fall 2008. Four additional TJC sites were selected through a competitive application process in August 2009: Davidson County, Tennessee; Kent County, Michigan; La Crosse County, Wisconsin; and Orange County, California. Each site received tailored technical assistance to implement the model through January 2012.

For more information on the TJC initiative, see <http://www.jailtransition.com>.

A Triage Approach to Interventions

Central to the TJC model is the notion of triaging the jail population and providing the appropriate interventions to those segments of the population most likely to benefit from them. Because jurisdictions are rarely, if ever, able to provide comprehensive services to all individuals exiting jail, it is crucial to determine which individuals have the highest risk of recidivating in order to allow jurisdictions to direct limited resources toward those most in need of services. The TJC model involves an initial screening of the entire jail population to determine each individual's risk to reoffend. Core interventions—including in-depth assessment, case management, and programming—are then provided to those individuals identified as the highest risk.¹ This approach is consistent with previous research indicating that high-risk clients reap the greatest benefits from interventions and services, while low-risk clients may actually experience worse outcomes as a result of these services (Lowenkamp and Latessa 2002).

The TJC model also encourages jurisdictions to develop a triage matrix, which categorizes clients based on risk to reoffend, offense type, length of stay, and disposition status (sentenced or pretrial), and indicates the appropriate treatment strategy for each type of client. Length of stay is particularly important as it determines which interventions can occur within the jail and which will need to occur in the community. A sample triage matrix is available in the TJC Online Learning Toolkit (module 1).

¹ For more information on this process, please see the TJC companion brief on screening and assessment (Christensen, Jannetta, and Willison 2012), available at <http://www.jailtransition.com>.

Box 1. The TJC Model

The TJC model incorporates findings from the considerable body of prisoner reentry research and the growing literature on evidence-based practices. The model consists of five elements:

- *Leadership, Vision, and Organizational Culture*—Leaders from both the jail and the community must be actively engaged, articulate a clear vision, set expectations, identify important issues, and involve other key constituencies.
- *Collaborative Structure and Joint Ownership*—Effective transition strategies rely on collaboration and information-sharing among jail and community-based partners and joint ownership of the problem and the solution.
- *Data-Driven Understanding of Local Reentry*—Regular analysis of objective data, including analysis of the jail population characteristics, informs and drives decisionmaking and policy formation.
- *Targeted Intervention Strategies*—The strategy to improve transition at the individual level involves introducing specific interventions at critical points along the jail-to-community continuum.
- *Self-Evaluation and Sustainability*—Self-evaluation involves the use of objective data to guide operations, monitor progress, and inform decisionmaking. Sustainability involves planning to maintain initiative progress despite changes in leadership, policy, funding, and staffing.

In the TJC model, this screening process is followed by an in-depth assessment of criminogenic needs for those individuals screened as medium or high risk to reoffend. Criminogenic needs are those that are likely to affect future criminal behavior (and that, consequently, can reduce recidivism when addressed appropriately).² Such assessment then informs the development of targeted treatment strategies (who gets what) and case plans, both within the jail and after release in the community. Screening and assessment results, as well as case plans, can be shared with community-based service providers to minimize duplication of effort, promote a consistent

² Criminogenic needs include antisocial personality pattern, pro-criminal attitudes, social supports for crime, substance abuse, family/marital relationships, school/work, and prosocial recreational activities (Bonta and Andrews 2007). While individuals may have other needs, these seven areas of need have been shown, through research, to be related to future criminal offending.

approach to working with clients, and ensure continuity of care after release. In the TJC approach, individuals who are screened as low risk are provided with less intensive interventions, such as a guide to resources available in the community.

While all six TJC learning sites used screening and assessment to determine which clients should receive which services, the size and composition of the population targeted for intensive services varied. Some sites were able to provide assessment, case management, and programming to a relatively large proportion of their high- and medium-risk clients, while other sites, due to resource constraints or logistical considerations, opted to provide these services to smaller subsets of their high-risk populations (such as those sentenced to a certain length of time in jail or those classified at a certain security level). Each strategy is consistent with the TJC model, which stipulates that available resources are directed toward those individuals most likely to benefit from them (i.e., those most likely to recidivate).

The TJC Case Management Approach

Case management plays a crucial role in the TJC model. Employed effectively, it can bridge the services received inside the jail facility and those received after release in the community, connecting clients to appropriate services and improving interagency information-sharing and continuity of care.

To properly provide these case management services, each community should have a case manager or a team of case managers working with clients in the jail and in the community. Case management services may be provided by jail staff, staff from other criminal justice agencies (such as probation), or staff from community-based organizations. For example, in Kent County, case management was provided by a local nonprofit agency in the jail's co-occurring intensive treatment unit, while in Davidson County, these services were provided by jail staff. Ideal as it may be to have staff dedicated to these activities, many jurisdictions do not have this capacity. In this case, it is advisable that institutions develop the case management resource, but much can be done with existing staff in the meantime. For the purposes of this brief, we refer to "case managers" as those staff members responsible for providing these vital services; however, with the proper support and training, any number of staff can fulfill this crucial role. Staff acting as case managers should be trained to administer assessments, develop

comprehensive case plans, make referrals to appropriate programs or services, and establish rapport with clients.

TJC Case Management Principles

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 coordinate with staff from community-based organizations to ensure that clients are referred to appropriate programs and services.
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Development of the Case Plan

In the TJC model, case plans are created during the incarceration period and follow clients into the community after release. Three components that should be present in any case plan include: (1) interventions to be carried out while the client is in jail that prepare the individual for release, (2) interventions that address the client's immediate post-release needs at the moment of discharge from jail, and (3) interventions that address the longer-term transitional period in the community. Specifying interventions aimed at each of these three stages in the transition process will help ensure continuity of care as the individual transitions back to the community. These case plans should be revised when needed during this process in response to changes in the client's circumstances.

Case plans should be clear and concise and should specify the client's risk level and identified criminogenic needs. As noted by Burke (2008), case plans should include realistic goals directly related to the client's needs, a timeline for achieving these goals, and the client's responsibilities in meeting these goals. Case plans should also indicate when these goals have been achieved, as well as which agency or organization is responsible for providing each service listed in the case plan. These services may include referrals to substance abuse or mental health treatment, employment or educational services, cognitive-behavioral classes aimed at

addressing criminal thinking, or other jail- and community-based programs as appropriate. For example, through its TJC efforts, Kent County implemented a process in which jail transition services began in the jail's intensive treatment unit and followed the individual into the community through referrals to local treatment providers.

"We're working on case management plans that include everyone in the community that might help the person transitioning, so that one person only does not have access to the case plan."

--TJC Stakeholder

Case plans should also include any relevant information pertaining to community supervision. If the client has been sentenced to a period of probation (or, in some local jurisdictions, to a period of parole), information about the assigned officer, when the client must report, and any other key information about terms and conditions of supervision should be included in the plan. Importantly, the development and handoff of the case plan should be coordinated with any community supervising officer before the client's release from jail (more information on this topic is provided below in the section on the role of probation/community corrections).

The TJC model also asserts that clients themselves should be active participants in the case planning process, working with their case managers to set short-term and long-term goals. Ideally, case managers should develop a supportive relationship with the client and endeavor to offer a welcoming atmosphere. These efforts should take into account the client's individual characteristics, including cultural and gender-specific factors (one site in particular, Denver, focused on enhancing cultural competency within its case management approach). The case manager should also review progress on case plan goals with the client regularly. In the TJC model, the client receives a printed copy of the case plan to take with him or her during the transition process. Wherever possible, case managers should also work with jail administrators to offer incentives and rewards, such as access to additional services or visitation privileges, to assist clients in accomplishing their goals. Finally, case managers should use techniques to enhance clients' internal motivation to change. One such technique is motivational interviewing, an empathic, nonconfrontational, and client-centered approach in which the goal is to help the client explore and resolve ambivalence (Miller and Rose 2009). Motivational interviewing can be used by case management and

program staff to develop and implement the case plan both before and after release.

Referral Process

Given the short length of time that most people remain in jail, it is essential that they are referred to programs and services in the community that can appropriately address their criminogenic needs. According to the TJC model, these programs should be evidence based (i.e., programs that have been found empirically to reduce recidivism or to demonstrate great promise in doing so) and should match the client's risk and needs in intensity and duration. For example, a high-risk individual for whom substance abuse is a criminogenic need should be referred to an intensive, evidence-based treatment program upon release. Less intensive services, such as support groups or 12-step programs, should serve as primary referrals only for lower-risk individuals and could supplement intensive programming for high-risk individuals.

Inventorying Available Programs and Services

To refer clients to the community-based services that best address their criminogenic needs, case managers must first be aware of what resources are available in the community, what types of individuals are most appropriate for each program (in terms of risk level and needs), whether each program adheres to evidence-based practices, and what eligibility restrictions may exist. Identifying existing evidence-based services is critical to reentry. In addition, this information can help justify funding requests and efforts to develop additional services by documenting programming gaps. Through their involvement with TJC, the learning sites worked to inventory both jail- and community-based programs. For example, Davidson and La Crosse counties used tools developed through the TJC initiative to gather information about existing programs and sort them according to the criminogenic needs addressed by each program. Denver conducted a survey of its community-based providers to gather information on specific services offered and program curricula used.

Equally important, clients should be referred to only those programs that are accessible and willing to serve the jail reentry population. Community-based providers listed on the case plan must also be willing to collaborate with jail programs staff and jail-based case managers. Ideally, these providers should focus on the reentry population, with programs that are designed to address specific criminogenic needs and that have been demonstrated effective for a jail-involved population.

Program staff should be familiar and comfortable working with this population.

Creating a Seamless Referral Process

In addition to developing a base of information on existing programs and services in the community, the TJC approach recommends that jurisdictions institute a systematic process for transitioning clients from the jail to these programs. This process requires developing close working relationships between jail staff (including program providers and case managers) and key community-based organizations. In Denver, for example, a transition process was developed between a core in-jail program, Life Skills, and a community provider as part of the county's overall TJC implementation strategy. Through this process, individuals participating in Life Skills received an assessment and a case plan and participated in programming within the jail. Upon release, all Life Skills clients were referred to the Community Reentry Project (CRP), a one-stop, community-based reentry center that provided programs and services to these clients and referred them to other providers as needed.

"We're working on using the assessment in our reentry success plans and using our relationships with our community partners. We'd never had a relationship with them like we have now. It's great to have a situation come up and be able to just call someone for assistance."

--TJC Stakeholder

Similarly, in Orange County, the jail offered a pre-release reentry class known as the Great Escape program. Once participants in the Great Escape program were discharged from the jail, they became eligible to use the services of the Great Escape Resource Center. The Resource Center also enabled staff to access the custodial program participation and release information for their clients. At the Resource Center, case managers worked with clients to offer employment assistance, deliver additional resources (including clothing and transportation), and provide referrals. This center was also positioned very close to the local probation department office.

In the TJC model, the referral process includes the transfer of transition plans and assessments to referral agencies. Sharing these materials with community-based providers is a crucial step toward facilitating continuity of care in the transition process and ensuring that the goals set for the client in the jail are carried out in the

community. It also reduces duplication of effort, relieving community-based organizations of the need to develop a new assessment and case plan and preventing the client from being asked to repeat the same information over and over again. Ideally, these documents should be electronic to maximize the ease with which they can be shared and used. Denver, through its TJC efforts, developed a case plan intended to be used by multiple agencies; however, because this case plan was not automated, it had to be shared in hard copy form, limiting its utility. As of the conclusion of the TJC technical assistance period, Denver was working to transfer the case plan it developed into an automated case management system, which would allow case plans to quickly and easily be shared with community partners.

When making referrals, case managers should schedule appointments for specific times, if possible, and should ensure that the program has the time and resources to take on a new client. The referral should include the date, time, and address for the appointment. It is critical that these appointments occur as close to the client's release date as possible, as this is the time at which the client is at greatest risk of recidivating (National Research Council 2007). Whether or not the service is free should also be considered, as those returning from jail frequently have very limited financial resources.³ Strategizing with service providers about the use of appointments may ensure a more successful transition, as some clients may have difficulties making their appointments due to lack of transportation or other logistical challenges, and may therefore benefit from drop-in hours.

To be useful to the client and to understand the impact of the services referred and/or provided, it is also important to track whether the client made it to the appointment and to determine what, if any, follow-up activities were arranged. This will require a great deal of information-sharing among all parties; it may also require community-based agencies to begin collecting information about which clients were referred to them from the jail and what services each client receives, if they do not already do so. For example, Denver was able to determine how many of the clients that were referred to the community-based CRP from the jail's Life Skills Program actually visited the CRP. This process is more complex when the jail makes referrals to several different community-based agencies. In Davidson County, for

³ Given these financial difficulties, many clients may need assistance in applying for public benefits, such as Medicaid, Supplemental Security Income (SSI), or food stamps, prior to release.

example, a wide range of service providers are available to serve clients in the community. Through TJC, the jail began to ask these providers to share data about the clients they were serving.

Establishing Continuity of Care

The term “continuity of care” originated from the medical field, referring to a plan for treatment in the community after discharge from a medical institution. The medical continuity-of-care process most typically involves two activities: (1) securing an appointment for follow-up in the community, post-institutional discharge (or, occasionally, placement into an inpatient treatment program); and (2) for those clients who have been prescribed medications, providing a sufficient dosage (or, at a minimum, a prescription) that will last until the client’s follow-up appointment date in the community (American Academy of Family Physicians 1982/2008). Since the late 1990s, correctional institutions (to varying degrees) have attempted to establish continuity of care for the purposes of stabilizing and managing clients with medical conditions, especially mental health diagnoses.⁴ In the TJC model, the concept of continuity of care extends beyond medical needs to target *all* criminogenic needs, including substance abuse, employment, family, and other needed services—although many strategies and core components remain the same.

As discussed above, the typical jail stay is quite short, often only a few days. Moreover, exact discharge dates are frequently unknown; in many jurisdictions, individuals are commonly discharged from regularly scheduled court appearances. Thus, it can be very difficult to plan services for clients while they are in custody and to prepare for their release. This uncertainty makes continuity of care in case management all the more important, especially for those individuals who pose the highest risk to reoffend. Due to the challenges involved and the importance of this work, it is crucial to implement strategies that simplify and encourage the provision of continuous case management services for the jail reentry population. Below, we describe a few key strategies used by the TJC initiative

to promote continuity of care for individuals released from jail, all of which should be coordinated by a case manager and through a case plan.

Jail “In-Reach”

One effective strategy, used to varying degrees in many jails across the country (including all the TJC learning sites), involves providing the opportunity for community-based agencies to meet with clients in the jail before release, a strategy known as “in-reach.” These in-reach activities may consist of informal informational sessions to educate clients about post-release services, formal interviews to determine acceptance of clients into programs before release, or the provision of programming or other services in the jail. In-reach provides an opportunity to develop rapport with clients before release, which is particularly important for high-risk individuals, who tend to have the greatest needs both while in jail and after release. A heightened level of trust will help ensure that the client follows through with accessing the necessary services in the community upon discharge, thus promoting continuity of care. Regardless of the level of service intensity that may be able to be provided in the jail (due to space, security, and other challenges), for the purposes of continuity of care, the value of conducting in-reach in the jail cannot be overstated.

In achieving continuity of care, it can also be valuable for personnel based in the community to co-facilitate classes with jail staff inside the correctional institution, or even for staff to be colocated at both the jail and a community-based reentry center. These partnerships can be very helpful for clients in bridging the gap between the two environments. For example, in two TJC learning sites—Douglas and Orange counties—some case managers split their time between the jail and a reentry center in the community. In Kent County, the corrections department established a community-based reentry center to provide for continuity of care in service provision. Staff from a nonprofit organization provided case management to clients in the jail’s co-occurring treatment unit, and these staff continued to meet with clients after release at the community-based reentry center. As described above, staff at Denver’s CRP reentry center worked closely with the jail’s Life Skills Program, including providing some jail-based services. Similarly, in La Crosse County, jail-based case management services were provided by a community-based government agency.

⁴ In fact, the impetus to provide discharge planning services in several state and local jurisdictions was born out of a desire, and sometimes even a mandate, to provide continuity of care for medically involved clientele, including those diagnosed with mental illnesses. For example, discharge planning efforts in New York City largely grew from the *Brad H., et al. v. The City of New York, et al.* (1999) lawsuit; more information about this settlement and the origins of the city’s discharge planning for health care can be found in Mellow et al. (2008).

Consistency of Programming and Services

Maintaining consistency across agencies in the service delivery process is another key factor related to continuity of care in the TJC approach. This element involves providing consistent assessment, case planning, programming, and other services between the jail, community-based service providers, and supervision agencies. A number of the TJC learning sites employed strategies to establish consistency in their service delivery approach, most notably through the provision of assessment and cognitive-based therapy. For example, as of the conclusion of the TJC technical assistance period, jail staff in Orange County were designing a format that would allow various agencies to use information from in-jail assessments and case planning as clients moved from the jail to the community. Probation officers would still be able to make adjustments based on policy and individual compliance, but the information would flow from one agency to the next, reducing duplication of effort and providing a cohesive, holistic approach.

Similarly, in La Crosse County, the community agency responsible for providing assessment and case planning to clients involved with the justice system—Chemical Health and Justice Sanctions (CHJS)—conducted assessments for jail-involved clients, and then made that information available to jail staff as well as the judiciary and legal providers (district attorney and public defender). CHJS used the assessment information in working with clients released from the jail who were sentenced to their agency and, as of the conclusion of the TJC technical assistance period, were examining opportunities to share this information more widely with other community-based organizations.

While participating in the TJC effort, several learning sites received training from NIC on Thinking for a Change (T4C), a cognitive-based curriculum. These sites were able to integrate this evidence-based curriculum into their overall case management and intervention approaches. Each site was able to train both in-jail and community-based providers, and these providers worked to coordinate their efforts to deliver consistent transitional services. For example, La Crosse County implemented T4C in both the jail and the community, and staff from various agencies in the county worked together to ensure coordinated delivery of the curriculum, in terms of both timing (so individuals discharged from the jail before finishing T4C could pick up where they left off after release) and content. In Denver, the jail-based Life Skills program and the community-based CRP both implemented T4C as a core

component of their service provision. In Orange County, T4C had been used by local probation for a number of years, and the jail began to offer T4C classes as well to promote consistency between the two agencies. In Kent County, the full T4C curriculum was provided by staff while in the jail to ensure that all modules were covered before release.

Effective communication is a critical element to maintaining consistency in service delivery across agencies. Communication among all participants ensures that the client has consistent and clear messages about his or her post-release efforts. To address this issue, some TJC learning sites, including Douglas and Kent Counties, held regular meetings with key stakeholders to review case plans. To assist with this effort, it is advisable that, whenever possible, all related agencies and partners use consistent forms, terminology, and processes. This is especially important for the use of transition case plans and assessment tools. When all involved parties use the same sets of tools and vocabulary when working with clients, agencies are more able to be clear about goals and objectives with their clients and help clients understand what is expected of them and where to go to seek assistance.

Information-Sharing

Providing effective continuity of care and case management services in general requires a great deal of information-sharing. The TJC approach recommends that the case plan and assessment be automated. Electronic versions of these documents allow for easy communication and transfer of information from jail providers to community-based services, and they allow the case plan to be updated over time. Some jails purchase case management software, while others develop tools internally and use them within their case management systems.

Jail-based case managers should provide community-based organizations with information on client needs—including the client's assessment and case plan—as well as the services that the client received in the jail. This not only reduces duplication of effort, but also helps enhance continuity of care. However, in the TJC model, information-sharing is a two-way street, and jail staff should also be provided with information from community-based case workers, including whether the client has received services in the community. For example, in La Crosse County, the community-based CHJS agency created case plans that were shared with jail programs staff. Moreover, in the event that a client returns to the jail, jail staff

should immediately inform the relevant community-based provider(s) that have worked with the client. This can allow all parties to work as a team in addressing any crises, relapses, or other problems the client may have encountered and can help stabilize the client when he or she returns to the community.

“We’re trying to include our community providers to create a more seamless approach. When the client gets to an agency, the provider already knows what is going on with the client and helps the client move ahead more quickly than they would if they didn’t have that information.”

--TJC Stakeholder

When sharing case plans containing medical, substance abuse, or mental health information, agencies must comply with HIPAA⁵ and other federal, state, and local laws governing the proper use of this information. Only the information that is needed for transition planning should be included in the case plan, while maintaining the confidentiality of the individual. In order to share any protected information, jurisdictions should develop and implement appropriate Release of Information (ROI) procedures and forms that allow clients to grant permission for their information to be shared. In Davidson County’s electronic system, the ROI form was located in the same place as the assessment and case plan so case managers could easily access it as a core part of the case management process. The ROI form should list the specific providers with whom client information may be shared and detail what information (only relevant information) will be shared. Moreover, at the system level, agencies should develop and implement interagency agreements or memoranda of understanding (MOUs) to explicitly specify the agreements of data sharing (i.e., who will share what information, how, and with what frequency). The TJC Online Learning Toolkit has more information on ROIs and MOUs (module 9, section 4), along with examples that TJC sites have adapted and implemented.

Technological limitations discourage many jurisdictions from implementing case management procedures and sharing information. These challenges, however, should not serve as a deterrent to conducting case management activities, including implementing and sharing

data from risk/needs assessments. Hard copies are an acceptable alternative. Another option is to designate an agency or individual as the “keeper” of assessment and case planning information and for all parties to provide updates and revisions so there is always a master and up-to-date version of these living tools. Irrespective of how information is shared (i.e., electronically or manually), successful case management cannot occur in a vacuum and, as such, requires real-time, accurate data.

Role of Probation/Community Corrections

Many of the considerations discussed above are just as important, if not more so, to implement with jail clients who are also involved with probation or other community supervision agencies. Large numbers of individuals discharged from local jails across the country are released to a period of community supervision; most typically, this is probation. To ease the transition from structured institutional jail living, the TJC approach advocates that clients meet with their probation officers prior to release so expectations, conditions, and terms of supervision are clear. Ideally, this can be achieved through probation officers conducting in-reach into the jail for those clients who they know will be discharged to their supervision.

Due to scheduling difficulties, resource constraints, or a lack of information about who will be released onto probation or when releases may occur, in-reach services may not always be feasible. In these instances, it is useful for jail staff to be provided with a copy of the probation terms and conditions so they can work with clients to ensure understanding of their conditional release onto community supervision. This requires coordination and information-sharing between the jail and probation department. Jail staff should also provide information to probation officers, such as the client’s assessment and case plan, as well as information on what (if any) services the client received while in jail.

Probation and parole agencies are critical partners in the TJC case planning and handoff process, particularly given that these agencies are able to compel clients to participate in needed services post-release. The supervision officer can play an important role in monitoring compliance with the case plan and often has access to contracted programs and services, such as inpatient drug treatment to which clients can be referred or even enter directly upon release. The more coordination that occurs between the jail and supervision agencies, the more likely

⁵ HIPAA refers to the Health Insurance Portability and Accountability Act of 1996 privacy and security rules, which regulate the sharing of personally identifiable health information.

that a coordinated case plan will be carried out at the point of transition.

Two TJC learning sites institutionalized processes for jail clients who would be released onto probation. The probation offices in La Crosse County were colocated with the jail during the county's participation in TJC, which enhanced the opportunity for these two agencies to work together and provide a seamless case management approach. Similarly, in Orange County, two probation officers were assigned to work in the jail, and, as previously mentioned, the jail's community-based Great Escape Resource Center was built adjacent to a probation office. Although the two probation officers were not assigned to work with every client released from the jail onto probation supervision, the process and opportunity for seamless case management was present for the clients of these individual officers.

There are numerous other ways in which personnel from the jail and probation can mutually reinforce and support the goals of case management and community handoff. For example, in Orange County, the role of probation in the TJC process extended beyond that of the two reentry probation officers located at the jail. The Orange County Sheriff's Department chose to implement the same criminogenic risk/needs assessment tool as the county's probation department had been using for many years. This allowed the two agencies to use the same vocabulary and risk categories for their shared clients, and it allowed the local jails to use a tool that the probation department had already validated. Jail staff also benefited from receiving training from probation staff in administering the tool; this provided an opportunity for the two agencies to come together and learn from each other. Moreover, several years before TJC implementation, the probation department implemented Thinking for a Change as the cognitive-based curriculum used with probation clients in day reporting centers and probation offices throughout the county. During the TJC initiative, the same curriculum was also implemented in the Orange County jails, allowing the two departments to support the same goals and share a common approach to addressing the cognitive-behavioral needs of their shared clients.

Conclusion

An effective case management and community handoff process is undeniably important for successful reentry from prison. This is even more true in the case of jail reentry. Short and often unpredictable lengths of stay,

combined with high rates of recidivism, necessitate a systematic and coordinated approach to ensure that individuals returning from the community are provided with programming and services that address their criminogenic needs and reduce the likelihood that they will return to jail.

The TJC model advocates a systems approach in which reentry is the sole responsibility of neither the jail nor the community, but a joint effort between the two. Those clients at the highest risk of recidivism should be assessed to identify their needs and provided with services both within the facility and upon their release to promote a successful transition process. Solid case management provides the roadmap for transition back to the community.

To be effective, this process requires strong coordination and collaboration among key stakeholders in both the jail and the community. In particular, jurisdictions should institute strong case management and referral processes in which the case manager works with the client to develop a clear transition plan and makes post-release appointments for the client with the appropriate community providers.

Creating such a unified system of case management can be a long and difficult road, as evidenced by implementation of the TJC model in the six learning sites. While many sites made substantial progress in their case management procedures, none was able to fully implement every element of the TJC model's approach to case management during the three-year technical assistance period. This was due partly to the fact that, in the TJC model, jurisdictions first concentrate their efforts on several other key processes to lay the groundwork for the initiative (including implementing screening and assessment, building an organizational structure for TJC implementation, strengthening interagency partnerships, implementing a system of core performance measurement, and assessing information on the jail population and current system gaps) before turning to the case management and coordinated handoff elements of the model. Therefore, for the most part, the learning sites began to focus heavily on this component relatively late in the technical assistance period, and they were continuing to move forward on their efforts as technical assistance came to a close.

In addition, jurisdictions encountered a number of challenges to fully implementing integrated case management approaches, including technological and

resource limitations. Nonetheless, each learning site was able to identify ways of improving upon their existing processes, often while dealing with serious resource constraints. As described throughout this brief, many sites were able to target case management services to high-risk clients; enhance the structure and content of their case plans (and, in some cases, implement a single case plan used by multiple agencies); build a base of information on services to which clients may be referred after release; improve coordination and information-sharing between the jail, community-based service providers, and supervision agencies; engage community-based providers in jail “in-reach” or even colocate staff in the jail and in the community; and increase consistency between services provided by various agencies (for example, by offering the same curricula in both the jail and community).

Moreover, each site’s approach to enhancing its case management and community handoff process depended upon the structure of the local system and the availability of resources, and each site developed unique strategies that built upon existing capacities. For example, Denver developed a case handoff process based upon an existing in-jail program, Life Skills, and a community-based reentry center, the CRP. All Life Skills participants were referred to the CRP, and assessments and case planning were conducted by both programs. Orange County used a similar strategy, with clients proceeding from the jail to a community-based resource center operated by the Sheriff’s Department. Orange County also coordinated the jail’s activities with those of the local probation department. In Kent County, in-jail case management services were provided by a community-based organization that continued to work with clients upon release. In contrast, Davidson County used its substantial jail programs and case management staff to carry out case planning and assessment responsibilities in the jail, then referred clients to various community-based service providers. La Crosse County used the capacity it had developed in creating Chemical Health and Justice Sanctions to conduct assessments, create case plans, and provide case management in that jail and in the community.

Despite the challenges inherent in implementing a seamless approach to case management, each of these sites was able to work within its existing systems to achieve greater collaboration, reduce duplication of effort, and create a more successful transition process for clients exiting the jail.

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