November 2019

DOUGLAS COUNTY, KANSAS

A County Justice and Behavioral Health Systems Improvement Project

Introduction

Commissioners in Douglas County, Kansas, passed a Stepping Up resolution in October 2015, joining a national movement to reduce the number of people in their local jail who have mental illnesses and co-occurring substance addictions. Launched in May 2015, Stepping Up is led by a partnership of The Council of State Governments (CSG) Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation.

Named among the inaugural group of Stepping Up Innovator Counties in May 2018, Douglas County was recognized for its ability to gather accurate, accessible data on the prevalence of people in their jails who have serious mental illnesses (SMI[1]) to understand the scale of the problem in its jurisdiction.[2] Building on their unique data capacity and strong interagency partnerships, Douglas County leaders sought a comprehensive analysis of the local criminal justice system. On June 12, 2018, Douglas County's elected officials and criminal justice and behavioral health leaders—represented by the county's Criminal Justice Coordinating Committee (CJCC), established in March 2016—asked the CSG Justice Center to conduct an in-depth, cross-systems data analysis of the flow of people with SMI and co-occurring substance addictions through the Douglas County criminal justice system and to identify ways to achieve better health and public safety outcomes.

DOUGLAS COUNTY, KANSAS AT A GLANCE

Population (as of 2018):
121,436 people

County seat:
LAWRENCE

5th
most populous county in Kansas

Law enforcement agencies:

- Baldwin City Police Department
- Douglas County Sheriff's Office
- Eudora Police Department
- Lawrence Police Department
- University of Kansas Public Safety Office

Douglas County Correctional Facility average daily population (as of 2018):
235 PEOPLE

For all counties, the Stepping Up partners suggest obtaining and analyzing data for four key measures that can highlight some of the best opportunities to reduce the number of people with mental illnesses in the jail and provide benchmarks against which to measure progress: (1) knowing **the number of people with mental illnesses booked into jail** helps county leaders determine whether new prevention and diversion strategies are resulting in fewer jail bookings of people with mental illnesses; (2) calculating **the average length of stay** for people who screen positive for mental illness helps the county recognize whether people with mental illnesses are especially likely to languish in the jail; (3) tracking **post-release connections to treatment** illuminates the extent to which there is continuity in care; and (4) establishing a baseline **recidivism rate** allows the county to assess whether investments in community-based supervision and treatment are reducing the rearrest and reincarceration rates among people with mental illnesses released from jail.

Based on the CSG Justice Center's intensive qualitative and quantitative data review of the system using Stepping Up's four key measures as a guide, and with support from the U.S. Department of Justice's Bureau of Justice Assistance and Douglas County, this report presents opportunities to expand what Douglas County is already doing well and improve upon systems performance.

Context and Methodology

Setting the county apart from many other jurisdictions, the Douglas County Sheriff's Office (DCSO) employs a full-time, PhD-level criminal justice data analyst (hired in December 2016), who played an essential role in collecting and analyzing the data along with CSG Justice Center research staff. In recent years, Douglas County has also invested in infrastructure to increase its ability to conduct cross-systems strategic planning. The CJCC established a work group in 2018 for the specific purpose of guiding the county's Stepping Up planning and implementation; this Stepping Up work group became the main advisors to the CSG Justice Center during the data collection and analysis process. Over the course of 15 months, CJCC stakeholders met with CSG Justice Center staff multiple times to advise on the methodology of the analysis, review the findings, and provide feedback on preliminary policy recommendations aimed at addressing the challenges associated with serving people in the criminal justice system who have SMI and co-occurring substance addictions.

QUANTITATIVE ANALYSIS

CSG Justice Center staff conducted quantitative data analyses based on more than 21,000 data records provided by 5 different agencies: DCSO, which provided data from the local jail, Douglas County Correctional Facility (DCCF); the county's mental health care provider, Bert Nash; Douglas County Criminal Justice Services, which serves people in the pretrial and sentencing stages for both misdemeanors and felonies; the district court; and DCCCA Inc. (DCCCA), one of the primary substance addiction treatment providers in the county. Specifically, data reviewed included the following:

- Level of Services Inventory–Revised (LSI-R)[3] data from the Community Corrections department within Douglas County Criminal Justice Services, October 2017–December 2018
- LSI-R data from the district court, January 2017–December 2017
- SMI diagnosis confirmations from DCCF, January 2017–December 2018
- DCCF mental health record indications of a positive score on the Brief Jail Mental Health Screen (BJMHS), all records recorded
- DCCF substance use record indications of a positive score on the CAGE Adapted to Include Drugs (CAGE-AID), January 2017–December 2018
- Booking report from DCCF, January 2015–December 2018

While the data analyzed by the CSG Justice Center span multiple years, for the purposes of this report, all data referenced are from 2018 unless otherwise specified. Note that much of the data discussed herein addresses jail bookings, which do not represent unique individuals, as one person could have more than one booking during the timeframe of the analysis. Average length of stay was calculated for all people booked into the jail. For a demographic breakdown of people in DCCF and Douglas County at large, see the appendix on page 24.

Mental Illness Data

DCCF currently conducts the BJMHS for everyone booked into the jail who is held there for three hours or more; this applies to both 2017 and 2018 data. If a person has a positive score on the BJMHS, they are referred within 72 hours of booking to a Bert Nash licensed mental health professional for a full clinical assessment called the Adult Psychiatric Rehabilitation Services Eligibility Worksheet, which may result in an SMI diagnosis. Most people receive the assessment within 24 hours of booking. Although severe and persistent mental illness (SPMI) and SMI are considered distinct diagnoses in Kansas, for the purposes of this report, anyone who was diagnosed as having SMI or SPMI is referred to as belonging to the SMI flag category. For this report, data were collected for the following categories:

- People without an SMI flag or an MH flag (i.e., those who did not score positive on the BJMHS and never received an SMI diagnosis)
- People who scored positive on the BJMHS but did not receive a diagnosis of SMI, who are referenced in this report as having a mental health (MH) flag in keeping with how they are flagged in the Spillman Jail Management System (JMS)
- People who are diagnosed as having an SMI and are flagged as such in the JMS

Note that the SMI and MH flag numbers do not overlap in the analysis, as everyone who had an MH flag but was eventually diagnosed as having SMI is only counted in the SMI data. For the purposes of this analysis, a person is counted as having an SMI if they were ever recorded as having an SMI during the years analyzed.

Substance Addiction Data

Behavioral health staff in DCCF's medical department offer the CAGE-AID substance addiction screen to people who score positive on the BJMHS, as well as all women and military veterans.[4] About 20 percent of people agree to take the CAGE-AID; at the time of the CSG Justice Center's analysis, DCCF recorded and shared these data in the form of a spreadsheet.

DCCF and DCCCA were able to match jail booking records with the clients known to DCCCA via treatment admissions from January 1, 2017, through December 31, 2018, in order to develop an understanding of what substance addiction treatment needs the jail population has. These data were provided to the CSG Justice Center in aggregate; no identifying information was shared.[5]

QUALITATIVE ANALYSIS

The CJCC, Stepping Up work group, and other key stakeholders provided additional context for and insight into the findings that resulted from this analysis. CSG Justice Center staff facilitated in-person and phone discussions with stakeholders in the county's justice and behavioral health systems, including community-based service providers, LMH Health (local hospital) staff, DCSO staff, Douglas County Health Department staff, pretrial and probation supervision staff, mental health screening personnel, members of law enforcement, and county commissioners. Members of the Stepping Up work group reviewed the findings and recommendations in this report prior to its public release.

Findings and Recommendations

Using both qualitative and quantitative data, the CSG Justice Center organized the following findings and recommendations under Stepping Up's four key measures to determine how much is known about the status of each measure and provide recommendations that could have the greatest impact on reducing the number of people with mental illnesses and co-occurring substance addictions in jail. Many of these recommendations can contribute to improvements related to multiple measures.

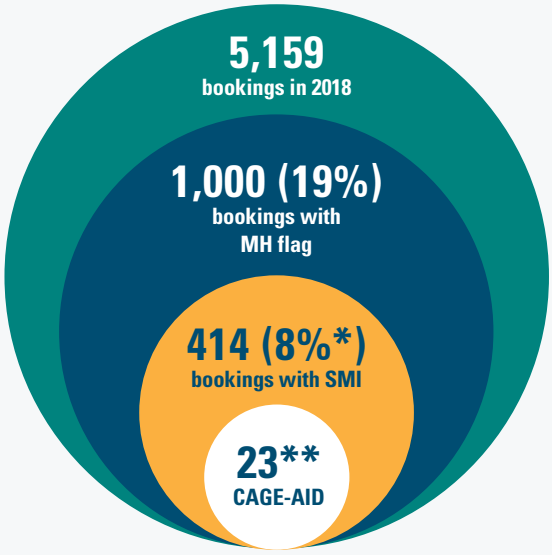
Key Measure 1: Reduce the number of people with mental illnesses and co-occurring substance addictions booked into jail.

Findings

1. **A slightly higher percentage of people booked into DCCF had SMI as compared to the general U.S. population, but the prevalence of SMI in DCCF at booking was lower than the national jail average.**

   - Eight percent of 2018 bookings into DCCF (414 of 5,159) were for people diagnosed as having SMI (see Figure 1). This percentage decreased from 2017, when 9 percent of DCCF bookings were for people diagnosed as having SMI (467 of 5,353 bookings).
   - Douglas County's SMI prevalence at booking was lower than the national estimate of SMI prevalence in jails, which is 17 percent.[6]
   - Five percent of unique individuals booked into DCCF in 2018 (195 of 3,606) were diagnosed with an SMI, while 4 percent of the general U.S. population has an SMI.[7]
   - About 27 percent of bookings into DCCF were of people who remained in the jail for three hours or less. As a result, this group of people did not receive full screenings at booking, and their SMI status is unknown if they had not been previously booked into the jail.

Figure 1. Douglas County's SMI prevalence at booking was 8 percent.



27% of all bookings led to jail stays of 3 hours or less, which means that, due to time constraints, the Brief Jail Mental Health Screen was not administered for these bookings.

*As a percentage of the total bookings, not of the MH flag cases
**The 23 CAGE-AID cases are only those who also had an SMI. A total of 87 CAGE-AIDs were administered.

2. There was some overlap between DCCCA and DCCF populations, but the number of people with co-occurring SMI and substance addictions booked into DCCF is unknown.

- Although DCCF utilizes the CAGE-AID substance addiction screening tool, in 2018 it was only conducted for people who chose to take it after screening positive on the BJMHS, as well as all women and veterans who agreed to take it. In 2017, of the bookings for a person with an SMI (467), 198 bookings also involved the administration of the CAGE-AID. Data for 2018 on the number of CAGE-AIDs administered is incomplete and therefore unable to be analyzed.
- For 2017 and 2018, the time period for which the county jail and DCCCA data were matched, the CSG Justice Center arrived at the following findings:
  - Of the 6,218 unique individuals booked into the jail, 487 people were identified as having received or currently receiving treatment in Douglas County through DCCCA.
  - During this period, 134 people booked into DCCF were admitted to DCCCA treatment before their first booking date, while 353 people booked into the jail were admitted to DCCCA treatment after their first booking date in the period.
  - Of the 487 people booked into DCCF and involved with DCCCA, the large majority were between the ages of 21 and 35 at booking (299 people), white (394 people), and male (296 people).

3. Failure to appear in court was the top charge for people with SMI booked into jail.

- Of the 414 bookings of a person with SMI, 116 booking records listed failure to appear as the top charge (see Figure 2).[8]

Figure 2. Failure to appear was the top charge for jail bookings in 2018.

Top Charges – SMI Flag	N = 414
Failure to Appear	116
Probation Violation*	35
Domestic Battery	34
Remand	31
Criminal Trespassing	26

Top Charges – MH Flag	N = 1,000
Failure to Appear	277
Domestic Battery	107
Municipal/County Violation – Other Offense	93
Probation Violation	76
Remand	49

Top Charges – No Flag	N = 3,745
Failure to Appear	967
Driving under the Influence	562
Municipal/County Violation – Other Offense	313
Domestic Battery	239
Probation Violation	160

*Probation violations without other charges are thought to be technical violations.

4. People booked into DCCF who have SMI experienced homelessness more often than those without SMI.

- DCCF records a person as homeless if they do not provide an address or if they provide an address of a homeless shelter. This process tends to undercount the true extent of homelessness; although a person may be able to provide a non-shelter address, that does not necessarily mean that they have stable, permanent, and affordable housing. Even with a potential undercount, in 77 of the 414 bookings of people with an SMI (19 percent), the person booked was found to be experiencing homelessness at the time of booking, compared to 5 percent of bookings wherein the person was not diagnosed with SMI and did not score positive on the BJMHS (175 of 3,745 bookings).

Recommendation 1: Implement a Police-Mental Health Collaboration (PMHC) to improve responses to calls for service that involve people who have mental health needs and develop opportunities to divert this population from jail into treatment, when appropriate.

Law enforcement officers often come in contact with people who have mental health needs. These encounters may result in jail bookings due to a lack of diversion strategies and options; supporting and leveraging a PMHC[9] can help reduce the number of jail bookings of people who have SMI. The CJCC should continue to engage law enforcement department heads from across the county to participate in the ongoing planning and implementation of strategies to improve law enforcement responses to people with mental health needs. Potentially falling under the oversight of the CJCC, PMHC response models[10] can be used to guide this cross-systems work. Currently, the DCSO does not have mobile crisis options. The county seat's City of Lawrence Police Department (Lawrence PD) administers a small co-responder team with two officers and one Bert Nash employee who is embedded at the police department. The Lawrence PD has also implemented Crisis Intervention Team (CIT) training, with approximately 65 percent of officers currently trained.

Where to Start

A. Improve the administration of law enforcement calls involving people with SMI.

- Create or designate a coordinator position or entity to administer oversight of all PMHC response models used throughout the county's five law enforcement agencies.
- Equip 911 dispatchers with CIT training to help them respond to calls for service involving people who are potentially experiencing mental health crises. Douglas County currently has a centralized dispatch system for all five police departments in the county; this consolidated model creates an opportunity for system-wide training of personnel who field 911 calls.
- Increase the number of CIT-trained law enforcement officers, with the goal of achieving continuous coverage of officers who are trained in CIT.

Douglas County's Integrated Crisis Team Model

The emergency department (ED) at LMH Health[11] is thoughtfully considering its role as a point of connection to behavioral health services to reduce the number of ED visits and improve long-term health for people in Douglas County. This effort is part of the Douglas County Behavioral Health Leadership Coalition's vision[12] to promote cross-systems integration through the creation of a group called the Integrated Crisis Team (ICT). The team consists of representatives from entities such as DCCF, law enforcement, Bert Nash, DCCCA, and Heartland Regional Alcohol and Drug Assessment Center (RADAC). LMH Health has invested in placing a behavioral health care coordinator at the ED to serve people who come there for a mental health crisis and/or substance use. If the triage nurse and doctor determine that a mental health assessment is needed, they offer the patient an opportunity to participate in the care coordinator program. Douglas County is funding four behavioral health crisis clinicians and six part-time peer specialists to support ED patients in behavioral health crisis. This team of clinicians and peer specialists works with participating patients for 90 days after their discharge from the ED to connect them to any services or appointments they may need to prevent further ED visits and provide a system of community care and support. Patients who are determined by the doctor and nurse to need social (non-medical) detox for substance use and do not require medical attention are connected to DCCCA.

The creation of ICT presents an opportunity to reduce the use of high-cost systems, such as EDs and jails, and instead focus on connections to community-based care. Future plans for the ICT include instituting a notification process for community-based provider partners when shared patients enter the ED; potentially establishing a Forensic Assertive Community Treatment team; and utilizing the county's forthcoming Behavioral Health Campus as a potential point of connection to providers for people in the ED and a potential diversion point from the ED (see text box on page 8). This ICT strategy, particularly the use of a behavioral health care coordinator, could also prove helpful for stabilizing people with a history of justice system involvement and connecting them to long-term care as needed. Tracking future justice system involvement among people who participate in the care coordinator program would be a useful measure for gauging success.

B. Build on existing programs and collaborative partnerships between law enforcement and behavioral health agencies to ensure that behavioral health crisis and treatment providers administer an effective, comprehensive response to people referred by local law enforcement.

- Develop mobile crisis intervention teams, available to the community and providers, that can respond to calls for service in person either alone or in partnership with a law enforcement officer. Establish a separate crisis line to respond via phone.
- As the Lawrence PD's co-responder team is at capacity, add another co-responder team that pairs a trained mental health professional with police officers to respond at the scene. Conduct a study of mental health-related calls for service in Eudora and Baldwin City to determine what capacity would be needed to expand the co-responder program to those cities.

- While considering the best use of law enforcement officer and staff time, the Lawrence PD should build on its relationship with Bert Nash, DCCCA, and Heartland RADAC to create a system for behavioral health providers to follow up with households that make a call for service to local law enforcement and are served by the co-responder team.

C. Expand crisis services.

- Use the forthcoming Douglas County Behavioral Health Campus and Crisis Center as an alternative place for law enforcement to direct people experiencing crises related to mental health, substance use, and homelessness. (See text box below.)
- Implement provisions for handling involuntary commitment cases and providing medical clearance to improve system responses to people in crisis and decrease the amount of time law enforcement personnel wait at the hospital for case resolutions.
- Create Assertive Community Treatment team(s), Forensic Assertive Community Treatment team(s), and Assisted Outpatient Treatment, or expand general forensic capacity of mental health agencies to serve people who are connected to community-based care and supervision, specifically those who are in crisis.
- Beyond mobile crisis services, develop additional opportunities for rapid response to people in crisis, such as peer-only response models.
- Designate one person to help coordinate available services to avoid duplication and ensure that there are defined roles across agencies. This position should have authority to work across law enforcement and behavioral health systems to ensure coordination and quality of processes and services.

Douglas County Behavioral Health Campus

An exciting opportunity for improved responses to people with behavioral health needs is the development of the Douglas County Behavioral Health Campus, which will be located in Lawrence. Voters in Douglas County overwhelmingly approved a quarter-cent sales tax to fund the Behavioral Health Campus in November 2018. The campus will include the aforementioned Crisis Center, mental health and substance addiction treatment services, and tiers of housing to meet needs ranging from temporary to sustained permanent housing. This campus will be an important avenue for enhancing diversion options for law enforcement officers and potentially continuing to decrease the number of people with SMI who are booked into DCCF. The proposal for the campus and its associated public support demonstrate Douglas County's commitment to building community capacity and connections to treatment and services. The housing units are expected to open in 2020, and the crisis portion of the campus should open in 2021.[13]

How to Track Progress

A. Monitor the nature of calls for service.

- Code 911 calls as "MH "or "non-MH"—indicating whether the police response required a specialized mental health response—followed by action taken and resolution (such as referral), specifying what the police role was in processing the disposition of the case.

- Lawrence PD should track the number of calls they respond to wherein they believe having a co-responder is necessary, and work with 911 and dispatch to determine where a co-responder would be most effective and necessary.

B. Use the county's robust data tracking capacity to continue managing, coordinating, and monitoring data across agencies.

- On an ongoing basis, track data on people with SMI from agencies including the local courts, law enforcement, the District Attorney's Office, Bert Nash, DCCCA, DCCF, Heartland RADAC, Court Services, and Community Corrections.
- Collect and analyze system-wide data quarterly, such that the CJCC can regularly report on the criminal justice population to see if new programs and policies are achieving their desired impact.
- Use data to identify priorities for reducing the number of people in jail who have mental illnesses and co-occurring substance addictions and incorporate those priorities into the CJCC's strategic plan for 2020 and beyond.

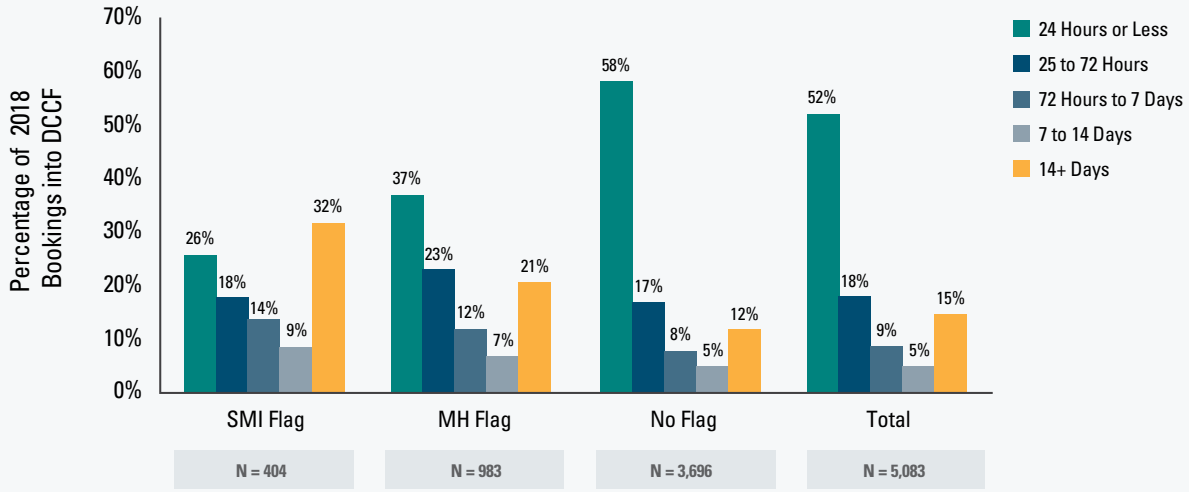
Key Measure 2: Reduce the average length of stay for people with SMI in jail.

Findings

1. People with SMI booked into DCCF tended to have longer jail stays than people without SMI.

- The average length of stay for bookings with an associated SMI diagnosis was 27 days, compared to 10 days for bookings with no SMI or MH flag.
- Thirty-two percent of bookings for people with SMI resulted in a length of stay of 14 days or more, compared to 12 percent of bookings for people without an MH flag or SMI diagnosis (see Figure 3).
- Twenty-six percent of bookings for people with an SMI diagnosis had stays of 24 hours or less, compared to 58 percent of bookings for people without an MH flag or SMI diagnosis.

Figure 3. In 2018, 32 percent of bookings for people with an SMI flag resulted in a length of stay of 14 days or more.



2. People with SMI released on bond had longer average lengths of stay, regardless of the charge.

- The average length of stay for all bond releases (for both felony and misdemeanor charges) is 18 days for people with SMI but 4 days for people without an MH flag or SMI diagnosis (see Figure 4).
- As shown in Figure 4, the average length of stay was 45 days for felony bond releases among people with SMI, compared to the average of 10 days for people without an MH flag or SMI diagnosis. This is an increase from 2017, when the average length of stay for felony bond releases among people with SMI was 35 days compared to the average of 17 days for people without an MH flag or SMI diagnosis.
- In 2018, for misdemeanor bond releases of people with SMI, the average length of stay was 10 days, compared to the average of 3 days for people without an MH flag or SMI diagnosis. This does not represent a notable change from the 2017 data.

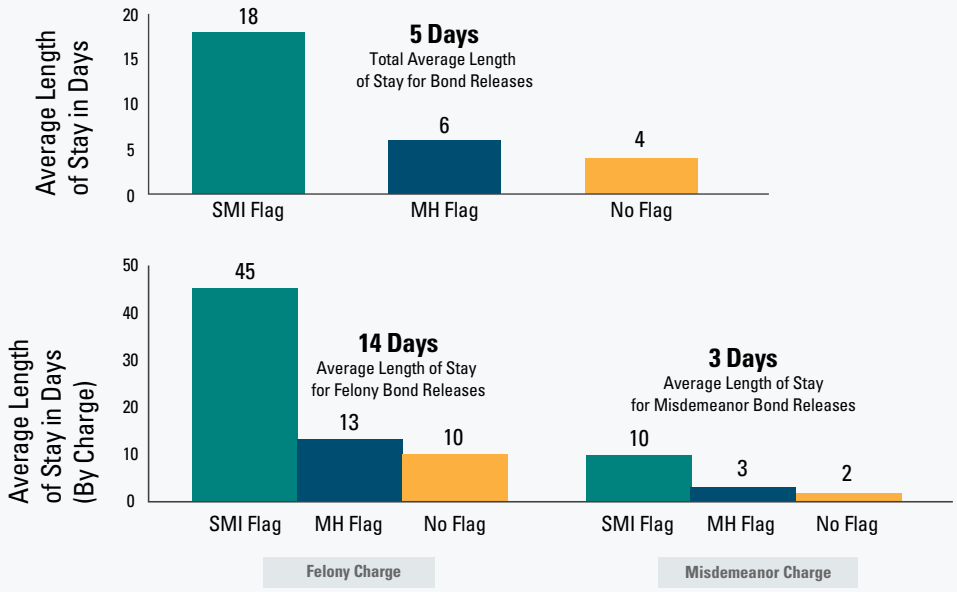
3. Across all risk levels, people with SMI stayed longer in jail than people without an MH flag or SMI diagnosis.

- Bookings of people with SMI at a low risk of reoffending resulted in an average length of stay of 34 days, whereas bookings of people without an MH flag or SMI diagnosis at the same risk level resulted in an average length of stay of 25 days. Interestingly, bookings of people with an MH flag who were assessed as low risk resulted in the longest average length of stay at 56 days.
- For bookings of people with SMI and a low/moderate risk of reoffending, the average length of stay was 56 days, compared with 29 days for bookings of people at the same risk level without an MH flag or SMI diagnosis.
- Bookings of people with SMI assessed at moderate and moderate/high risk resulted in an average length of stay of 32 days, compared with 18 days for bookings of people at the same risk level without an MH flag or SMI diagnosis.

4. Supervision decisions vary in the degree to which they are informed by risk screening and assessment at the pretrial stage.

- Community Corrections conducts pretrial services, including administering a pretrial risk screening tool at the jail at booking, providing pretrial risk screening results to the first appearance judge, and supervising people as ordered by the court at first appearance. According to the Community Corrections department, judges follow recommendations based on the screening tool results approximately 50 percent of the time.[14]
- The county's pretrial risk screening tool has not been validated specifically for its population.
- Pre-sentence investigations (PSIs) are completed by Court Services on all felony cases; a PSI is completed on misdemeanor cases only when ordered by the court. Court Services administers the LSI-R on felony cases, with a few exceptions.[15] For misdemeanor cases when no PSI is ordered, the LSI-R is completed during the first 45 days of supervision.

Figure 4. People with MH and SMI flags released on bond had longer average lengths of stay across charges.



Recommendation 2: Use validated screenings and assessments to identify people with SMI entering DCCF, make informed case decisions, and provide the right level of supervision and treatment.

Screening and assessment results can inform individual case decision-making, such as filing of charges, bail decisions, and supervision levels, potentially resulting in a reduction of the average length of stay. It is recommended that screening for SMI, substance addictions, and pretrial risk be implemented universally at jail booking. Additionally, as time and staffing allow, it is recommended that Douglas County continue to conduct screening for trauma and criminogenic risk during the booking process.

While competency to stand trial issues or case processing were not specifically examined as part of this analysis, the CSG Justice Center recommends that Douglas County continue to review competency and case processing strategies to determine if any improvements in those areas would significantly impact the average length of stay for people with SMI booked into DCCF.

Where to Start

A. Ensure consistent screening and assessment for SMI and substance addiction.

- Implement the CAGE-AID—or ideally another substance addiction screening that has been validated specifically for criminal justice populations[16]—universally at booking.
- Complete follow-up assessments for all people who score positive on the substance addiction screening and remain in jail for longer than 72 hours.
- For all individuals who screen positive on either screening and are released prior to completion of a follow-up assessment, as part of reentry planning, implement a process for completing the assessment in the community to connect people to community-based care.

B. Using a validated pretrial risk screening tool, assess every defendant before their first appearance in court to inform release and supervision decisions.

- Implement a validated pretrial risk screening tool. County leaders have completed training through Arnold Ventures as they consider implementing the Public Safety Assessment (PSA) tool, which is nationally validated and would thereby eliminate the need to validate the county's current pretrial risk screening tool.
- Adhere to pretrial risk screening tool results and properly assign defendants to specialized mental health-focused caseloads (see Recommendation 4), which could potentially increase successful completion of pretrial supervision, lower the aforementioned failure to appear rate, and ultimately reduce the average length of stay for people with SMI.
- Comprehensively implement the selected pretrial risk screening tool in Community Corrections, including providing consistent and ongoing system-wide training, developing a pretrial decision matrix to ensure that judicial decision-making regarding release is consistent and informed by pretrial risk screening tool results, and reviewing failure to appear and compliance rates on a regular basis to compare actual outcomes to screening tool results. This level of implementation should improve fidelity to the tool results.
- Revalidate the pretrial risk screening tool periodically to ensure its predictive validity.[17]

How to Track Progress

A. Ensure that screening and assessment information is consistently collected electronically.

- Implement a system at the jail to electronically track which people completed which screenings in the booking process so DCCF can tell how many people received the BJMHS, followed by how many agreed to receive the CAGE-AID, trauma screening, risk screening, etc.

B. Develop a process to share screening and assessment results for collaborative case management purposes.

- To share information across agencies on an ongoing basis, Douglas County stakeholders will first need to make sure that they are in compliance with both federal and state information-sharing laws related to mental health and substance addiction information. Douglas County agencies should explore the options of release of information forms, memoranda of understanding (MOUs), or data-sharing agreements to allow for agencies or specific stakeholders to access mental health information—specifically about people discharged from DCCF—in a timely manner. Each agency should make an effort to obtain consent for release of information when gathering information from individuals.
- DCCF should share SMI assessment and diagnosis information with pretrial and probation staff to provide for seamless transition to supervision and prevent duplication of screening and assessment upon assignment to supervision.
- DCCF should share mental health and substance addiction screening and assessment data with Bert Nash, DCCCA, Heartland RADAC, and other appropriate community-based service providers to facilitate prompt connection to treatment. Relevant community-based service providers should also regularly match their data with DCCF's to track how their shared populations fare.

Key Measure 3: Increase the percentage of people with SMI who are connected to care.

Note: Data for this measure are often difficult to obtain due to the complexity of defining "connections to care" and creating related flags to track in a jail management system, as well as inherent challenges to obtaining information from community-based mental health care providers.

Findings

1. **Although Douglas County has a robust reentry planning process with strong working relationships among criminal justice and behavioral health entities, county officials identified that they do not have a definition(s) of connection to care in place.**

   - Douglas County employs an array of strategies to connect people to care upon release, including referrals to community-based treatment providers and scheduling first appointments prior to release.
   - When release times are known, people are transported directly to care upon release from jail.
   - Douglas County officials are committed to establishing a definition of connection to care.

2. **Douglas County does not currently have capacity to track connections to care in a way that allows for quantitative analysis.**

   - Once a definition is established, county leaders plan to track connections to care in the JMS according to that definition.
   - Some Douglas County leaders hope to also measure engagement in treatment (the number of treatment events in which a person participates within a designated time period), which requires an information-sharing process with community-based mental health service providers.

Recommendation 3: Increase the county's ability to track and support connections to community-based treatment for people who have SMI and/or co-occurring substance addictions upon their release.

Research indicates that connecting people leaving jail to the right type and level of behavioral health care and services that also address criminogenic needs can decrease rates of recidivism for people who are at a medium to high risk of reoffending.[18] Therefore, it is important for jails to understand and track connections to community-based care upon release to ensure that these connections are occurring. Since quantitative data was not available for this measure, the CSG Justice Center based the content of this recommendation on conversations with DCCF and Bert Nash staff.

Where to Start

A. **Establish a shared definition(s) of connections to care.**

   - DCCF staff should meet with personnel from Bert Nash, DCCCA, and other referral agencies to discuss how to define connection to care and whether to define and track engagement in treatment.[19]
   - Identify metrics to track connections to care according to the chosen definition(s).
   - Work with IT staff to determine how DCCF can track data corresponding to the agreed-upon definitions and related information in the JMS.

B. Enable connections to care at multiple stages of criminal justice involvement.

- Add pretrial release services to ensure connection to treatment and community-based services before conviction. Currently, DCCF has a Reentry Program focused on connecting people to care solely after conviction.
- Regularly assess the capacity needs for Bert Nash and DCCCA staff embedded in DCCF. Monitor the number of people referred for services to determine whether there is a need to expand DCCCA services with additional hours of coverage to identify substance addiction needs, make appropriate connections to treatment inside and outside of the jail, and coordinate with pretrial and probation supervision staff.

C. Leverage partnerships with community-based treatment providers to promote connections to care for people who have SMI and/or co-occurring substance addictions.

- Facilitate timely connections to care, which may include scheduling appointments after regular business hours or establishing standing appointment times with treatment providers reserved for people being released from DCCF.
- Consider automating DCCF's JMS to send notices of release of people who have SMI to the Reentry Program, DCCCA, Bert Nash, and Heartland RADAC.
- Enhance current efforts by further coordinating release times and intake into community-based treatment programs.
- Continue to engage in collaborative cross-agency meetings to discuss the most difficult cases and the most frequently booked people, as well as planning for reentry and opportunities to divert people from the criminal justice system. Consider adding members to the Stepping Up work group to enhance connections to care, including university police, members of the local National Alliance on Mental Illness chapter, and housing services representatives.

D. Enhance community-based providers' capacity to offer behavioral health care for people released from DCCF who have SMI and/or co-occurring substance addictions.

- Conduct an inventory of existing community-based behavioral health services to identify gaps, prioritize the most needed services, inform the development of a funding plan, and pinpoint potential low-cost process improvements, such as eliminating duplicative efforts.
- Expand existing and identify new programming and treatment that can be supported by local, state, and federal funding streams and is designed to serve people assessed as moderate to high risk who have SMI and/or co-occurring substance addictions.
- Collaborate with the Douglas County Behavioral Health Leadership Coalition as plans are developed for LMH Health crisis triage teams. This can lead to the identification of shared populations and coordination of services.
- Develop services specifically targeted to people in the criminal justice system with SMI and co-occurring substance addictions who are experiencing homelessness. For example, Bert Nash, DCCCA, and/or Heartland RADAC could provide direct services in the county shelter or act as a liaison with the shelter. Consider creating an assessment that helps identify the best housing options for individuals within the local homelessness Continuum of Care.

How to Track Progress

A. Match data among relevant agencies.

- Explore the potential to leverage My Resource Connection (MyRC),[20] a data-sharing web application,[21] to facilitate data matching. Create different flags for each established definition of connection to care and track people's outcomes upon release.
- For more accurate identification of people who have SMI, are at risk of or experiencing homelessness, and are involved in the local justice system, consider a long-term collaboration with the local Homeless Management Information System for a data match.

B. Establish a baseline rate of connections to care.

- Using the information gleaned from the data matches described above, develop a baseline rate of connections to care upon discharge from the DCCF in order to demonstrate progress, determine ongoing capacity needs, and justify future funding requests.

Key Measure 4: Decrease the rates of recidivism among people with SMI.

Findings

1. People with SMI returned to DCCF more often than people without SMI.

- Among people booked and released more than once between 2015 and 2018, people with SMI were booked more frequently (an average of 4.2 times) than people without SMI or an MH flag (an average of 2.2 times), as shown in Figure 5.
- Thirteen percent of people with SMI booked into DCCF in 2018 (25 of 195 people) were booked 4 or more times in 2018, compared to 3 percent of people with no SMI or MH flag (97 of 2,573 people). This represents a slight drop from 2017; that year, 15 percent of people booked into DCCF and diagnosed with SMI were booked 4 or more times.
- Perhaps most striking, in 2018, 66 percent of people with SMI returned to DCCF within 6 months of release, compared to 30 percent of people without an MH flag or an SMI diagnosis (see Figure 6). Of the 66 percent of people with SMI who returned within 6 months of release, almost a quarter had returned for failure to appear. In 2017, 68 percent of people with SMI returned to jail within 6 months of release, compared to 30 percent of people with no MH flag or SMI diagnosis. Of the 68 percent of people with SMI who returned to the jail within 6 months of release in 2017, 36 percent had returned for failure to appear.

Figure 5. People with SMI were booked more frequently than others between 2015 and 2018.

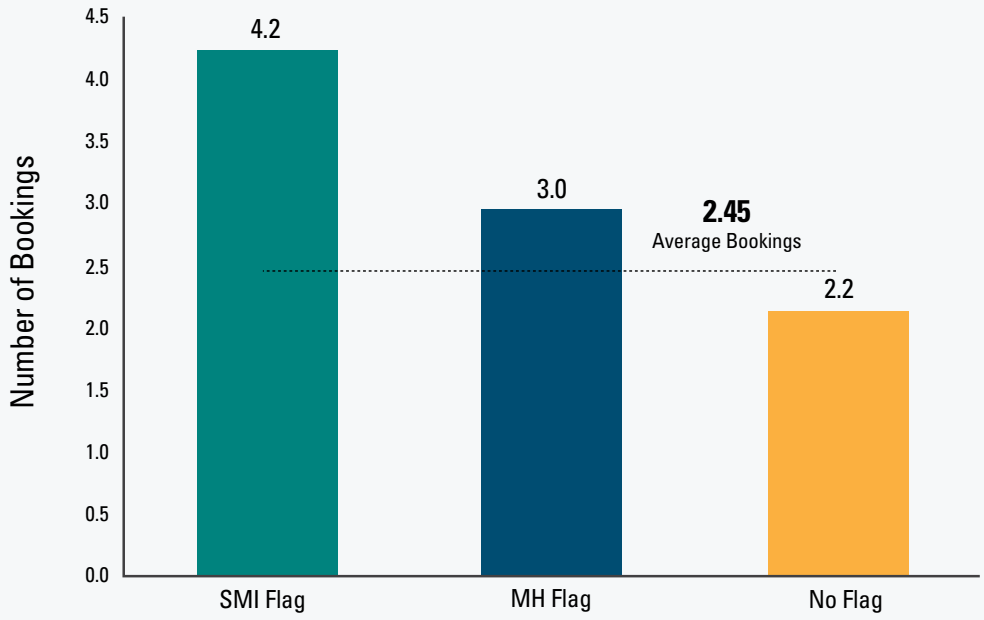
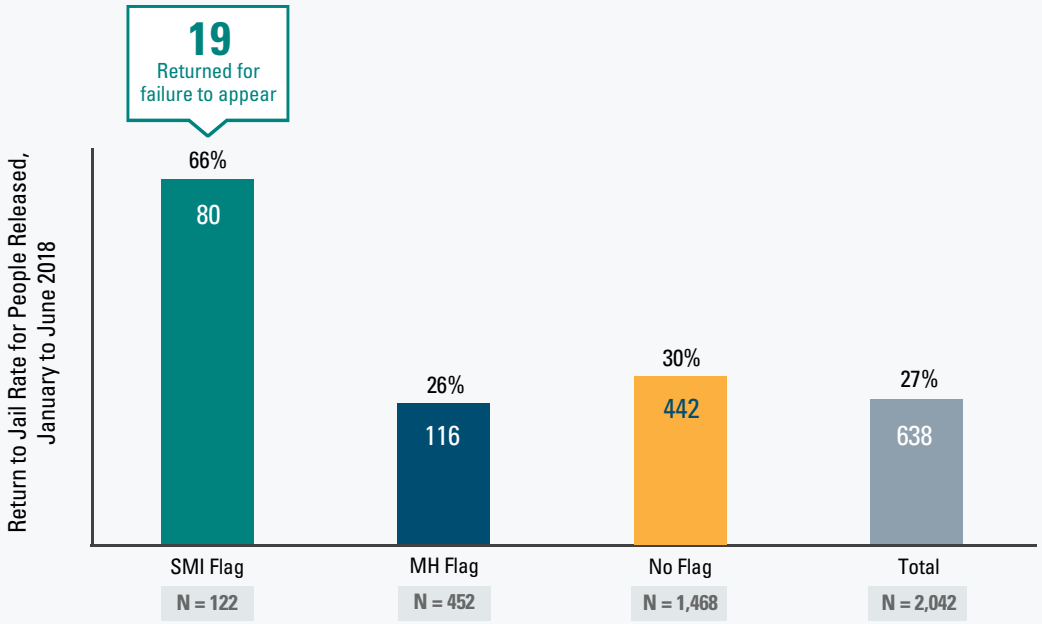


Figure 6. More than half of people with SMI returned to DCCF within six months of release.



2. Probation violation is the second most frequent top charge for people with SMI booked into jail.

- Of the 414 DCCF bookings of a person with SMI, 35 booking records listed probation violations as the top charge.

3. Half of people with SMI in Community Corrections were assessed as having a low or low/moderate risk of reoffending.

- Of the 10 percent of bookings for which the CSG Justice Center was able to obtain risk assessment data, 50 percent of bookings for people with SMI who ended up being supervised by Community Corrections had a low to low/moderate risk assessment score. Forty-five percent of bookings without an MH flag or SMI diagnosis had a low or low/moderate risk assessment score.

4. Probation supervision in Douglas County is bifurcated and therefore incredibly complex.

- While pretrial services are provided by Community Corrections, probation supervision is provided by both Community Corrections and Court Services.
- Court Services staff are state employees under the state judicial branch who report locally to the chief judge of the district court. This agency is responsible for the supervision of all misdemeanor cases and felony cases with an associated score of 23 or lower on the LSI-R.
- Community Corrections staff, on the other hand, are employees of Douglas County Criminal Justice Services and report to the county manager. Community Corrections is responsible for the supervision of felony cases with associated scores of 24 and higher on the LSI-R and provides intensive supervision and electronic monitoring.
- Community Corrections and Court Services each have their own data system, which presents additional challenges for collecting and analyzing data across agencies.

Recommendation 4: Minimize reoffending for people who have SMI and co-occurring substance addictions by implementing strategies to increase successful completion of pretrial and probation supervision.

To reduce recidivism among people with SMI on pretrial and probation supervision, Community Corrections, Court Services, and DCCF should develop strategies to offer service connections[22] to people with SMI and co-occurring substance addictions who have been assessed at a moderate to high risk of reoffending. Strong collaboration among Community Corrections, Court Services, Bert Nash, DCCCA, Heartland RADAC, and other community-based service providers will ensure that people on pretrial and probation who have SMI and co-occurring substance addictions are being referred to the appropriate type of treatment and level of supervision.

Where to Start

A. Implement personnel policies that build staff capacity and hold staff accountable for the use of evidence-based practices.

- Staff training and program implementation plans must include requirements to monitor for program fidelity and quality assurance.
- Institute a quality control process to ensure that LSI-R scores are determined with fidelity and evidence-based programming is administered per the required protocols. Quality control may include, among other strategies, designating a fidelity officer or engaging an independent contractor to regularly review the implementation of evidence-based practices.
- Reward officers and clinicians who implement evidence-based practices with fidelity and demonstrate

effective case management skills, potentially evaluating these skills in staff performance reviews to drive promotions or using other employee appreciation tactics, such as public recognition, additional vacation days, bonuses, etc.

- Institute cross training among Community Corrections, Court Services, Bert Nash, DCCCA, Heartland RADAC, the Reentry Program, and other community-based service providers to improve collaborative case management.

B. Implement promising and evidence-based supervision strategies.

- Ensure that people with SMI assigned to probation receive a full LSI-R assessment, are supervised according to their assessed risk level, and are connected to treatment and services.
- Record LSI-R data consistently and share relevant information in a timely manner with all entities providing services to people on supervision; this might involve proactively communicating with the jail if someone with a revocation is being sent there, for instance. This information can help the jail better determine what services to provide people while they are incarcerated and inform discharge planning.
- Establish specialized mental health caseloads for Court Services and Community Corrections. These caseloads should be determined by risk level as well as mental health and substance addiction treatment needs.
- Develop a process to connect people with SMI who are assessed as low risk to the appropriate community-based care and the lower levels of supervision that are provided in both Community Corrections and Court Services as alternatives to jail time.

C. Adopt practical solutions that can benefit the population that frequently cycles in and out of jail.

- Work with the leaders of the Douglas County Behavioral Health Campus and Crisis Center to enable probation officers to utilize the services offered there.
- Consider establishing full-time staff at the municipal court to link people with Bert Nash or DCCA, rather than using student interns, to promote sustainability and professionalization of this service.
- Given that the most common reason for a jail booking is failure to appear, consider providing defendants with additional support for court appearance, such as transportation and text message reminders of court dates.[23] Specialized pretrial supervision of people with SMI should involve additional reminders to encourage appearance.
- Provide defendants with legal representation at first appearance so that they have someone to advocate on their behalf for the most appropriate options for a safe release, including release with supervision and connection to care in the community.

D. Provide collaborative case management,[24] informed by LSI-R scores and behavioral health assessment information, for people under pretrial or probation supervision.

- Information from DCCF, Bert Nash, and DCCCA regarding people who have SMI and co-occurring substance addictions should be used to inform case planning discussions, and collaborative case management resources should be prioritized for those who are assessed as having a high risk of recidivism.
- A Bert Nash employee should participate in case management of people with SMI and co-occurring substance addictions who are assigned to pretrial supervision or probation to inform treatment plans and recovery goals.

- Ensure that Community Corrections and Court Services case management practices include tools that incorporate a cognitive behavioral strategy balanced with proper responses to behavioral health needs.
- For people on pretrial and probation supervision who have SMI and have been connected to care, supervision officers should work collaboratively with the treatment provider to ensure that mental health treatment is paired with the appropriate level of supervision.
- Develop systemic processes and capacity within Community Corrections and Court Services to connect people to services such as treatment, housing, job placement, and education.

E. Ensure that screening and assessment information collected at earlier points in case processing is accessible to supervision staff.

- If a screening was completed at the jail, consider utilizing the JMS for an automatic flag to be turned on for probation staff to view. If not, and probation staff complete a screening, they should input that information into the JMS so it is accessible by the jail in case of future bookings.
- To properly assign people to specialized caseloads and refer them to community-based services, train Court Services and Corrections staff on how to access and use the results of screening and assessment completed by Bert Nash and DCCCA at DCCF.

F. Develop Community Corrections and Court Services policies that can reduce the number of probation violations that result in DCCF admissions.

- Develop a response grid that is based on criminogenic risk level in relation to the seriousness of the violation and sensitive to people with SMI who may not respond successfully to traditional probation supervision.
- Consider developing guidelines for imposing shorter probation sentences as appropriate. Shorter probation sentences can allow for higher probation success rates, quicker turnover of probation cases, and improved caseload management.[25]
- As an alternative to making sentences shorter, formalize incentive procedures such that people on probation are able to earn time credits off sentences for good behavior.

How to Track Progress

A. Use the JMS to monitor pretrial supervision and probation violations for people with SMI.

- Track pretrial supervision and probation violations in DCCF's JMS to assess whether there are differences in outcomes for people with SMI compared to the general population. This entails tracking releases consistently and creating new offense codes at booking to capture who is being booked due to pretrial supervision or probation violations. If it is not possible to track this in the JMS, pretrial risk screening scores and pretrial caseload entries and exits should be shared with DCCF on a regular basis.

B. Develop a process for tracking the reasons behind probation revocations.

- This process should identify whether a person was revoked due to a technical violation or a new offense; if the reason was a technical violation, it should indicate the nature of the technical violation. This information should then be regularly matched to the DCCF database to inform what percentage of the jail population is there because of a revocation from Community Corrections and Court Services.

C. Determine whether strategies to encourage court appearance are effective.

- Collect data on the usage of transportation, text message reminders, additional reminders for people with SMI, and other similar strategies to assess whether they contribute to the desired outcome of reducing the failure to appear rate.

Coordinating State and County Efforts

Some of the challenges facing Douglas County cannot be resolved by the county alone, but would be best addressed with the support of the state of Kansas. In Douglas County's efforts to have a measurable impact on the number of people who have SMI in DCCF, their average length of stay in DCCF, their connections to treatment in the community, and their recidivism rates, local leaders will need to identify and address the gaps in services for this population and implement integrated treatment and supervision approaches. To help the county achieve these goals, the state should consider taking measures to strengthen collaboration with Douglas County to identify specific ways the state can be of assistance; build local capacity to collect data and share information; reduce avoidable contact with the justice system; and improve access to care and services.

As a starting point for collaboration between the state and the county, the CSG Justice Center has identified the following specific opportunities the state can pursue in partnership with Douglas County to create better outcomes at the local level:

- Integrate funding streams for mental and behavioral health agencies for increased service capacity;
- Facilitate the provision of evidence-based treatment for co-occurring mental illnesses and substance addictions by creating a single license requirement for treatment providers who choose to serve this population (i.e., a single license for co-occurring disorder treatment programs);
- Support increasing the capacity of housing options;
- Encourage the development of PMHCs;
- Adopt statewide screening tools for mental illness and substance addiction for use at the local level;
- Support pretrial policy implementation;
- Assist in implementing specialized supervision responses, including decision matrices and specialized caseloads, to reduce the number of revocations and technical violations for people with SMI; and
- Fund the judiciary across the state to meet its capacity needs.

Douglas County leaders may also take advantage of state funds to support the goals described herein. For example, leaders from Heartland RADAC, Community Corrections, and DCSO's Reentry Services are discussing using Kansas Department for Aging and Disability Services funds to embed a RADAC care coordinator to serve people in Community Corrections, Court Services, and DCCF's Reentry Program to link them to community-based services.

Prioritizing Improvements in Douglas County

Knowing where to start in tackling the many recommendations in this report can be challenging. The chart on the following page, developed in partnership with stakeholders in Douglas County, is intended to assist in prioritizing which strategies to pursue under each of the four key measures. These top recommendations were identified because they present opportunities for high potential impact and are most realistically achievable in the current local context, per input from Douglas County stakeholders.

Douglas County officials continue to be leaders in their cross-systems commitment to change. In order to track their progress on the priority recommendations for each of the four key measures and sustain planning efforts, they should continue efforts to create a dashboard that monitors the four key measures; expand data collection and matching among key agencies to continuously identify people in jail who have SMI and co-occurring substance addictions and their needs; and maintain the CJCC's Stepping Up work group to regularly report on progress in addressing the following priorities.

Top Recommendations for Each Key Measure

Legend:
Low cost projection = $0 to $10,000
Medium cost projection = $10,000 to $100,000
High cost projection = $100,00 and above

Short term = Less than 18 months
Long term = More than 18 months

KEY MEASURE	RECOMMENDATION	IMPLEMENTATION PERIOD	COST PROJECTION
Key Measure 1: Reduce the number of people with SMI booked into jail	Develop mobile crisis response team(s).	Long term	Medium to high depending on number of staff
	Expand the co-responder program to include Baldwin/Eudora PDs and expand coverage hours.	Long term	Medium to high depending on number of staff
	Fund a program coordinator for expanded co-responder, mobile crisis, and other alternative services.	Long term	Medium to high
Key Measure 2: Reduce the average length of stay for people with SMI	Implement a text messaging service to remind people of court appointments.	Short term	Low to medium
	Implement a validated pretrial risk screening tool.	Long term	Low
	Implement system-wide training on the pretrial risk screening tool.	Short term	Low
	Develop a pretrial decision matrix to guide judicial decision-making.	Short term	Low
Key Measure 3: Increase connections to care for people with SMI	Develop a definition(s) of connection to care.	Short term	Low
	Continuously assess capacity needs of Bert Nash and DCCCA staff embedded at the DCCF.	Ongoing	Low
	Ensure connection to care by establishing a process to inform service providers and supervision staff of release from DCCF.	Short term	Low

KEY MEASURE	RECOMMENDATION	IMPLEMENTATION PERIOD	COST PROJECTION
	Implement a plan for transportation to services upon release.	Short term	Low
	Collaborate with the Douglas County Behavioral Health Leadership Coalition to ensure that the criminal justice population is included in planning for crisis triage teams and services at the new Behavioral Health Campus.	Short term	Low
Key Measure 4: Reduce recidivism among people with SMI	Implement a plan in Court Services and Community Corrections to identify the population with moderate to high criminogenic risk, SMI, and substance addictions for targeted placement in programming.	Short term	Low
	Complete the BJMHS on people assigned to pretrial and probation supervision who did not receive screening at the DCCF.	Short term	Low
	Develop a specialized caseload for people assigned to probation who have SMI.	Short term	Low
	Embed a Bert Nash mental health professional within Court Services/ Community Corrections (new position).	Short term	Medium
	Develop a response grid to consistently address probation violations with the lowest level of response needed.	Short term	Low

Appendix: Demographic Data

The following chart illustrates the demographic breakdown of the DCCF population that was diagnosed as having an SMI as compared to the total DCCF population and the population of Douglas County at large.

RACE			
	DCCF SMI Population	**Total DCCF Population**	**Census Population[26]**
Asian	0	50	6,061
Black	37	669	5,680
Native American	6	188	3,348
White	152	2,699	101,288
Two or More Races	(Unavailable)	(Unavailable)	5,059
Total	**195**	**3,606**	**121,436**

AGE			
	DCCF SMI Population	**Total DCCF Population**	**Census Population**
Age 17–24	29	1,047	28,351*
Age 25–44	120	1,973	32,010
Age 45–64	46	554	24,032
Age 65+	0	32	14,954
Total	**195**	**3,606**	**121,436**

SEX			
	DCCF SMI Population	**Total DCCF Population**	**Census Population**
Female	75	1,012	60,916
Male	120	2,594	60,520
Total	**195**	**3,606**	**121,436**

* This figure accounts for ages 18 to 24; 17-year-olds are counted in a different age category by the U.S. Census.

Notes

1. The abbreviation "SMI" is used to denote both singular and plural forms of "serious mental illness."
2. See "Innovator Counties," the Stepping Up Initiative, accessed June 28, 2019, https://stepuptogether.org/innovator-counties.
3. The Level of Services Inventory–Revised is a criminogenic risk and needs assessment that helps guide supervision and treatment decisions.
4. DCCF offers the CAGE-AID to all women and military veterans as part of a federal grant program.
5. DCCF provided DCCCA with 10,515 booking records, constituting 6,218 unique individuals with booking dates between January 1, 2017, and December 31, 2018. The records include booking ID, the person-specific number assigned by the jail, last name, first name, birth date, sex, race, booking date, and release date. DCCCA matched 5,766 treatment episode records of 4,747 unique individuals from all DCCCA treatment locations across Kansas with admission dates between January 1, 2017, and December 31, 2018, to jail data on last name, first name, and birth date. DCCCA's data include last name, first name, birth date, treatment location, admission date, and discharge date. Aggregate counts were produced using the data elements provided by DCCF.
6. Henry J. Steadman, Fred C. Osher, Pamela Clark Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 60, no. 6 (June 2009): 761–765.
7. Substance Abuse and Mental Health Services Administration, *Results from the 2017 National Survey on Drug Use and Health: Detailed Tables* (Washington, DC: Substance Abuse and Mental Health Services Administration, 2017), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab8-33A.
8. In cases where a person has multiple charges, the "top charge" refers to the most serious charge.
9. A PMHC is in place when a law enforcement agency invests in a comprehensive, agency-wide approach and partnership with the behavioral health system to effectively respond to people with mental health needs. PMHCs build on the success of mental health training and specialized teams by layering multiple types of response models and implementing one or more of these models as part of a comprehensive approach to meet their needs.
10. See CSG Justice Center, *Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Response Models for People Who Have Mental Health Needs* (New York: CSG Justice Center, 2019), https://csgjusticecenter.org/law-enforcement/publications/police-mental-health-collaborations-a-framework-for-implementing-effective-law-enforcement-responses-for-people-who-have-mental-health-needs/.
11. Formerly known as Lawrence Memorial Hospital. For more information on LMH Health's behavioral health crisis services, see "Behavioral Health," LMH Health, accessed July 16, 2019, https://www.lmh.org/get-care/behavioral-health/.
12. See "Promote Integration," Douglas County, Kansas, accessed July 16, 2019, https://www.douglascountyks.org/bh/promote-integration.
13. For more information about the Behavioral Health Campus, see Elvyn Jones, "Voters Overwhelmingly Approve Sales Tax to Fund Behavioral Health Campus, Services," *Lawrence Journal-World*, November 6, 2018, https://www2.ljworld.com/news/county-government/2018/nov/06/voters-overwhelmingly-approve-sales-tax-to-fund-behavioral-health-campus-services/.
14. Douglas County Criminal Justice Services, *2018 Departmental Report* (Lawrence, KS: Douglas County Criminal Justice Services, 2018), 26, https://www.douglascountyks.org/sites/default/files/media/groups/cjcc/pdf/douglas-county-criminal-justice-services-2018-departmental-report.pdf; Mackenzie Clark, "Some Alternatives to Incarceration in Douglas County Jail Becoming 'Robust,' Leader Says," *Lawrence Journal-World*, March 17, 2019, https://www2.ljworld.com/news/county-government/2019/mar/17/douglas-county-program-becoming-robust/.

15. Exceptions include if the case is a DUI or falls under the state's Senate Bill (SB) 123 guidelines, which require that funding through the Kansas Sentencing Commission covers substance addiction treatment for certain people who are convicted of drug possession.

16. An example of such an assessment is the TCUDS-IV.

17. Pretrial Justice Institute, *Pretrial Risk Assessment: Science Provides Guidance on Assessing Defendants* (Rockville, MD: Pretrial Justice Institute, 2015), 5.

18. Jennifer Skeem et al., "Offenders with Mental Illness Have Criminogenic Needs, Too: Toward Recidivism Reduction," *Law and Human Behavior* 38, no. 3 (2014): 212–224, doi: 10.1037/lhb0000054.

19. For example, the first treatment appointment made can be tracked as a type of connection to care, and attending 3 appointments over the course of 45 days can be tracked as a type of engagement.

20. Douglas County selected MyRC; the CSG Justice Center does not endorse any specific type of software.

21. MyRC enables multiple service providers and criminal justice agencies to share information regarding client service usage.

22. Note that the court cannot order people under pretrial supervision to engage in services.

23. Douglas County instituted automated court reminder calls in November 2018 in line with best practices to help reduce failure to appear rates.

24. "Collaborative Comprehensive Case Plans," the National Reentry Resource Center, accessed July 17, 2019, https://csgjusticecenter.org/nrrc/collaborative-comprehensive-case-plans/.

25. For more on probation sentence lengths, see Alexis Lee Watts, *Probation In-Depth: The Length of Probation Sentences* (Minneapolis: Robina Institute of Criminal Law and Criminal Justice, 2016), https://robinainstitute.umn.edu/publications/data-brief-probation-depth-length-probation-sentences; Center for Effective Public Policy, Dosage Probation: *Rethinking the Structure of Probation Sentences* (Kensington, MD: Center for Effective Public Policy, 2014), https://www.fppoa.org/sites/default/files/dosage.pdf.

26. All census population data for Douglas County was drawn from "American FactFinder: Community Facts," United States Census Bureau, accessed August 16, 2019, https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml.

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