A Process and Impact Evaluation of the Sheridan Correctional Center Therapeutic Community Program During Fiscal Years 2004 through 2010

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Acknowledgements

Just as the operation of the Sheridan Correctional Center Therapeutic Community reflects the effort and hard work of many individuals, agencies and organizations, so too has the evaluation of the program. Everyone involved in the Sheridan Correctional Center program has, in some way, contributed to the evaluation, including Illinois Department of Corrections (IDOC) and Treatment Alternatives for Safe Communities (TASC) staff working at the IDOC's Reception and Classification Centers who collected information regarding the extent and nature of the participants' substance abuse history and other inmate characteristics, the staff of Gateway and WestCare, who provided the evaluation team with additional detailed information on program participants and met with the evaluation team frequently to discuss program operations and procedures, staff from Safer and TASC, who provided the evaluation team with information about the post-release services and experiences of those discharged from Sheridan, along with staff from the Illinois Criminal Justice Information Authority, who provided information on the participants' and comparison groups' criminal histories. The quality and availability of all of these data provided by these organizations has allowed the evaluation to be a very complete and detailed accounting of who is being served by Sheridan, the types of services they are receiving and the impact this program has had on participant recidivism. In addition, appreciation and thanks is extended to all of the staff working on the Sheridan Program who have provided the evaluation team with feedback during numerous presentations of the evaluation findings, provided support when we have been on-site at Sheridan, and who have given us information to better understand the operations of the program. Included among these are the Sheridan/Southwestern Correctional Centers Advisory Council and the Sheridan/SWICC Evaluation Workgroup.

EXECUTIVE SUMMARY

In response to increases in Illinois' prison population, low rates of access to substance abuse treatment services while in prison, and high rates of recidivism, on January 2, 2004, the Illinois Department of Corrections opened the Sheridan Correctional Center as a fully-dedicated, modified therapeutic community for incarcerated adult male inmates. Since the program began, a process and impact evaluation has been conducted by researchers from Loyola University Chicago, the Illinois Department of Corrections, the Illinois Criminal Justice Information Authority, Treatment Alternatives for Safe Communities (TASC), the Safer Foundation, and WestCare. After 6 ½ years of operation, covering the period from January 2, 2004 through the end of State Fiscal Year 2010 (June 30, 2010), the evaluation has found the following:

- The pre-operational target population identified for the program is being served, with those admitted to Sheridan having extensive criminal and substance abuse histories, and a substantial unmet need for treatment, vocational and educational programming;

- As a result of strong support from IDOC executive staff, the Sheridan program has been allowed to evolve and be implemented in a manner that has ensured the clinical integrity of the program and the availability of sufficient resources for needed services;

- As a result of Sheridan, IDOC has developed and implemented a process by which *all* adult inmates admitted to prison undergo a screening to identify substance abuse treatment need, the integration of this information into their automated Offender Tracking System, and the development of a treatment waiting list for inmates;

- During the past 6 ½ years, the following significant accomplishments and improvements to the operation of the Sheridan Correctional Center have been achieved:
    - A consistently low rate of inmates being referred to Sheridan who are subsequently determined to not meet the eligibility criteria, and quicker identification and removal of these inmates from Sheridan. Overall, less than 5 percent of all inmates admitted to Sheridan were determined to not meet the eligibility criteria during the 6 ½ years of operation.
    - A consistently low rate of inmates being removed from Sheridan due to disciplinary reasons, despite the serious criminal histories of the population. The ratio of inmates who successfully complete the prison-phase of the program to those removed for disciplinary reasons was 4 to 1;
    - An increasing proportion of inmates being admitted to Sheridan via the treatment wait list from other institutions. During the first year of operation, less than 4% of admissions came from other prisons, but by 2007, nearly 25% of all Sheridan admissions came from other facilities via the treatment wait list;
    - During the course of program participation, inmates at the Sheridan Correctional Center improved their levels of psychological and social functioning, and reduced their criminal thinking patterns;

- During the time period examined in this report, 32 percent of Sheridan graduates completed at least one vocational certificate program, and this reached a peak of 50 percent of inmates released during SFY 2008; and,
- The implementation of enhanced pre-release planning for Sheridan releasees, including the involvement of a multidisciplinary case staffing team representing the institutional staff, parole and aftercare staff and the inmate.

- In addition to these enhancements at the Sheridan Correctional Center, significant accomplishments, enhancements and improvements to the post-release phase of the program have also been evident during the 6 ½ years of program operation, including:
  - A pattern of aftercare referrals consistent with the pre-operational expectations, with all Sheridan releasees receiving referrals to either outpatient or residential treatment services;
  - An increased rate of successful treatment admission among Sheridan releasees, fewer releasees failing to show up for aftercare referrals, and a decreased length of time between an inmate's release and aftercare placement; and,
  - An increased rate of successful aftercare treatment completion among the Sheridan releasees. Among the SFY 2005 releasees from Sheridan only about one-half successfully completed post-release aftercare, but among the SFY 2009 and 2010 releasees, aftercare completion rates exceeded 70 percent.

- As a result of the successful implementation of the prison-phase of the Sheridan Correctional Center, coupled with the post-release aftercare component, the Sheridan program has produced the following outcomes:
  - The earned good conduct credits many of the inmates received at Sheridan for their participation in treatment during the first six full state fiscal years of operation (SFY 2005-2010) translates into a savings of 714 years of incarceration, which equates to $16.7 million, or $2.78 million per year, in reduced incarceration costs;
  - Sheridan participants who earned a vocational certificate were almost twice as likely to have job starts than those released from Sheridan who did not earn a vocational certificate;
  - As a result of the treatment services and aftercare received, those inmates released from Sheridan had a 16 percent lower likelihood of being returned to prison after three years in the community than a statistically similar comparison group of inmates released from Illinois' other prisons during the same time period, and a 25 percent lower recidivism rate than those removed from Sheridan due to disciplinary reasons; and,
  - The largest reductions in recidivism—both in terms of rearrest and return to prison--were evident among those Sheridan releasees who successfully completed aftercare treatment. Those Sheridan graduates who also completed aftercare had a 44 percent lower likelihood of being returned to prison after three years in the community than a statistically similar comparison group. Given that rates of aftercare treatment completion have improved substantially over the past year, it is likely that in the future the overall reductions in recidivism associated with Sheridan will be even larger.

I. INTRODUCTION

The Context

In 2004, the Illinois Department of Corrections opened the Sheridan Correctional Center as a fully-dedicated, modified therapeutic community for incarcerated adult male inmates. Prior to the opening of the facility, researchers from the Illinois Criminal Justice Information Authority and Loyola University Chicago provided assistance to those designing the new program, including a review of the relevant research literature and data analyses to help identify the appropriate target population for the program. Prior to the actual opening of Sheridan, senior staff in the Illinois Governor's Office and the Illinois Department of Corrections requested that the Illinois Criminal Justice Information Authority provide assistance and support to the new program in the form of an ongoing process and impact evaluation, which began when the Sheridan Correctional Center program began in January 2004. This report is the third in a series of evaluation reports documenting the implementation and impact of the Sheridan program, and is intended to provide a detailed and comprehensive assessment of the program after having been operational for 6 ½ years.

The Impetus for Sheridan

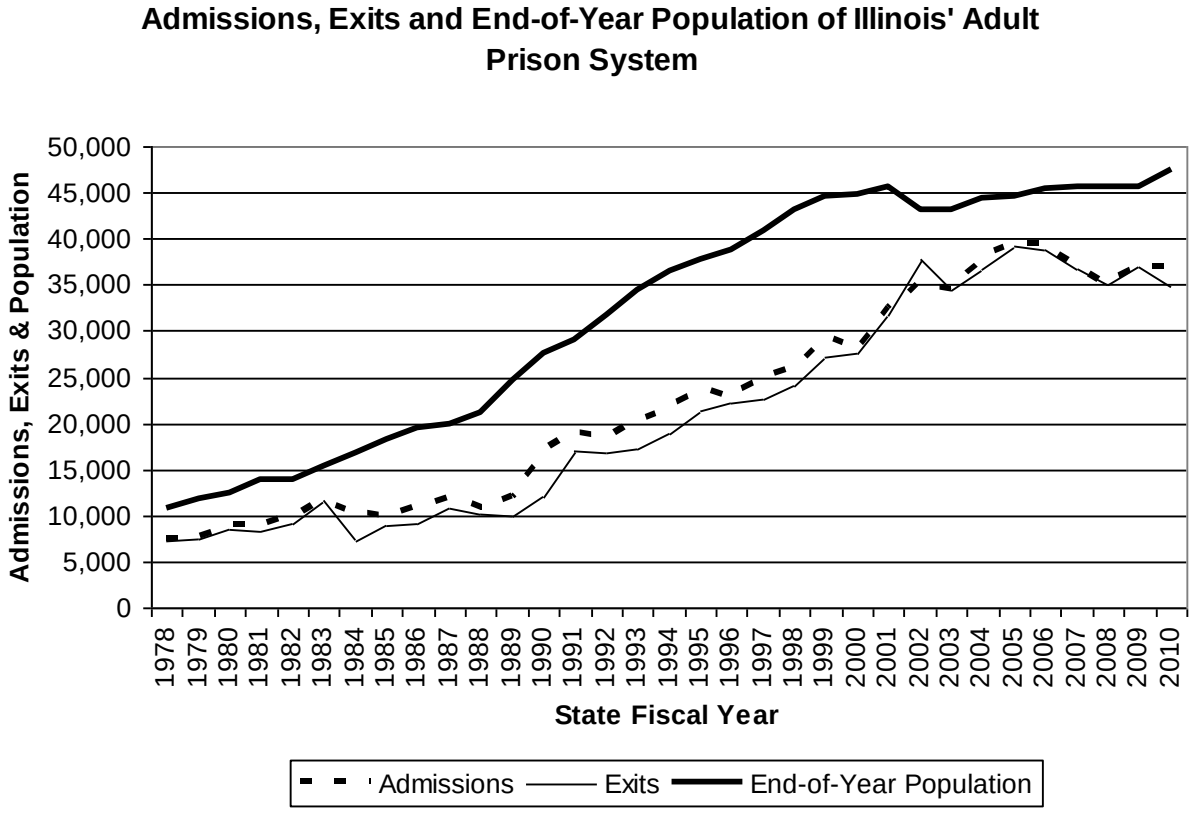
The Sheridan Correctional Center was reopened on January 2, 2004, as a prison that was fully-dedicated to providing adult male prison inmates with substance abuse treatment services and other rehabilitative programming through a modified therapeutic community design.[1] Every inmate admitted to Sheridan has been identified as in need of substance abuse treatment, and is required to fully participate in a wide array of treatment, vocational and educational programming while at the facility and following their release back into community. The impetus to have Sheridan focus specifically on the substance abuse treatment needs of inmates was fueled by a dramatic increase in the state's prison population, high rates of recidivism, and relatively low rates of access to substance abuse treatment services by inmates within Illinois' prison

[1] The Sheridan Correctional Center was closed in 2002 as a result of budget cuts. Sheridan reopened as a drug treatment prison on January 2, 2004.

system. Currently, Sheridan is one of 27 adult prisons (referred to as Correctional Centers) operated in Illinois by the Illinois Department of Corrections (IDOC).

During the 1980s and 1990s, Illinois' adult prison population grew at an unprecedented rate, steadily climbing from fewer than 20,000 inmates prior to 1987 to more than 45,000 by the end of calendar year 2001 (Figure 1). Since then, Illinois' prison population has stabilized, and at the end of fiscal year 2009 stood at roughly 45,000 inmates. This growth during the 1980s and early 1990s was fueled by three primary factors: 1) a dramatic increase in the number of felony drug-law violators arrested, convicted and sentenced to prison during this period; 2) an increase in the number of previously incarcerated individuals returning to prison due to new arrests or technical violations of their mandatory supervised release (MSR); and 3) an increase in the length of sentences, and time to serve, for those convicted of violent crimes, particularly those crimes subject to Truth-in-Sentencing. Illustrative of these patterns is not only the high proportion of prison admissions and exits in Illinois for drug-law violations, but a high proportion of the existing, end-of-the-year population accounted for by those sentenced to prison for violent crimes. For example, during 2004, 42.3 percent of all adults *admitted* to IDOC were convicted of a drug law violation, as were 43.2 percent of all those *released* from prison that year. However, that same year, only 22.7 percent of those admitted to prison in Illinois were convicted of a violent crime, but these same offenses accounted for more than one-half (51.8 percent) of the 44,054 adults in prison on December 31, 2004. This difference is due to the fact that, while violent offenders account for a relatively small proportion of admissions to prison, due to their relatively long lengths of stay, they accumulate, or build up, in the prison population. Drug law violators, on the other hand, despite accounting for a large proportion of admissions and exits from IDOC, accounted for only 25 percent of the prison population on that same date in 2004 (Jones, 2005), due to the fact that their lengths of stay in prison are relatively short, and therefore, they turn over in the prison population much more quickly than do the violent offenders.

Figure 1



Prior research in Illinois has also documented high rates of prior substance abuse histories and treatment need among those admitted to prison, regardless of their conviction offense, and drug-use and involvement in illegal drug activity also had a significant role in the high recidivism rate of inmates released from the Illinois Department of Corrections (IDOC). For example, during 1994, it was estimated that roughly 50 percent of adults admitted to IDOC were substance abusers in need of treatment (Cho, Johnson, Kelly-Wilson and Pickup, 2002), which is consistent with 2004 national estimates that have placed the prevalence of drug dependence or abuse at 53 percent among the nation's prison population (Mumola & Karberg, 2006). Despite this pattern, the availability of substance abuse treatment programs and services within IDOC, and nationally for that matter, during the 1990s and into the early 2000s was quite limited, and it is estimated that less than 20 percent of adult male inmates released from prison in Illinois who were in need of treatment were actually able to access it while incarcerated (Olson, 2005). Although there have been substance abuse treatment services provided to inmates within Illinois' prison system

prior to Sheridan, oftentimes the programs were very small and served only a fraction of those in need of these services. For example, during 2004 (the year that Sheridan opened), there were fewer than 2,000 substance abuse treatment "beds" available throughout IDOC facilities for adult males, and roughly one-third of these were within the Southwestern Illinois Correctional Center, or SWICC. SWICC is a 600-bed, minimum security prison located in East St. Louis, and operates as a fully-dedicated substance abuse treatment prison (i.e., all of the inmates at SWICC are involved in substance abuse treatment programming). All of the other treatment beds were distributed across different correctional centers in Illinois, most often operating as relatively small, specific treatment housing units within a larger, "traditional" prison.

The gap between treatment need and access is not only clearly evident *within* IDOC facilities, but it also extends to the communities Illinois' prison inmates are released back into, with relatively few able to access the needed services upon their release. Based on research conducted by the Urban Institute through their assessment of the needs of formerly incarcerated inmates returning to Chicago neighborhoods (LaVigne, 2004), it was determined that less than 10 percent had participated in substance abuse treatment programs within eight months following their release from prison.

Finally, Illinois, like most other states in the U.S., has experienced considerably high rates of recidivism (measured as return to prison) among those released. Leading up to the implementation of the Sheridan program, IDOC's 3-year recidivism rate (again, defined as return to prison) averaged around 50 percent, meaning that within three years of their release from prison, one-half of inmates released were returned to prison either as a result of a violation of their Mandatory Supervised Release (MSR, or "parole") or as a result of a new conviction and prison sentence. This recidivism rate peaked at 54.6 percent during 2004, the year Sheridan opened. Other research in Illinois published in 2004 found that the recidivism rate of inmates was even higher—nearly 66 percent-- when based on *rearrests* for a new crime within three years (i.e., regardless of whether it resulted in their subsequent return to prison) (Olson, Dooley, and Kane, 2004).

It was in response to these three factors: 1) large numbers of inmates being admitted to IDOC who were in need of substance abuse treatment, 2) relatively little substance abuse treatment services available within Illinois' prisons, and 3) a desire to reduce admissions to prison in Illinois by cutting the recidivism rate through effective treatment and rehabilitation programs, that the Sheridan Correctional Center was developed and opened as a fully-dedicated therapeutic community on January 2, 2004. Now, after 6 ½ years of operation and 4,328 successful graduates having matriculated through the prison-phase of the program, the evaluation team, which includes researchers from Loyola University Chicago, the Illinois Criminal Justice Information Authority, the Illinois Department of Corrections, and all the service providers involved with Sheridan, has examined in detail the program's operations, the extent and nature of services provided to the program participants and the impact on post-prison recidivism. This evaluation provides a detailed description of the major findings from the process and impact evaluation of Sheridan after 6 ½ years of operation.

What is the Sheridan Correctional Center Therapeutic Community?

The Sheridan Correctional Center is a medium security prison[2] housing adult male inmates who have been convicted of a felony offense and sentenced to the Illinois Department of Corrections by a judge. The prison is located about 70 miles southwest of Chicago, in Sheridan Illinois,[3] and when it was reopened in 2004, was rated to house 950 inmates. During 2006, an additional housing unit was built at Sheridan, and renovations of existing housing units that were in disrepair were made, so that as of December 31, 2008 Sheridan had a rated capacity of 1,300 inmates. Budget limitations and staffing did not allowed all 1,300 beds to be filled until spring of 2010, and Sheridan now has a 350 bed pre-treatment unit in addition to the 950 treatment beds at the facility. Sheridan is one of 27 prisons operated by the Illinois Department of Corrections. The facility consists of separate housing units of varying size and design, and each of these units is further separated into distinct Therapeutic Community (or TC) "families" or groups, consisting of roughly 20 to 25 inmates. Each group of inmates reside together, engage in group treatment

[2] In Illinois, prison security ratings range from Level 1 to Level 8, with Level 1 facilities being "Maximum Security," Level 7 being "Low Security," and Level 8 being "Transitional Living" (i.e., "Half-way" houses/Adult Transition Centers or ATCs). The Sheridan Correctional Center is classified as a Level 4 (Medium Security) facility.
[3] The City of Sheridan is relatively small, with a 2000 Census resident population (i.e., excluding inmates in the prison) of fewer than 1,000.

together, and support each other using the TC components of peer influence, including activities and interventions designed to learn and adopt social norms as well as personal and social responsibility.

In general, TCs are "residential [programs] that use a hierarchical model with treatment strategies that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills" (National Institute on Drug Abuse, 2002). At Sheridan, this is accomplished through the provision of individual and group treatment delivered by a contractual service provider. During the first two and a half years this was provided by the Gateway Foundation and, since November 2006, WestCare Foundation has been the treatment provider at Sheridan. In addition, inmates receive a variety of ancillary services, including educational programming, job training, vocational training, anger management classes, parenting skills, etc. (A more detailed description of the substance abuse treatment and other services provided to the inmates is described in Section IV).

Because Therapeutic Communities are one of the most common and widely studied drug treatment modalities for prison inmates (Lurigio, 2000), there is now a substantial body of empirical evidence that has shown how prison-based treatment programs operating under a TC design can generate substantial reductions in post-release recidivism patterns and drug use. The literature includes evaluations of specific prison-based TC programs, such as the Amity program operating in California (Wexler et al., 1999), those operating in Texas prisons (Knight et al., 1999; Knight et al., 2004) and the Key-CREST program in Delaware (Inciardi et al., 1997), as well as a number of meta-analyses of prison-based drug treatment interventions (Lipton, 1995; MacKenzie, 1997; Pearson & Lipton, 1999; Pearson et al., 2002; and Mitchell, Wilson & MacKenzie, 2006). The Mitchell et al (2006) review is one of the most comprehensive, rigorous and recent meta-analyses published on the effectiveness of incarceration-based drug treatment.

In general, most of the research on prison-based TCs has documented reductions in recidivism, although the magnitude of the reduction varied depending on the length of stay, the population served, and the inclusion of educational and vocational programming. For example, in the review

by Mitchell et al (2006; 31), it was noted that among the TCs examined most (15 of the 24 studies) were programs serving "non-violent" offenders, and that those programs serving "mixed" types of offenders (i.e., violent and non-violent) tended to produce lower, albeit still significant, improvements in outcomes. Further, Mitchell et al (2006;30-31) also concluded that corrections-based TCs that served large proportions of non-white offenders (where 70 percent or more of the sample was non-white), programs serving exclusively male offenders, and those institution-based TCs that did not require post-release aftercare all had smaller reductions in recidivism than did their counterparts. However, despite the apparent benefits of prison-based treatment and aftercare, a number of barriers to effectively implementing these strategies have been identified (Mears et al., 2003), including restrictions on the criminal backgrounds of program participants (Farabee et al. 1999), staff retention (Inciardi et al. 1992), prison crowding and limited bed-space (Office of National Drug Control Policy, 1999), and conflicting goals between the criminal justice and treatment personnel (Farabee at al. 1999; Morrissey, Steadman, and Kilburn, 1983; and Inciardi et al., 1992).

The literature on the effectiveness of prison-based drug treatment also appears to have reached the consensus that the benefits of in-prison treatment are magnified and sustained when offenders participate in aftercare services following their release from prison (Inciardi, et. al., 2004), although it should be noted that some (Welsh, 2007) have found reductions in recidivism associated with prison-based TCs that do not include aftercare. Thus, most have argued that in order to ensure long-term benefits of prison-based treatment, institutional treatment must be followed by aftercare or continued treatment in the community (Cullen & Gendreau, 2000; Gaes et al., 1999). Indeed, this recognition of the importance of aftercare for prison-based drug treatment was the primary reason the federal Residential Substance Abuse Treatment (RSAT) program had encouraged that participants in these federally funded prison-based treatment programs also receive aftercare services (Bureau of Justice Assistance, 2007). However, despite this encouragement, Harrison & Martin (2000) found that few sites receiving RSAT funds for prison-based treatment provided post-release aftercare, and Lipton, Pearson & Wexler (2000) specifically found that less than one-half of RSAT-funded programs placed participants in some type of aftercare. Further, it has generally been concluded that "inmates who complete treatment

frequently are transitioned directly into society without any type of reentry planning or development of plans for maintaining continuity of care" (Mears et al., 2003;6-8).

The Sheridan TC program is staffed by a combination of employees from the Illinois Department of Corrections and staff employed by contractual service providers, including WestCare (and until the fall of 2006, Gateway), the Safer Foundation, Treatment Alternatives for Safe Communities (TASC), Illinois Valley Community College, the Illinois Home Builder's Association and the Illinois Manufacturer's Association. Based on information published in the Illinois State Budget Book for fiscal years 2007 through 2010, the total number of IDOC staff employed at Sheridan, including the security, counseling, educational and administrative staff, totaled 278 during state fiscal year (SFY) 2007, 279 during SFY 2008, 303 for SFY 2009, and the SFY 2010 budget called for a total of 304 IDOC employees to support the expansion of Sheridan's capacity to 1,300 inmates. In addition to IDOC staff, there are also a number of other staff employed by the contractual service providers. For example, during 2007, additional, non-IDOC staff, included 76 staff from WestCare, primarily substance abuse counselors; 29 staff from the Safer Foundation, a non-profit organization that provides job preparedness classes and programming at Sheridan, as well as job placement support once inmates are released; and 33 staff from TASC, which screens inmates for Sheridan eligibility at the IDOC Reception and Classification Centers in Illinois, and also provides clinical case management and treatment referrals for inmates after they are released from Sheridan. Finally, there are also staff at Sheridan who are employed by Illinois Valley Community College, the Illinois Home Builder's Association and the Illinois Manufacturer's Foundation (IMF), both of which provide vocational training and programming. In total, there are more than 420 full-time staff serving the inmates at Sheridan as well as those released from Sheridan and on Mandatory Supervised Release.

The overall budget for the Sheridan Correctional Center TC, which includes IDOC staff, all of the contractual service providers, and contractual arrangements for all the post-release aftercare treatment and ancillary services, has totaled between $34 million and $47 million annually during the six full state fiscal years it has been in operation.[4] On an annual basis, the proportion

[4] Sheridan opened mid-way through state fiscal year (SFY) 2004. The enacted appropriation for SFY 2005 was $35.4 million, in SFY 2006 it was $34.6 million, in SFY 2007 it was $37.7 million, in SFY 2008 it was $41.7 million, in SFY 2009 it was $47.5 million, and in SFY 2010 it was $45.3 million. The increase for SFY 2008, 2009, and 2010 was to allow for the newly constructed housing unit to be fully staffed, which increased the capacity of

of Sheridan's overall budget designated for contractual services, which is primarily for the services provided by WestCare, TASC, Safer, Illinois Valley Community College, the Illinois Home Builder's Association and the Illinois Manufacturer's Association, ranged from 37 to 42 percent. Sheridan's total operational budget comes from state general revenue funding, and does not include any federal funding.[5] Although the published per-inmate costs of operating the Sheridan Correctional Center during SFY 2008 was roughly $43,000 (Illinois Department of Corrections, 2009), one of the difficulties in attempting to measure the "per-participant" cost of the Sheridan program is that there are incarceration costs incurred while the inmate is housed at Sheridan, which include the costs associated with the security and treatment services provided *at Sheridan*, *as well as post-release costs incurred during the participant's post-release supervision*, including clinical case management, additional aftercare treatment, employment referrals and placements, and housing-related referrals and placements. Thus, the average daily population (ADP) of inmates *at Sheridan* during SFY 2008 was 943 (which was used to calculate the per-inmate cost of $43,000), but there were also more than 600 Sheridan inmates released to MSR during SFY 2008, and on June 30, 2008, 421 Sheridan releasees were on active parole supervision *in the community*. Thus, the expenditures for Sheridan in SFY 2008 served more than 1,300 Sheridan participants on any given day (the ADP of 943 plus the 421 Sheridan releasees on MSR on any given day), which would translate into a cost of roughly $30,000 per person that year.[6]

When the Sheridan program is discussed in this report, the two primary components of the program—the institutional component and the post-release component--will be described separately. The institutional component includes the time spent and services inmates receive while in prison, whereas the post-release component includes the period following release from Sheridan during mandatory supervised release (MSR), and the services they receive in the

Sheridan from 950 to 1,300 inmates, however, due to fiscal pressures, it was not possible to actually expend all of these appropriated funds to increase the capacity until SFY 2010.

[5] Although all operational costs for Sheridan come from state general revenue funds, a portion of the funding for the construction of the new housing unit that was built to expand the capacity from 950 to 1,300 inmates did come from federal Violent Offender Incarceration/Truth-in-Sentencing (VOI/TIS) grant funding.

[6] The average daily population of Sheridan during SFY 2008 was 943 plus the 421 Sheridan releasees still on active MSR at the end of SFY 2008 totals 1,364. This can be interpreted as the average number of participants being served by the Sheridan program (and supported through the Sheridan budget) on any given day. Taking the SFY 2008 expenditures for Sheridan of $41 million and dividing it by this average of 1,364 produces an annual per-participant cost of $30,058.

community. This post-release component of the program, which requires inmates released from the Sheridan Correctional Center to participate in clinically determined aftercare treatment services, has been emphasized as critical to long-term success (i.e., reductions in recidivism and subsequent drug use) in both the research literature described previously as well as federal regulations when states utilize Residential Substance Abuse Treatment (RSAT) grant funds to support in-prison treatment programs.

Assessment for Sheridan Eligibility & Recruitment

When an adult male inmate is sentenced to prison in Illinois, he is initially admitted into one of three Reception and Classification Centers (R&Cs)—the Stateville R&C in northern Illinois, the R&C at the Graham Correctional Center in central Illinois and the R&C at the Menard Correctional Center in southern Illinois-- where he undergoes a variety of interviews and assessments to gauge his needs and security risks. It is during this R&C process that inmates are screened to make security classifications and to identify specific types of service needs an inmate may have. Following a brief period of time at the R&C, which can range anywhere from one to two weeks to a month, inmates are then transferred to their "parent" institution, which is selected based on a combination of factors, including available bed space, security classification, and the programmatic needs of the inmate. For example, inmates in need of specialized sex offender treatment may be transferred and housed at the Big Muddy Correctional Center, which has these types of services available. Similarly, inmates suffering from severe mental illness may be transferred and housed at the Dixon Correctional Center where they will be given specialized services. At the other end of the continuum, inmates sentenced to death or life in prison, or those who have attacked staff in the past or have extensive histories of violence and attempted escape, will be transferred to one of the state's maximum security prisons based on the high security risk that such inmates may pose.

During the R&C process, one of the dimensions of need that is assessed is the extent and nature of the inmate's substance abuse history and their need for treatment. Prior to the implementation of Sheridan, there was no formal, system-wide mechanism to determine an inmate's substance abuse history or need for substance abuse treatment within IDOC. As a result of the Sheridan

program, and the need to objectively identify inmates in need of the treatment services being implemented at Sheridan, the Illinois Department of Corrections contracted with a community-based organization, Treatment Alternatives for Safe Communities (TASC), to screen ***every*** inmate admitted to each of the Reception and Classification Centers for drug abuse and treatment need. To achieve this, TASC staff adopted the Texas Christian University Drug Screen II (TCUDS-II) instrument to triage those inmates who demonstrated a need for substance abuse treatment. The validity and reliability of the TCUDS II has been tested and determined to accurately and efficiently identify those in need of treatment (Peters et al., 2000). Although the use of the TCUDS-II has been in place at the Stateville R&C since Sheridan reopened (January 2004), its use was not fully implemented in the other two R&Cs until April 2004.

Further, it was not until the end of 2006 that the information obtained through the TCUDS-II was fully incorporated into IDOC's system-wide computerized information system, referred to as the Offender Tracking System, or OTS. As a result of the system-wide use of the TCUDS-II, and its incorporation into IDOC's OTS, IDOC now has the capability to track inmate need for substance abuse treatment throughout all of their institutions. In addition, IDOC is also now able to maintain a system-wide waiting list of inmates identified as in need of substance abuse treatment. Inmates placed on the waiting list may not have been eligible for Sheridan (or any of the other substance abuse treatment programs within IDOC) when they were admitted, such as when their time to serve was too long, or there were no treatment slots open at Sheridan. For other inmates, their initial security classification may have prevented them from initially being housed in a facility that may have offered treatment programming, but over time this may change, making them eligible for placement in a lower-security level facility. As will be seen later in this report, this treatment waiting list is now being used to identify inmates for Sheridan.

Eligibility for Sheridan

Relative to other prison-based TCs in the United States, which often limit eligibility to only those convicted of a drug-law violation or DUI, or are only used to serve probation or parole violators,[7]

[7] During the planning phase of Sheridan, staff from the Illinois Criminal Justice Information Authority contacted the Department of Corrections in every state to determine if they operated a prison/large unit within a prison as a TC,

the eligibility criteria for inmates to participate in Sheridan is quite inclusive. Indeed, during the planning phase of Sheridan in 2003, initial "pipeline" studies performed by staff from the Illinois Criminal Justice Information Authority and the Illinois Department of Corrections determined that in order to keep Sheridan operating at a level that would maximize access to the services (i.e., keep the population around 950 inmates), the eligibility criteria could not be too restrictive. For example, one proposed target population for Sheridan had been inmates sentenced to prison exclusively for "low-level drug possession offenses." However, based on analyses of prison admissions and some assumptions regarding need for treatment,[8] it was projected that fewer than 400 inmates per year would meet the basic criteria of being appropriate for a medium security facility and having 6 to 24 months of time to serve, primarily due to the short length of stay for a large number of those admitted to IDOC. After a number of different iterations of potential eligible populations, the following final criteria were ultimately developed and adopted to identify the eligibility pool[9] for inmates to participate in Sheridan:

1) They are identified as in need of treatment based on a brief drug-screen (the TCUDS-II described above) at the Reception and Classification Center and a subsequent comprehensive drug assessment (the Addiction Severity Index, or ASI) performed at Sheridan;[10]
2) They are projected to serve between 6 and 24 months in prison at Sheridan based on the general research literature regarding treatment effectiveness and treatment "dose." The length of time to serve in order to be Sheridan-eligible was later changed in the fall of 2006 to 9 to 24 months, as a result of an evaluation finding that indicated inmates who spent less than 9 months at Sheridan did not have recidivism rates substantively lower

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and many specified that only those convicted of drug-possession were eligible, whereas a few others selected only those admitted to prison for DUI offenses.

[8] It is important to note that, as described earlier in this report, prior to the opening of Sheridan there were no systematically collected data within the Illinois prison system to gauge need for substance abuse treatment. Thus, in order to project the likely prevalence of treatment need during the pipeline studies, the estimated prevalence of treatment need generated from a small-scale prevalence study done in 1994 by the Illinois Department of Alcoholism and Substance Abuse (DASA) was one of the data points used in the projected numbers of inmates who would be eligible/need treatment services at Sheridan.

[9] Based on the final set of eligibility criteria, it was projected that each year there would be roughly 8,000 to 9,000 inmates admitted to IDOC that would be in need of treatment, appropriate for a medium security prison, and meet the length of time requirements.

[10] During the first 6 ½ years of operation, only 10 inmates out of the more than 6,680 inmates admitted to Sheridan were identified as not having a substance abuse problem after the ASI was completed.

than inmates who did not get treatment (these findings are described in more detail in section VI of this report), and during SFY 2010, the length of time participants can be at Sheridan was changed to a minimum of 9 months and a maximum of 36 months. In order to ensure between 9 and 36 months of participation in the prison-phase of the program, inmates who are technical parole violators or who have outstanding warrants/detainers are excluded from participating because their length of stay in IDOC cannot be accurately determined and it could limit their ability to access or receive aftercare services.

3) They are not serving a sentence for murder or a sex offense, and do not have murder or sex offenses in their criminal background;[11]
4) They are appropriate for placement in a medium security facility and do not have current mental or medical health issues so severe that they cannot be addressed/managed at Sheridan;
5) They volunteer for the program; and,
6) They have not previously participated in the Sheridan program.

During the implementation of Sheridan, some of these eligibility criteria proved difficult to fully assess or gauge during the Reception and Classification phase of processing, and again, prompted some changes to the R&C process and specifically how potential Sheridan-eligible inmates were identified and screened. For example, during the period of R&C processing when inmates are assessed for their substance abuse treatment need by TASC staff, oftentimes the estimated projected length of time to serve has not been fully determined or calculated. Inmates admitted to prison in Illinois may or may not have been given credit for time served in a county jail while waiting for the disposition of their case, may or may not be required to serve 85 percent of their sentence based on Illinois' Truth-in-Sentencing laws, and may or may not be eligible for day-for-day good conduct credit (GCC), meritorious good conduct credit (MGCC), supplemental meritorious good conduct credit (SMGCC), or Earned Good Conduct Credit (EGCC) for their participation in substance abuse treatment, vocational and educational

[11] Prior to April 2006 the restriction was on inmates serving a current sentence for a murder or sex offense. In April 2006 the restriction was modified to also prohibit inmates with *prior* murder or sex offenses from participating in the Sheridan program.

programming.[12] Thus, out of all those inmates admitted to prison in Illinois with, for example, a 4 year sentence, the exact amount of time they will actually spend in prison can range from less than 6 months to 3 ½ years, depending on jail credits and eligibility for various good conduct credits. As a result, TASC staff now attempt to make rough estimates of projected time to serve in IDOC before they actively recruit inmates who may be in need of treatment and could potentially be eligible for Sheridan.

Another issue related to eligibility was identified early on during the implementation of the Sheridan program and pertains to an inmate's prior arrests for sex offenses or murder. During the initial discussions of program eligibility—prior to the facility actually opening—it was determined that sex offenders and murderers would not be eligible to participate at Sheridan. For the most part, this was of little concern in terms of screening because inmates sentenced to prison in Illinois for these offenses would almost always be excluded from eligibility due to their projected lengths of time to serve. In Illinois, those sentenced to prison for criminal sexual assault and murder must, under Illinois' Truth-in-Sentencing law, serve 85 percent and 100 percent of their sentences, respectively. Given the original goal of 6-24 months of projected time to serve, the likelihood of sex offenders and murderers ending up at Sheridan was almost non-existent. However, during preliminary analyses of the profile of inmates admitted to Sheridan it was determined that a *small* proportion of inmates did have *prior* arrests for sex offenses,[13] although no one was admitted to Sheridan who was serving their current sentence for a sex offense. After this was determined, those involved in the development of Sheridan clarified that their intent of prohibiting sex offenders at Sheridan included barring those with past arrests for sex offenses as well. Thus, the eligibility criteria for Sheridan were specified further to exclude inmates with *prior* arrests for sex offenses.

[12] Unless prohibited by Illinois' Truth-in-Sentencing law, which limits the amount of good conduct credit that can be earned by those convicted of specific offenses, inmates sentenced to prison in Illinois are able to reduce their length of stay by 1 day for every day that they are compliant with IDOC's rules, which essentially reduces their length of stay to ½ of their sentence. In addition, most inmates are also eligible to receive an additional 90 days good conduct credit for meritorious service (meritorious good conduct credit), and another 90 days of supplemental meritorious good conduct credit for inmates who were not convicted of specific violent crimes.

[13] During the 6 ½ years of operation, a total of 19 inmates out of the 6,680 admitted to Sheridan were subsequently removed from Sheridan because they had prior sex offenses in their criminal background and were transferred to another facility. Almost all of these cases—16 of the 19--occurred during the first two years of operation.

Sheridan's Pre-Treatment Unit

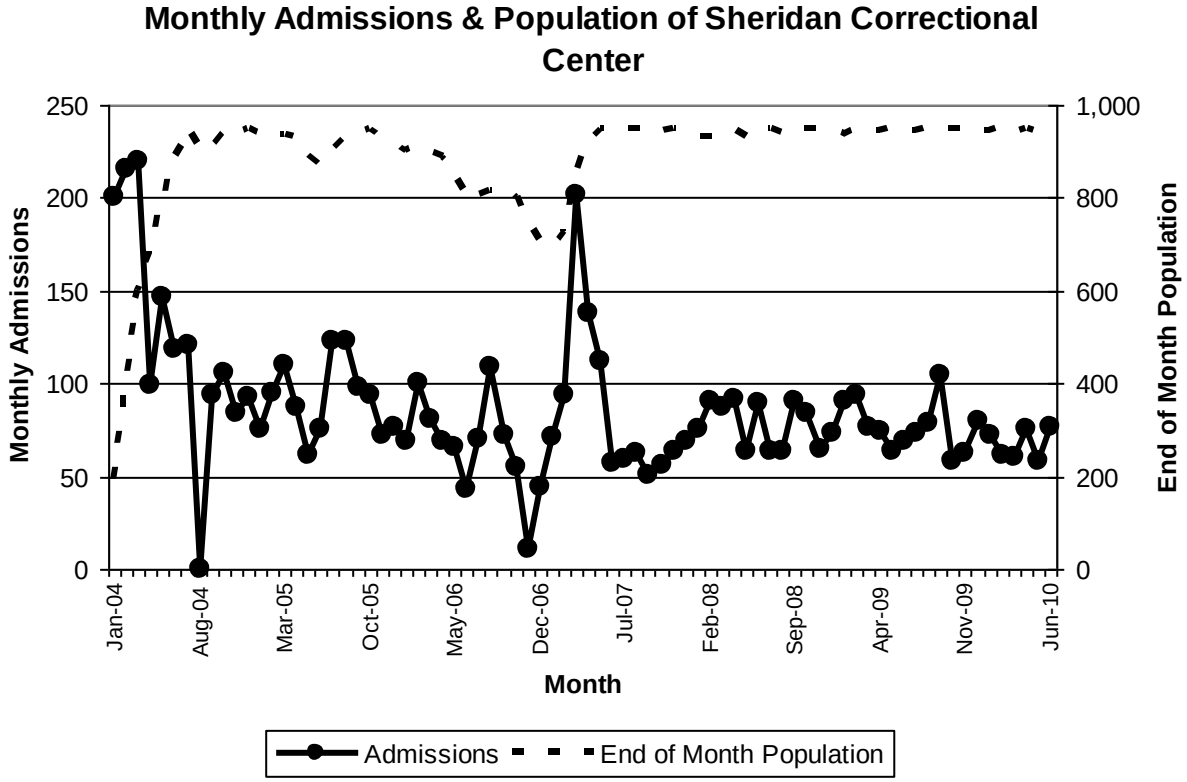
As described earlier, in the Spring of 2010, a pre-treatment unit was opened at the Sheridan Correctional Center, increasing the number of inmates housed at the facility from 950 to 1,300. Part of what necessitated the need to open this pre-treatment unit, and utilize the 350 vacant beds at Sheridan, was a crowding situation within Illinois' prison system. However, while there were resources available to have IDOC personnel staff this unit, the contracts with the service providers—namely the substance abuse treatment provider, Westcare, Safer, TASC, Illinois Valley Community College, and the Home Builder's Institute—were only budgeted to serve the inmate population of 950. As a result of this situation, there were very few resources available to provide any services to the inmates housed in the pre-treatment unit other than the "basic" types of programming available to inmates at other facilities, such as Adult Basic Education (ABE) or GED-preparation classes. Many of the inmates transferred to Sheridan from other facilities and placed in this pre-treatment unit were not aware that they would not be going directly into treatment, which caused some degree of resentment among those inmates transferred into the pre-treatment unit. Although Westcare staff have attempted to provide some counselor-led group discussion and pre-treatment readiness programming to inmates in the pre-treatment unit, this is limited to only about 1 hour per day per housing unit and the time spent in this "stage" does not count towards an inmate's Earned Good Conduct Credit, if they are eligible for this credit to their sentence. Because inmates in the pre-treatment unit are not formally enrolled in treatment (i.e., are not getting substance abuse treatment counseling services), they are not included in the analyses of participant characteristics, matriculation, services received or post-release outcomes. Further, because of this pre-treatment unit, it is now possible that inmates eligible for Sheridan other than their projected length of time to serve being above the maximum can be admitted to Sheridan, housed in the pre-treatment unit, and then transferred into the treatment program once their projected time to serve in the treatment is consistent with the eligibility criteria.

II. ANALYSIS OF SHERIDAN POPULATION FLOW

Admissions & End of Month Populations

During the 6 ½ years of program operation described in this report (January 2, 2004 through June 30, 2010), a total of 6,680 inmates were admitted to Sheridan, with monthly admissions ranging from 200 or more per month during the start-up of the program in 2004, and as recently as March 2007, to fewer than 50 per month during periods when the facility was operating at capacity or periods of program transition (Figure 2). In November 2009, the pre-treatment unit was established, resulting in an overall increase in the population at the Sheridan Correctional Center to 1,362 by June 30, 2010. All analyses presented in this report are only for those individuals who are actually admitted into the treatment program at Sheridan, and do not include the pre-treatment participants. In general, the pre-treatment unit consists of inmates who meet the eligibility criteria for Sheridan, but are not receiving any treatment services since these were budgeted for 950 inmates and not the entire 1,300 inmates housed at the facility.

Figure 2



During the first three months of program start-up, the goal was to admit roughly 50 inmates per week (200 per month), and the program easily accomplished this goal. Admissions for the following months were a bit below this original goal of 50 per week because of the need to continue hiring staff, particularly treatment staff, so that all of the housing units had the full complement of treatment staff. By the end of July 2004, the facility had reached its operational capacity—at that time-- of housing 950 inmates. Thus, during August 2004, there were no new admissions to Sheridan because the facility had reached its capacity and the first cohorts of program graduates were being released from the facility. During this month, Sheridan did not have any new admissions and worked extensively to ensure that the pre-release planning and post-release linkage to services were in place and operating as expected. During the remainder of 2004 and all of 2005, the number of new admissions to Sheridan was primarily driven by capacity and the number of exits from the program: as inmates were discharged or removed from Sheridan, and beds became available, new admissions were made to the facility. During the first two full years of operation, the average end of the month population at Sheridan ranged between 900 and 950 inmates (the dashed line in Figure 2).

As seen in Figure 2 (solid line), admissions to Sheridan during 2006 averaged approximately 66 per month, which was lower than in the previous year, and the average end of the month population of the facility also decreased considerably, ranging from a high of 915 in February 2006 to a low of 697 in January 2007. This decrease in admissions during 2006, and the subsequent impact on the population of Sheridan in early 2007, can be attributed to four specific factors, including (in chronological order):

1) A strike by some of the treatment staff during June 2006;[14]

2) Staff shortages at Sheridan (among both the treatment provider and the IDOC security staff) during the end of state fiscal year 2006 (which ended June 30, 2006), resulting in the need to have some of the housing units empty due to these security staffing issues;

3) A change in the primary treatment provider (from Gateway to WestCare) in November

[14] On June 6, 2006, approximately 40 of the 53 treatment counselors employed by Gateway Foundation, Inc., walked off their jobs after 6 months of contract negotiations due to issues related to salaries. The strike finally ended in August when Gateway Corporation agreed to discontinue its role in the Sheridan program, as well as treatment programs at other prisons in Illinois (http://cbs2chicago.com/topstories/lasalle.prison.lasalle.2.331615.html). The treatment services for the inmates were delivered during the period of the strike by management staff and counselors who did not strike. By November 2006, a new treatment provider (WestCare) was selected and took over the provision of substance abuse treatment services at Sheridan.

2006; and,

4) A change in the eligibility criteria from a minimum of 6 months to a minimum of 9 months projected time to serve at Sheridan in November 2006.

However, as seen in Figure 2, by the beginning of 2007, admissions to Sheridan once again began to increase and the population at the facility rose to full capacity as the new treatment provider was in place at Sheridan and the strike by the counselors had ended. In addition, the issues related to having more accurate estimations of projected time to serve at the R&Cs had been resolved, and staffing levels among both the IDOC staff and the treatment provider had been increased. Thus, admissions to Sheridan increased dramatically, from an average of 66 per month during 2006 to an average of 86 per month during 2007, including 201 admissions in March 2007. As a result, by the end of State Fiscal Year 2007 (June 30, 2007), Sheridan was once again operating at its full capacity, with an end of the month population of almost 950 (949). Between July 1, 2007 and June 30, 2010, Sheridan has been able to maintain an end-of-the-month population of between 921 and 952 inmates (Figure 2), before increasing to 1,362 as a result of the pre-treatment unit opening on the grounds of the Sheridan Correctional Center.

Another aspect of admissions to Sheridan that needs to be pointed out is that most of those admitted to Sheridan have been admitted directly from one of the Reception and Classification Centers shortly following their admission to prison. However, a portion of those admitted to Sheridan were inmates who had been serving their sentences at other prisons in Illinois, and were transferred from those facilities to complete their sentences at Sheridan. In fact, among the first cohort of inmates admitted to Sheridan was a group of 25 inmates who had been incarcerated in other prisons in Illinois where they were already participating in TC programs; although in these other facilities, the TC programs were operating as specific housing units within larger prisons. The goal with this initial cohort of transfers was to have a group of inmates that knew how TCs operated, but there was also a need for some of those inmates who were going to be among the first admitted to the facility to also "know IDOC." Specifically, the institution needed inmates who could be ready to work in various assignments that were necessary for the operation of the prison, including dietary and maintenance. Thus, during the first month of operation (January 2004), 25 of the 200 inmates admitted to Sheridan came from other institutions rather than

directly from an R&C, which is from where the other 175 inmates admitted during January 2004 came.

During the 6 ½ years of operation evaluated, the proportion of admissions to Sheridan that came from other prisons, as opposed to directly from one of the R&Cs, increased dramatically between 2004 and 2008, primarily as a result of the development of the statewide treatment waiting list described previously. As seen in Table 1, during 2004, there were a total of 53 inmates admitted to Sheridan from other facilities (accounting for roughly 4 percent of all Sheridan admissions that year), but by 2007, nearly one-quarter (255 of the 1,039 admissions) were transfers from other facilities. During 2008 and 2009, less than 15 percent of Sheridan admissions were accounted for by inmates transferred from other IDOC facilities as opposed to coming directly from an R&C.

Table 1
Number and Percent of Sheridan Admissions from Reception & Classification Centers versus Transfers from Other Illinois Prisons, 2004-2010

Calendar Year	Admissions from R&C	Transfers from Other Facilities	Total Admissions	Percent of Total Admissions from Other Facilities
2004	1,445	53	1,498	3.5%
2005	1,032	58	1,090	5.3%
2006	715	74	789	9.4%
2007	784	255	1,039	24.6%
2008	806	131	937	14.0%
2009	800	124	924	13.4%
2010*	287	116	403	28.8%
Total	5,869	811	6,680	12.1%

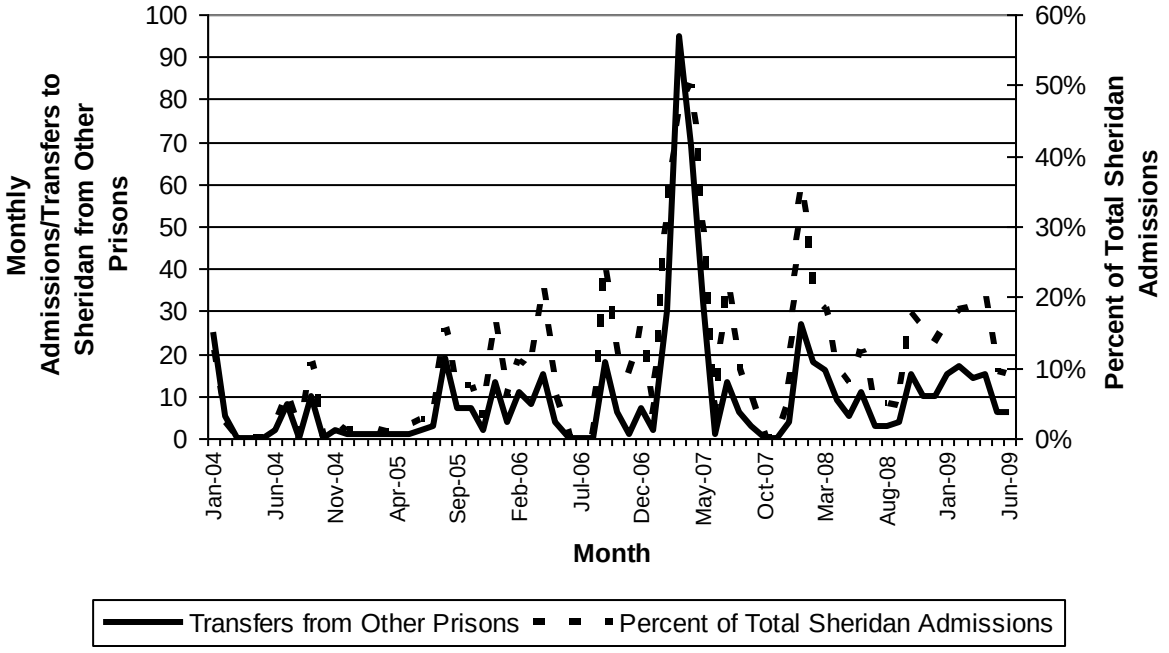
*Through June 30, 2010

However, examining admissions into Sheridan accounted for by transfers from other prisons on a *monthly* basis reveals that the number and proportion of Sheridan admissions from other facilities (as opposed to the R&Cs) varied widely during the 6 ½ year period, reaching a peak of 94 inmates during March 2007, or nearly 50 percent of all admissions during that month (Figure

3).[15] Much of this increased ability to transfer inmates in need of treatment from other facilities to Sheridan was the result of the statewide treatment waiting list that was developed within the Illinois Department of Corrections Offender Tracking System (OTS), which now makes it easier to identify inmates who may have been in need of treatment when admitted to IDOC, but who had too long of a projected time to serve at that point (i.e., more than 24 months) to be eligible for Sheridan, or there was no room at the facility. Of those transferred from other institutions from SFY 2004 through 2010, the *median* time between their admission to prison and their ultimate transfer to Sheridan was 356 days (almost one year), and the *average* was 504 days. [16]

Figure 3

Monthly Admissions/Transfers to Sheridan From Other Prisons in Illinois (Excluding R&Cs), Number & Percent of Total



[15] The large number of inmates transferred from other facilities in March 2007 was achieved through a combination of the treatment wait list and concerted efforts by staff at other IDOC facilities to identify eligible inmates for transfer to Sheridan.

[16] This higher average, relative to the median, is due to a relatively small number (8 percent of those inmates transferred from other facilities) having spent relatively long periods of time —3 years or more—at other facilities prior to being transferred to Sheridan. Among those Sheridan inmates transferred directly from one of the Reception and Classification Centers, the average number of days between admission to IDOC and transfer to Sheridan was 18.6 days, with a median of 14 days.

Patterns of Exits & Removals from Sheridan

There are essentially 3 different mechanisms through which an inmate can exit the Sheridan Correctional Center. First, are those inmates who successfully complete the prison-based component of Sheridan and are subsequently released back to the community under Mandatory Supervised Release (MSR), or "parole." Second, are those inmates who violate the rules at Sheridan and are subsequently removed due to disciplinary reasons and transferred to another prison in Illinois. Depending on the nature of the disciplinary infraction, inmates can be transferred to higher-level security facilities, including being placed in one of the state's maximum security facilities. Lastly, are those inmates who, after being transferred to Sheridan, are determined to not meet the eligibility criteria for Sheridan (e.g., their time to serve is too long or short, they have severe mental health or physical health issues that cannot be addressed at Sheridan, etc). Again, these inmates are removed from Sheridan and transferred to another facility, although usually not to a higher-level security facility, but rather, to one that can better serve their needs (i.e., medical, mental health).

Examining the population flow into and out of Sheridan in aggregate also provides a picture of the effectiveness of the screening process and the capacity to matriculate participants through the program successfully. Summarized in Table 2 are the total numbers of inmates admitted to, and released or transferred from, the facility during the entire 6 ½ year period of operation examined in this evaluation (2004 through June 2010). As seen in Table 2, out of all those admitted to Sheridan during the 6 ½ year period (6,680), a total of 4,328 inmates (75.6 percent of all exits) had successfully completed the prison component of the program and were released to Mandatory Supervised Release (MSR or "parole")[17] or an Adult Transition Center (ATC).[18] On

[17] Illinois operates under determinate sentencing, meaning that an inmate's release from prison is not based on the decision of a parole board, but rather the completion of the sentence imposed by the court. However, inmates released from prison are required to be supervised for a period of time, and often this time period is referred to as "parole" by practitioners, policy makers and the media, and the "agents" that supervise these offenders are referred to as "parole agents." How long a released inmate serves on "mandatory supervised release," or MSR, is set by Illinois statute based on the felony class of the crime for which the inmate had been sentenced to prison. Specifically, those sentenced to prison for murder or a Class X felony must be on MSR for a period of 3 years, Class 1 or 2 felonies a period of 2 years, and Class 3 or 4 felonies a 1 year period of MSR. If an inmate violates the conditions of their release, they can be returned to prison and can be required to serve the remainder of their MSR back in prison.

the other hand, 1,069 inmates were removed from Sheridan for disciplinary reasons, accounting for 18.7 percent of all those exiting Sheridan and 16.0 percent of all those admitted to Sheridan during the 6½ year period. Finally, 325 inmates were removed from Sheridan due to non-disciplinary reasons or 5.7 percent of all those who exited Sheridan and 4.8 percent of those admitted to Sheridan during the 6 ½ year period. A more detailed description of the characteristics of those admitted to Sheridan, and the characteristics and reasons for disciplinary and non-disciplinary removals, follows. The post-discharge experiences and outcomes of those participants who successfully completed the institutional phase of Sheridan are discussed later in this report in Section VI.

Table 2
Sheridan TC Admissions, Exits & Existing Population, January 2004 – June 2010

	Number	Percent of Total Admissions [1]	Percent of Total Exits [1]
Total Admissions	6,680	100.0%	
Currently At Sheridan (6/30/2010)	949	14.2%	
Exits *	5,731	85.8%	100.0%
Successful Graduates/Exits **	4,328		75.6%
Disciplinary Removals	1,069		18.7%
Non-Disciplinary Removals	325		5.7%

[1] Percentages may not add up to 100% due to rounding.
* Included in the total exits, but not within the specific sub-categories, are 5 inmates who died at Sheridan and 4 inmates who had their sentences vacated or had other extraordinary circumstances resulting in their released.
** Includes 4,162 discharged to Mandatory Supervised Release and 166 released to an IDOC Adult Transition Center (ATC).

Non-Disciplinary Removals

The number and rate of inmates initially admitted to Sheridan and subsequently removed for non-disciplinary reasons—primarily because it was determined that they did not meet the eligibility criteria-- has remained relatively low and stable. During the entire 6 ½ year period, only 325 of those admitted to Sheridan, or less than 6 percent of all exits from Sheridan (Table

[18] Out of all those who successfully completed the prison-phase of the Sheridan program and released, 166 of the 4,328 were released to an Adult Transition Center, a minimum-security, community-based residential setting operated by either the IDOC or a contractual provider. ATCs allow inmates to leave this residence to work or attend treatment or other vocational programming, but they must return and reside there during non-working or non-treatment hours.

2), were removed due to non-disciplinary reasons and were subsequently transferred to another IDOC facility. The most frequent reasons for non-disciplinary transfers included:

1) Mental health issues that interfered with the inmates' ability to participate in the program, accounting for 65, or 20 percent of all non-disciplinary transfers;
2) Outstanding warrants or detainers that were either going to require the inmate to appear in court frequently, and therefore resulted in their not being able to participate fully in the program, or that were going to result in the inmate being sentenced to prison again or deported following their release from prison for their current offense, which would limit their ability to participate in aftercare, accounting for 69, or 21 percent of all non-disciplinary transfers;
3) Inmates who were initially admitted to Sheridan but were later determined to have either too much or too little time to serve to meet program eligibility requirements, or who had a criminal history that prohibited their participation in Sheridan, accounting 74, or 23 percent of all non-disciplinary transfers;
4) The remaining 116, or 36 percent of the non-disciplinary transfers, included inmates with a variety of issues that prohibited their participation at Sheridan, including serious medical conditions, safety concerns related to being housed with specific inmates, or staff "familiarity concerns" (i.e., the inmate was somehow related to staff, or was a friend of a staff person prior to their incarceration).

Although the overall rate of "inappropriate" inmates being referred to Sheridan is low, and has been relatively stable over the 6 ½ years of operation (Table 3), it does illustrate the difficulty of being able to determine or access certain types of information or records during the relatively brief (2 weeks) period of screening at an R&C. For example, during 2004, the 74 non-disciplinary removals accounted for less than 5 percent of all the admissions to Sheridan that year, while, during 2009, there were 54 removals for non-disciplinary reasons, which accounted for less than 6 percent of all the 2009 admissions (Table 3). As seen in Table 3, during the first half of 2010, the number and percent of admissions removed for non-disciplinary reasons has been even lower than in previous years.

Table 3
Number and Rate of Non-Disciplinary Removals from Sheridan, by Year

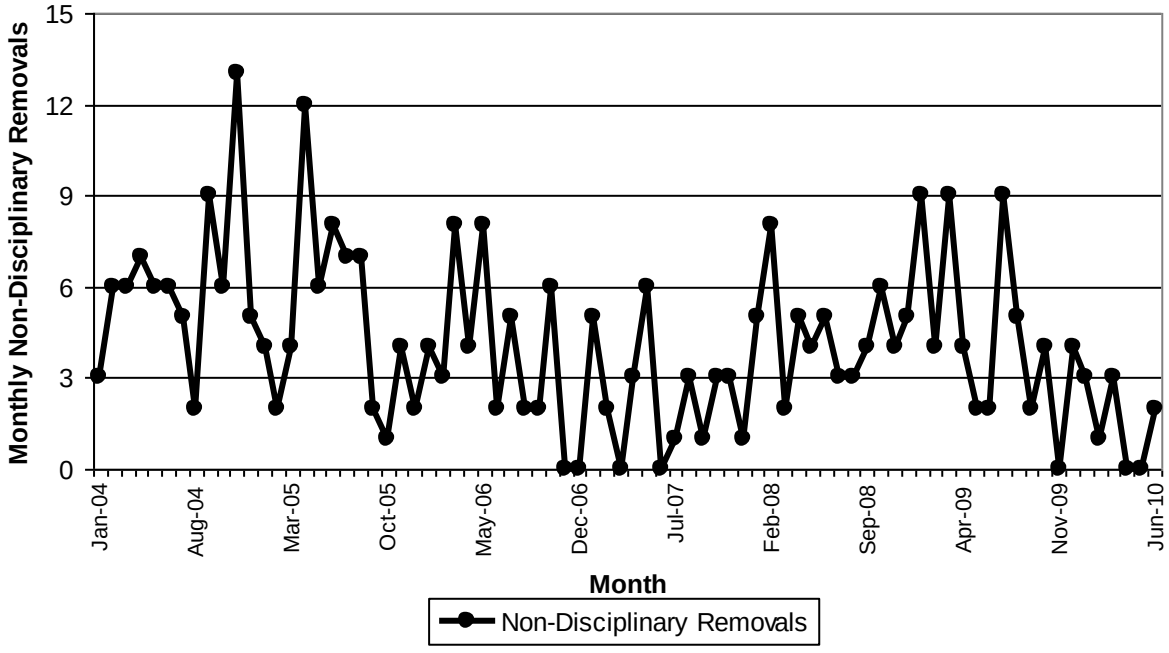
Calendar Year	Non-Disciplinary Removals	Total Admissions to Sheridan	Non-Disciplinary Removals as a Percent of Admissions
2004	74	1,498	4.9%
2005	59	1,090	5.4%
2006	44	789	5.6%
2007	28	1,035	2.7%
2008	54	937	5.8%
2009	54	924	5.8%
2010 *	8	403	1.9%
Total	**324**	**6,680**	**4.8%**

* Through June 30, 2010

However, when the number non-disciplinary removals were examined on a *monthly* basis, the number ranged from 0 in four of the months to more than 10 in others (Figure 4).

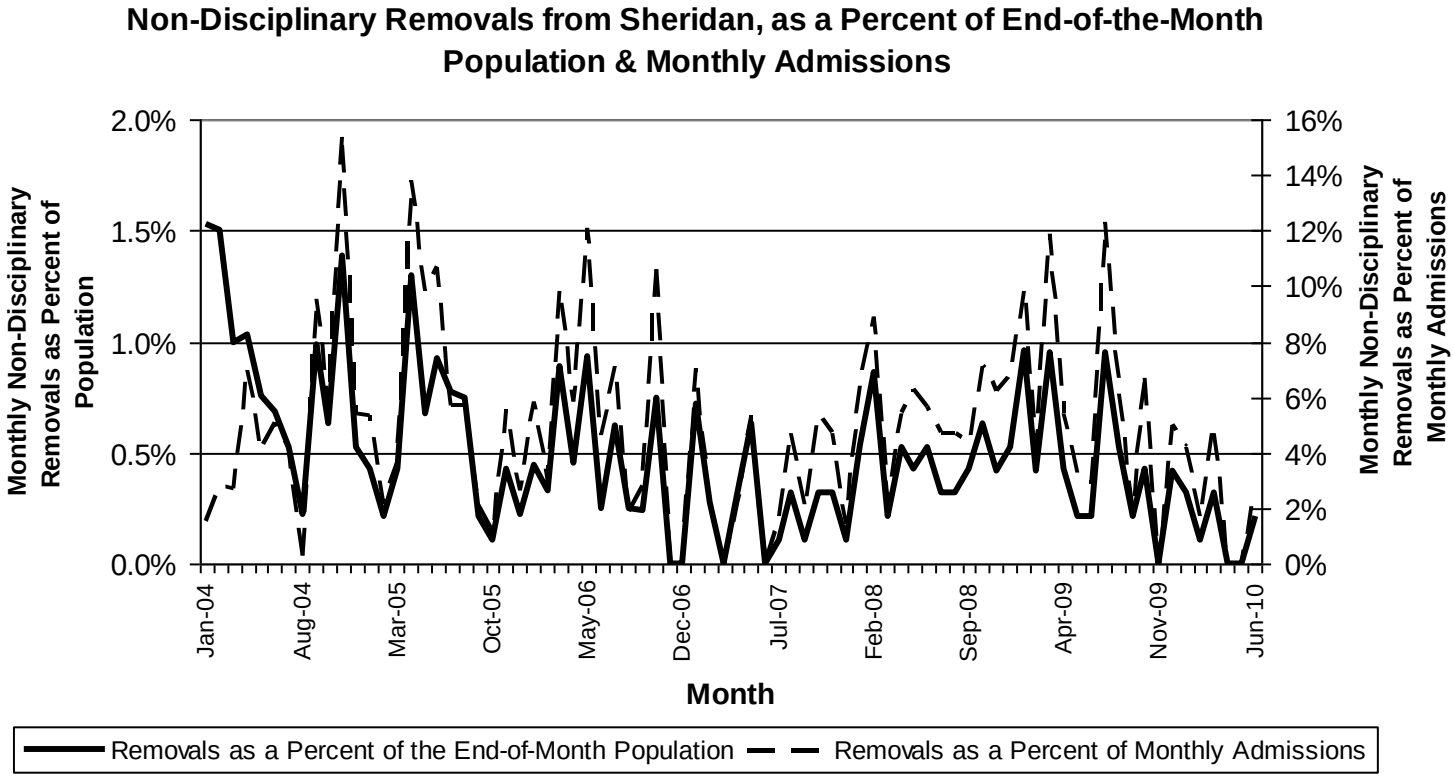
Figure 4

Non-Disciplinary Removals from Sheridan, Actual Number by Month



Similarly, the *rate* of non-disciplinary removals (both as a percent of the end of the month Sheridan population and as a percent of the monthly admissions into Sheridan) varied considerably from month to month. As seen in Figure 5, when the non-disciplinary removal rate is calculated by comparing removals to the overall population at Sheridan it is relatively low, ranging from 1.5 percent or less per month during the 6 ½ year period, and has fluctuated widely. Similarly, the rate based on removals divided by the number of admissions per month also varied considerably, but the rate was higher (since there are fewer admissions per month than the end of the month population), ranging from more than 10 percent in some months to less than 2 percent or 0 percent in others.

Figure 5

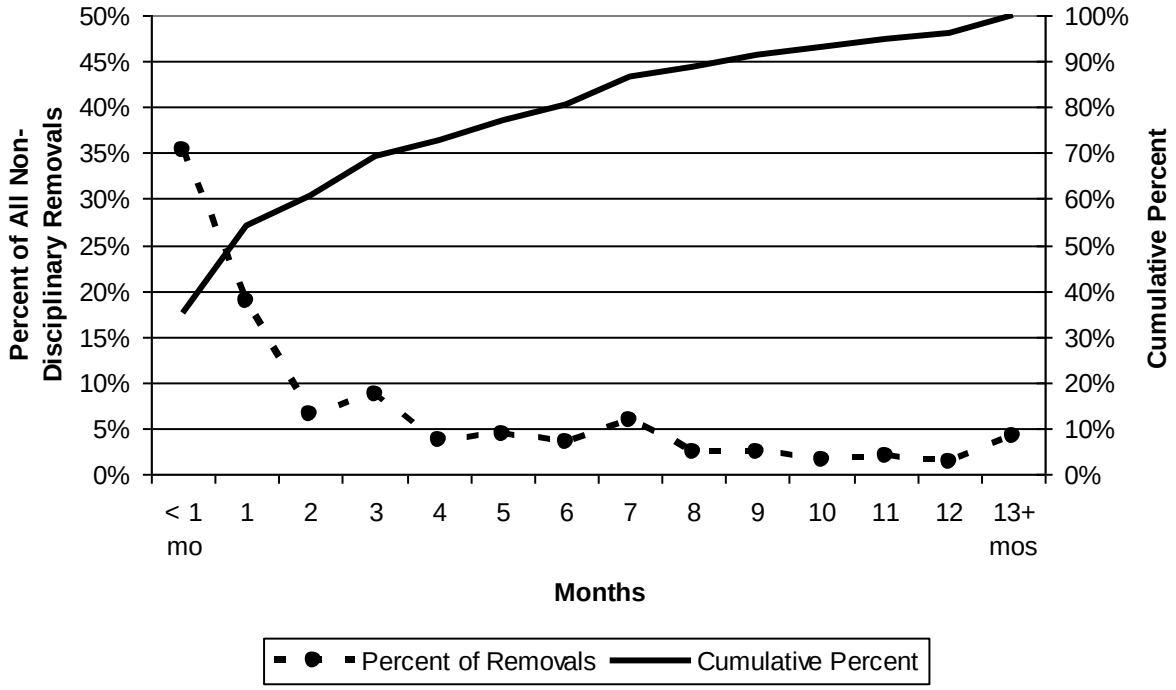


Another dimension to the issue regarding those admitted to Sheridan and subsequently transferred for non-disciplinary reasons is the length of time they spend at Sheridan before they are actually transferred. The median length of time spent at Sheridan among those removed for non-disciplinary reasons was 50 days, or just under two months, meaning that one-half of the non-disciplinary removals left within 50 days of their admission to Sheridan and the other half

spent more than 50 days at Sheridan prior to their removal. Figure 6 illustrates in greater detail the length of time between admission to, and exit from, Sheridan among the non-disciplinary removals, and reveals that roughly one-third (35 percent) of the non-disciplinary removals spent less than one month at Sheridan, roughly another third (34 percent) spent 1 to 3 months at Sheridan before removal, and just under one-third (31 percent) spent 4 or more months at Sheridan. Closer inspection of these data over time also reveals that the amount of time between admission and transfer for the non-disciplinary removals has decreased substantially. For example, among those admitted to Sheridan in 2004 and subsequently transferred for non-disciplinary reasons, the median days between admission and transfer was 110 days, whereas among those admitted to Sheridan in 2008 and 2009, and subsequently transferred for non-disciplinary reasons, the median days between admission and transfer was 29 days. This provides further evidence of the improved screening and identification of inmates not appropriate for Sheridan as the program has been implemented and evolved over the first 6 ½ years of operation.

Figure 6

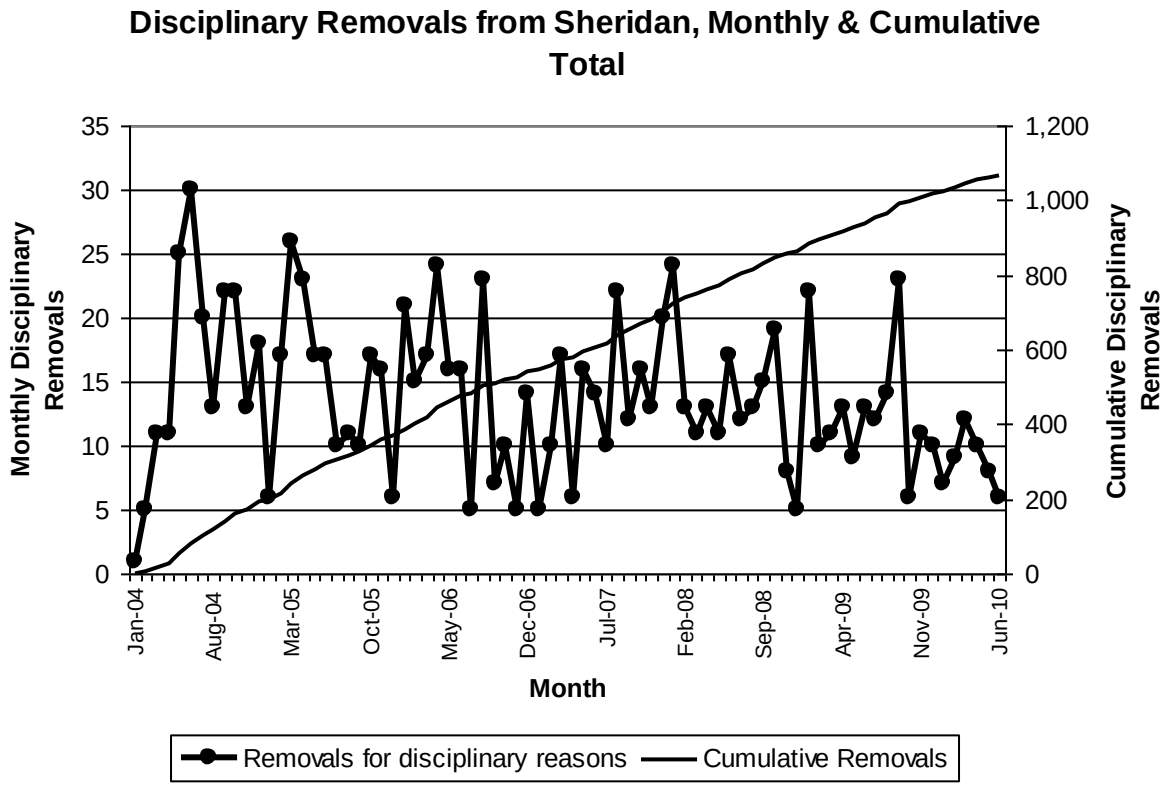
Length of Stay at Sheridan Among Non-Disciplinary Removals



Disciplinary Removals

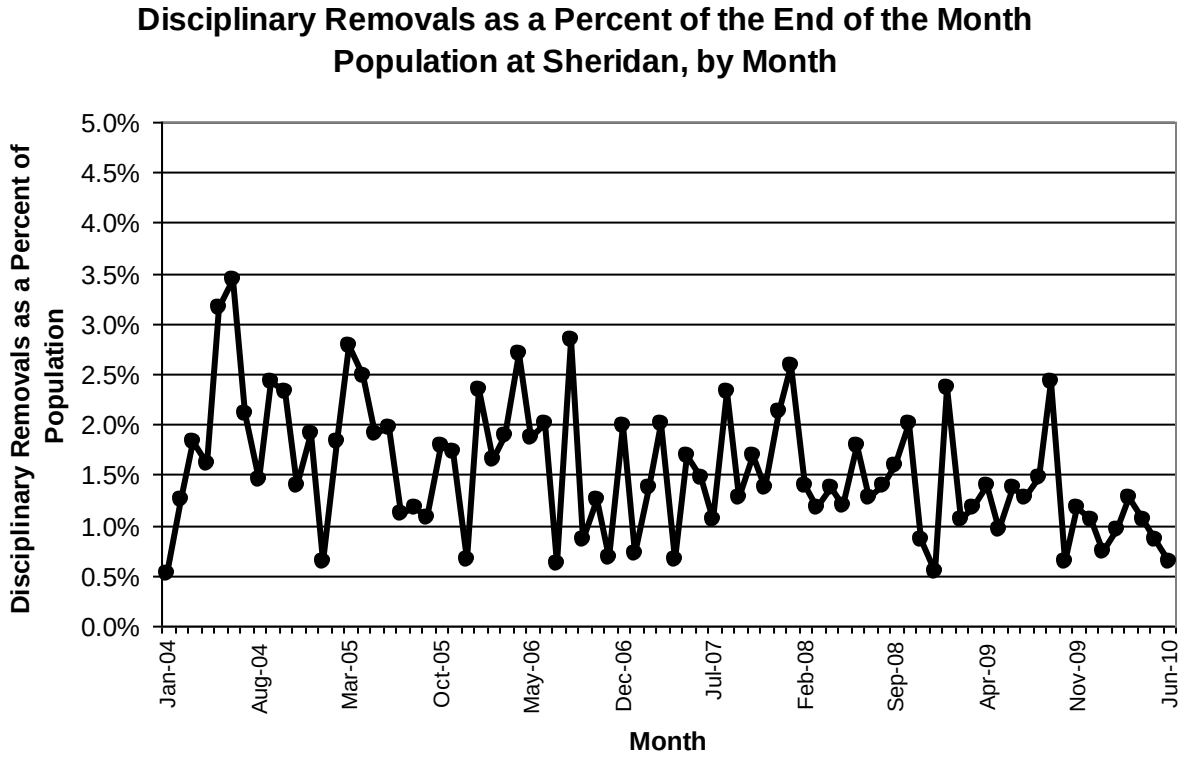
During the 6 ½ year period, there were 1,069 inmates who were removed from the program for disciplinary reasons, including the violation of "general" institutional/IDOC rules and/or refusing to participate in treatment. Again, relative to the overall number of inmates admitted to and/or discharged from Sheridan, these 1,069 removals for disciplinary reasons account for a relatively small proportion—18.7 percent—of the 5,731 exits from the facility (Table 2). Looked at another way, the ratio of successful graduates to disciplinary removals during the 6 ½ year period was 4:1; for every disciplinary removal (unsuccessful completion) from Sheridan there were 4 inmates who successfully completed the institutional phase of the program, or, excluding non-disciplinary transfers, almost 80 percent of those who left the facility did so successfully. Looking at the number of Sheridan participants removed for disciplinary reasons by month, as with non-disciplinary removals, reveals a relatively wide variation from month to month, from a high of 30 during June of 2004, to a low of 5 during a number of months (Figure 7).

Figure 7



During the first six months of 2010, the rate of disciplinary removals at Sheridan has been considerably lower than in previous years, partly due to crowding within the Illinois Department of Corrections that has slowed transfers out of Sheridan, but primarily as a result of an increased emphasis on trying to work more with inmates involved in disciplinary incidents to reorient them to the treatment program at Sheridan. For example, in the first six months of 2010, less than 6 percent of admissions to Sheridan were removed for disciplinary reasons, compared to an average of 12 to 15 percent from 2004 to 2009. Similarly, disciplinary removals as a *proportion* of the population at Sheridan also varied widely from month to month, from a high of 3.4 percent during June 2004 (30 removals out of an end of the month population of 874) to under 1 percent during a number of other months (Figure 8), and again, relatively low rates were seen in the first six months of 2010.

Figure 8

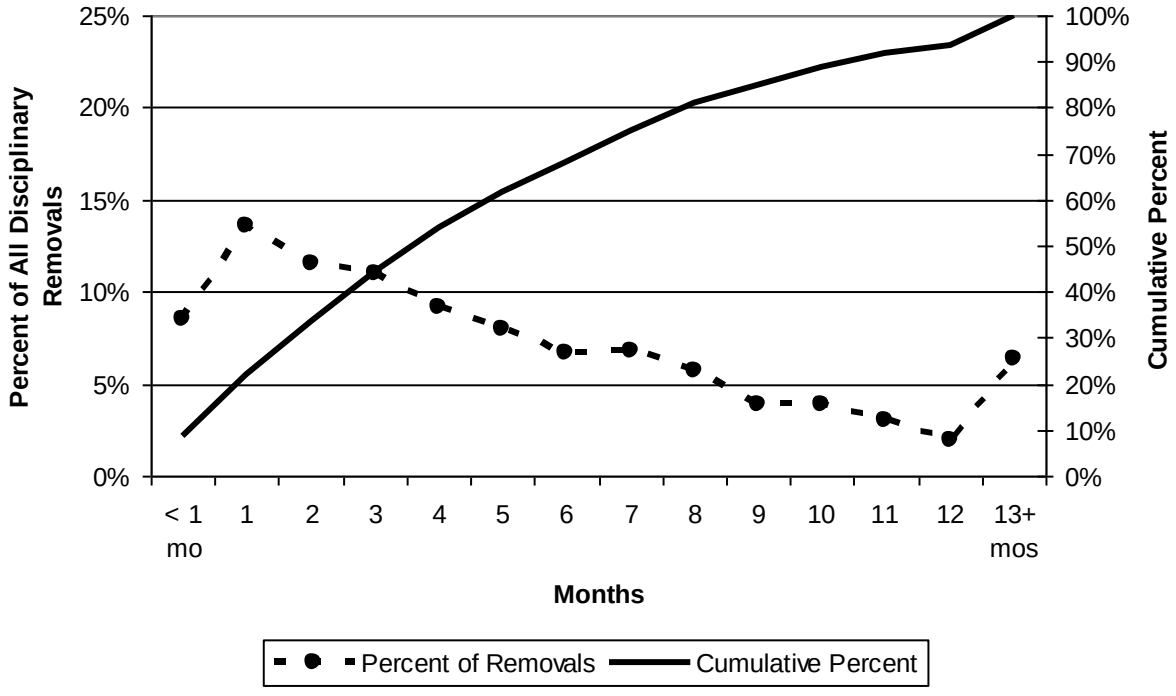


Looking at the length of time inmates who were ultimately removed for disciplinary reasons actually spent at Sheridan reveals that, on average, those removed for disciplinary reasons spent 170 days (or roughly 5 ½ months) before they were transferred to another facility. However, this

average is slightly skewed towards a longer length of time due to a number of inmates who spent more than a year at Sheridan before they were removed for disciplinary reasons. The median length of time at Sheridan for these inmates who were disciplinarily removed was 138 days, indicating that one-half of those removed from Sheridan for disciplinary reasons spent less than 4.6 months at the facility, whereas one-half spent more than 4.6 months at Sheridan prior to their removal for disciplinary reasons. Further, among those removed because they refused to participate in treatment—a disciplinary removal, the median time at Sheridan was 2.9 months, compared to a median of 5.3 months for other disciplinary removals. In general, these mean and median lengths of time at Sheridan among those removed for disciplinary reasons has not changed much over the 6 ½ years examined in this report. Figure 9 illustrates in greater detail the length of time between admission to and exit from Sheridan among all the disciplinary removals, and reveals that while one-third (33 percent) of the disciplinary removals spent less than 3 months at Sheridan, another 25 percent spent 8 or more months at Sheridan before removal. Among those who refused to participate, only one-third was at Sheridan more than 4 months.

Figure 9

Length of Stay at Sheridan Among Disciplinary Removals



Although it is important to keep in mind that the majority of those admitted to Sheridan successfully complete the prison-phase of the program, closer examination of the characteristics that distinguish the successful graduates from the disciplinary removals can provide some guidance to the operation of the Sheridan program and replication of the program in other jurisdictions. A closer examination of the characteristics of those that graduate versus disciplinary removals found that eight specific variables were associated with program removal, including (in order of relative strength): 1) projected length of time to serve, 2) eligibility for earned good conduct credit, 3) age, 4) prior arrests for a violent crime, 5) having children, 6) primary substance of abuse, 7) prior substance abuse treatment episodes, and 8) race. Specifically, those participants who had a longer projected time to serve in the program (in prison) were *more likely to be removed than successfully complete*, as were those ineligible for earned good conduct credit, younger participants, those with more prior arrests for a violent crime, those that did not have children, those identified as marijuana abusers, those who had never been in treatment before (and those with extensive prior treatment episodes), and non-whites (i.e., African-American and Hispanic combined). All of these characteristics were associated with an increased likelihood of disciplinary removal from the program versus graduation/completion of the prison phase of the program relative to participants with the opposite characteristics. Other factors, including marital status, education level, pre-prison employment history, being gang involved, total prior arrests and those specifically for drug-law violations, and current offense had *no* independent relationship with program outcomes (for a more detailed description of the analyses of characteristics that predict disciplinary removal from Sheridan summarized here, see Olson & Rozhon, 2011).

However, it is important to point out that while those with certain characteristics were more likely to be removed from the program for disciplinary reasons, the ***majority*** of even those with the most risk factors still ***successfully completed*** the prison-phase of the program. To illustrate, it was found that the more extensive the Sheridan inmates' prior history of violent arrests, the more likely they were to be removed for disciplinary reasons. Specifically, those Sheridan inmates with 5 or more prior arrests for violent crimes (accounting for 25 percent of those admitted to Sheridan during the period examined) were more than twice as likely as those with no prior arrests for a violent crime (accounting for 23 percent of those admitted to Sheridan during the

period examined) to be removed from Sheridan for disciplinary reasons when all other inmate characteristics were statistically controlled. However, what is just as important is that the overall likelihood of being removed from the program is relatively low, and the difference between those with extensive (5 or more) versus no prior histories of violence is based on this low rate: less than 18 percent of those with no prior violent arrests were disciplinary removals compared to 33 percent of those with extensive (5 or more) violent arrest histories. Looked at another way, ***most*** (two-thirds) of those with extensive histories of violence successfully completed the prison-phase program, and these inmates account for a relatively large proportion of those admitted to prison in Illinois. If inmates with 5 or more prior arrests for violent crime were excluded from Sheridan eligibility, that would reduce the eligibility pool by roughly 25 percent.

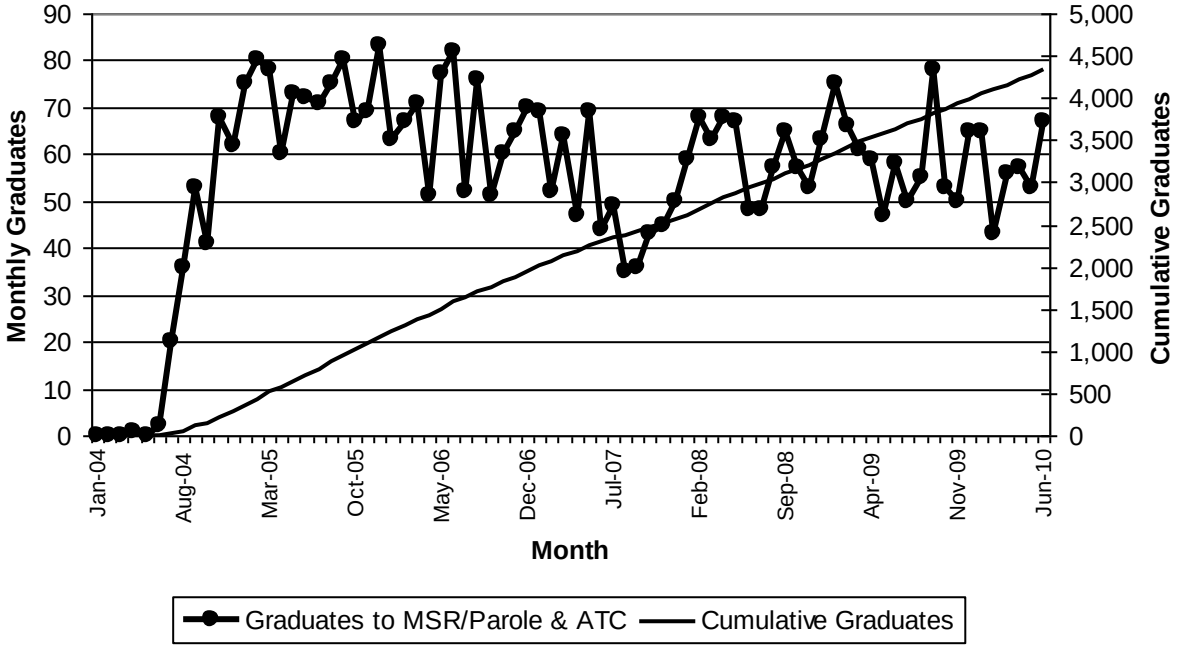
Graduates/Successful Releases

Given that Sheridan participants were originally required to have at least 6 months of time to serve at Sheridan in order to be admitted to the program (9 months is now the minimum), the first cohort of Sheridan graduates did not leave the facility until July 2004 (after the program had been running for 6 months). As seen in Figure 10, following this first group of 23 Sheridan participants released in July 2004, the number of successful graduates released on a monthly basis steadily increased to 76 by February 2005 before leveling off and averaging between 60 and 80 graduates per month through the end of 2006 (Figure 10).

During 2007, the number of monthly graduates from the program decreased slightly, averaging roughly 50 per month during the most recent year of program operations (Figure 10). Most of this decrease during 2007 can be attributed to the reduced *admissions* and lower average daily population of the facility during *2006* (as seen in Figure 2), which, as explained earlier, were the result of a combination of budget limitations and staff shortages keeping the facility from operating at its capacity of 950, a strike by some of the treatment staff, and the transition/change to a new substance abuse treatment provider that took place during 2006. However, during 2008 and through 2009 and the first half of 2010, the number of graduates released from Sheridan was back up to an average of 60 per month.

Figure 10

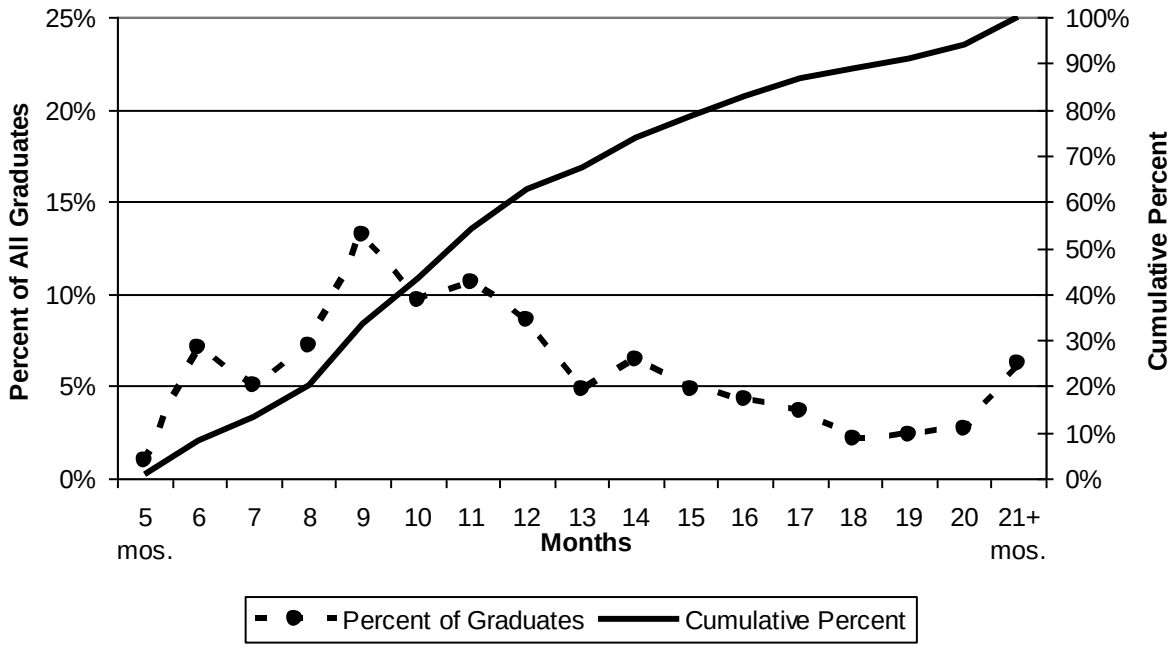
Graduates from Sheridan Correctional Center, Monthly & Cumulative Total



Among program participants who successfully completed the in-prison phase of the Sheridan program during the first 6 ½ years (N=4,328), analyses of their actual time spent at Sheridan reveals that the average length of stay at Sheridan was 382 days, or just over 12 months. Closer analyses of the length of time at Sheridan shows that 20 percent spent 6 to 8 months at Sheridan, 42 percent spent between 9 and 12 months at Sheridan, 26 percent spent between 13 and 18 months, and 11 percent spent 19 or more months at Sheridan (Figure 11). Also, as a result of the changes over the course of program implementation in the minimum and maximum projected time to serve at Sheridan (i.e., from a minimum of 6 to a minimum of 9 months, and a maximum of 24 months to a maximum of 36 months), there has also been a slightly increase in the average amount of time spent at Sheridan among the graduates. For example, among graduates released in SFY 2005 from Sheridan, the average time spent at Sheridan was 327 days, but among graduates released in SFY 2010, the average time at Sheridan was 441 days.

Figure 11

Length of Stay at Sheridan Among Graduates



In order to ensure that program participants are exposed to a sufficient "dose" or "duration" of treatment at Sheridan, the initial criteria for admission to Sheridan was that inmates had to have a projected length of time in prison of between 6 and 24 months. However, as a result of the on-going analyses of post-discharge recidivism patterns, it was found that those inmates who spent *less than* 9 months at Sheridan did not do any better than a group of similar inmates that did not receive Sheridan services (i.e., a comparison group). As a result, the eligibility criteria was subsequently changed in the fall of 2006 to exclude from Sheridan inmates with less than 9 months of projected time to serve so as to maximize/focus the impact of the program on those inmates who would actually benefit from the resources and services available at Sheridan and in the community.[19] Because the majority of inmates admitted to prison in Illinois received credit for time served in jail prior to their conviction, are eligible for good conduct credit and meritorious good conduct credit, and some may also be eligible for Earned Good Conduct Credit

[19] The average lengths of time served at Sheridan among the successful graduates released between 2004 and 2006 was 331 days, compared to an average of 425 days among those released between 2007 and 2010--after the change in time to serve eligibility was increased to a minimum of 9 months.

(EGCC), it is necessary when inmates are being screened for program eligibility that these factors are taken into consideration when examining the sentence lengths of those sentenced to IDOC. In general, this process of effectively estimating the projected length of time to serve during the R&C process has been successful and only a handful—53 out of the more than 6,680 admissions to Sheridan—were removed from Sheridan shortly after their admission because they ended up having too short (i.e., less than 6 months, and then later 9 months) or too long (i.e., more than 24 months) of a projected length of time to serve.

What Impacts Length of Time Served at Sheridan?

In general, the length of the sentence imposed on those convicted and sent to prison is considerably longer than the actual amount of time served in prison for most offenders. Unless an inmate has been sentenced for a crime subject to truth-in-sentencing,[20] which includes offenses such as murder and criminal sexual assault (these inmates are not eligible to participate at Sheridan) or other violent crimes that involve great bodily harm, they are eligible to earn day for day good conduct credits (which reduces the sentence by 1 day for every day the inmate does not violate institutional rules), plus meritorious good conduct credit and supplemental meritorious good conduct credit, which allows for the granting of up to an additional 90 to 180 days of credit towards one's sentence.[21] Finally, any time inmates spent incarcerated in a county jail waiting for the disposition of their case can also be granted by the judge as credit towards the time they must serve in prison. Among those inmates who were admitted to Sheridan, all but four had received credit for jail time served. For example, during SFY 2009, those inmates who were released from Sheridan received, on average, a 55.2 month sentence to IDOC (roughly 4.6 years) (Table 4). Among these inmates, the average amount of time spent in jail waiting for the

[20] The number of inmates admitted to Sheridan that had been convicted of a crime subject to truth-in-sentencing has been relatively low. During the entire 6 ½ year period of operation, only 78 out of the 6,680 (or less than 2 percent) were convicted of truth-in-sentencing offenses. Most of these offenses were armed robberies or aggravated discharge of a firearm. Under Illinois law, these offenders must serve 85 percent of the court imposed sentence. However, despite this, they were still eligible for Sheridan because they were projected to serve between 6/9 and 24 months (after credit for jail time was factored in).

[21] The granting of Meritorious and Supplemental Meritorious Good Time (MGT & SMGT) credit is discretionary, and in December 2009, the Illinois Department of Corrections suspended the granting of MGT and SMGT until a revised policy regarding how this credit is awarded to inmates is developed. This only applied to inmates who had not yet been awarded the MGT and SMGT credit, which only impacted inmates admitted to prison since December 2009.

disposition of their case prior to being sentenced to IDOC was 5.3 months, for which they received credit by the sentencing judge (Table 4). In addition, the average amount of meritorious good conduct credit (MGCC) received among those released from Sheridan during SFY 2009 was just under 90 days (3 months), plus an additional 3 months of supplemental meritorious good conduct credit (SMGCC), and finally an average of 2.2 months of earned good conduct credit for their participation in substance abuse treatment. Combined, all of these sentence and good conduct credits resulted in an average length of time served in IDOC (primarily at Sheridan) of 15.5 months among those released during SFY 2009.

Table 4
Summary of the Sentence Lengths, Sentence Credits & Actual Time Served at Sheridan Among Those Successfully Discharged During SFY 2009

	Months (Mean)
Sentence Length	55.2
Jail Credits	5.3
Average Day-for-Day Good Conduct Credits	24.9
Average MGCC	3.0
Average SMGCC	3.0
Average EGCC – Substance Abuse Treatment	2.2
Average Actual Time Served in IDOC/Sheridan	15.5

III. SHERIDAN PARTICIPANT CHARACTERISTICS

Introduction

Although the number of inmates admitted to Sheridan over the past 6 ½ years has grown considerably, the general characteristics—demographic, socio-economic, substance abuse pattern and history, prior criminal history, conviction offense, region of Illinois they are from, etc. -- of those admitted to Sheridan has remained quite stable and consistent, and is also very reflective of adult male prison admissions in Illinois as a whole. As has been the case during the entire 6 ½ year period, most of those admitted to Sheridan (and the entire Illinois prison system for that matter) were African-American, with an average age of 32 years old, and primarily sentenced to prison from Cook County/Chicago and other urban areas of the state for drug and property crimes. The description that follows, and Tables 5 through 9, provides a more detailed summary of the characteristics and backgrounds of those admitted to Sheridan during the 6 ½ year period from January 2, 2004 through June 30, 2010.[22]

Committing Counties/Geographic Distribution of Sheridan Admissions

As indicated previously, when an adult male is sentenced and admitted (i.e., committed) to prison in Illinois, they are initially admitted to one of IDOC's three Reception and Classification Centers, which serve northern, central and southern Illinois. Although inmates admitted to any one of the three R&Cs can be transferred to Sheridan, provided they meet the eligibility criteria, examination of the county of commitment, and which R&C the inmates were processed through, reveals that the majority of inmates at Sheridan came from northern Illinois (Table on page 41), in particular Cook County (which includes Chicago) and the suburban counties that surround Cook (referred to as the "Collar County Region"). Specifically, of the 6,680 admissions into Sheridan, 96.6 percent (6,453 of the 6,680) were admitted through the Stateville R&C in

[22] During the entire 6 ½ year period there were 12 inmates admitted twice to Sheridan.

northern Illinois,[23] while only 155 (2.3 percent) were admitted through Graham (which serves central Illinois) and only 53 (less than 1 percent) were admitted through the R&C that serves southern Illinois (Menard). The most likely explanation for this pattern is that inmates must volunteer for the program, and given the fact that the Sheridan Correctional Center is located in northern Illinois, many of the inmates want to be closer to their family. In addition, the Stateville R&C in northern Illinois handles the largest volume of admissions into Illinois' prison system, and because of this, the recruitment process for Sheridan and the screening for substance abuse treatment need was implemented at this R&C before it was fully in place at the other R&Cs.

By far the county that accounted for the largest number of admissions to Sheridan was Cook County, which is the county where Chicago is located. Cook County not only accounts for the largest number of admissions to prison in Illinois *in general*, but accounted for more than one-half (52.3 percent) of the 6,680 admitted to Sheridan during the first 6 ½ years of operation. After Cook County, the next largest group of inmates admitted to Sheridan were sentenced to prison from Winnebago County (Rockford), followed by the suburban counties bordering Cook County/Chicago of DuPage, Will, Lake and Kane counties (See map on following page). Combined, these 6 counties (Cook, Winnebago, DuPage, Will, Lake & Kane) accounted for nearly three-quarters (71.1 percent) of all those admitted to Sheridan. The remaining 28.9 percent of Sheridan admissions came from 73 other counties, primarily in northern Illinois, but spread throughout the state. All told, inmates admitted to Sheridan were committed to prison from 79 of Illinois' 102 counties. Table 5, on the following page, summarizes the number of admissions to Sheridan during the first 6 ½ years of operation across each of Illinois' 102 counties.

[23] An additional 19 inmates were identified as having been admitted through the R&C at the Joliet Correctional Center, which is now closed but previously operated as the R&C that served northern Illinois. All 19 of these inmates were among those transferred to Sheridan from another IDOC facility and thus were admitted to IDOC prior to Sheridan having been opened.

Table 5
County of Commitment Among Sheridan Admissions, 2004 through June 2010

County Name	Number of Admissions	Percent of Total Admissions [1]
Cook (Chicago)	3,494	52.3%
Winnebago (Rockford)	433	6.5%
Will (Joliet)	292	4.4%
Lake (Waukegan)	266	4.0%
DuPage	261	3.9%
Kane	222	3.3%
Champaign	189	2.8%
Peoria	169	2.5%
McLean	150	2.2%
Kankakee	149	2.2%
LaSalle	140	2.1%
Vermilion	96	1.4%
Rock Island	88	1.3%
Tazewell	73	1.1%
Whiteside	58	0.9%
Henry	52	0.8%
Kendall	47	0.7%
McHenry	47	0.7%
Stephenson	46	0.7%
DeKalb	43	0.6%
Livingston	38	0.6%
Bureau	25	0.4%
Boone	24	0.4%
Lee	20	0.3%
Madison	18	0.3%
Sangamon	18	0.3%
Iroquois	17	0.3%
Woodford	17	0.3%
St. Clair	16	0.2%
Grundy	15	0.2%
Ogle	13	0.2%
Adams	10	0.1%
Jackson	10	0.1%
Knox	9	0.1%
Macon	9	0.1%
Edgar	6	0.1%
Jefferson	6	0.1%
Henderson	5	0.1%
Mercer	5	0.1%
Morgan	5	0.1%

Table 5 (Continued)
County of Commitment Among Sheridan Admissions, 2004 through 2008

Williamson	5	0.1%
Coles	4	0.1%
Ford	4	0.1%
Logan	4	0.1%
Saline	4	0.1%
Bond	3	Less than 0.1%
Jo Daviess	3	Less than 0.1%
Lawrence	3	Less than 0.1%
Marion	3	Less than 0.1%
Putnam	3	Less than 0.1%
Randolph	3	Less than 0.1%
Shelby	3	Less than 0.1%
Cass, Christian, Clark, Douglas, Franklin, Hancock, McDonough, Marshall, Massac, Pulaski	2 from each county	Less than 0.1% from each county
Carroll, Crawford, Fulton, Hardin, Johnson, Mason, Menard, Montgomery, Perry, Pike, Pope, Richland, Stark, Wabash, Warren, Wayne, White	1 from each county	Less than 0.1% from each county
Total	6,680	100.0%

[1] Percentages may not add up to 100% due to rounding.

Demographics & Socio-Economic Characteristics

The majority of those admitted to Sheridan during the 6 ½ years of operation have been African-American (66 percent) and the average age of participants during this period was 32 years old (Table 6). In general, a higher proportion of those inmates admitted to Sheridan from Cook County (primarily Chicago) were African-American (81 percent) than those from the rest of the committing counties: 50 percent of those admitted to Sheridan from outside of Cook County were African-American. Although most (84 percent) of the Sheridan participants were not married, the majority—67 percent -- of participants at Sheridan did have children. Of those inmates at Sheridan that did have children, the average number was 2.6, and 60 percent had 2 or more children. At the time of their admission to Sheridan, less than one-half (43.5 percent) were

high-school graduates or had received their GED, and a relatively small proportion (27 percent) were employed full-time prior to their current incarceration. Most Sheridan inmates were unemployed prior to their current incarceration. Even more illustrative of the limited formal employment experiences among those admitted to Sheridan is the fact that 63 percent had never previously held a job for more than 2 years, despite an average age of 32 years old.

However, what is also important to note regarding the characteristics of those admitted to the Sheridan Correctional Center TC program is that they are nearly identical to the characteristics of most adult male inmates admitted to Illinois' prison system that meet the general eligibility criteria for Sheridan (i.e., not convicted of murder or a sex offense, projected to serve between 6 and 24 months, and appropriate for placement in a medium security facility).[24] As seen in Table 6, those at Sheridan are very similar to the larger group of those admitted to prison in Illinois during the time period examined who met the general eligibility for Sheridan in terms of their age, marital status, having children, education level, committing county, and current conviction offense. There were some difference noted, however, with those at Sheridan having more extensive gang involvement than the larger population of eligible inmates (39.8 percent versus 28.5 percent, respectively), more likely to be African-American (66.2 percent versus 58.8 percent), have more prior prison sentences, and have a higher current felony class offense conviction. The primary difference in terms of current felony class between Sheridan inmates and the larger pool of eligible inmates is driven by the difference in those incarcerated for drug sale/delivery offenses. Among the inmates admitted to the Sheridan program during the time period examined 24.7 percent were convicted of sale/delivery of a controlled substance (Table 9), compared to 13.2 percent of the total pool of Sheridan-eligible inmates admitted to IDOC during the same time period. Since drug sale/delivery offenses tend to be higher felony class offenses (i.e., Class X-2 offenses), this pattern explains much of this difference.

[24] To determine the number and characteristics of Sheridan-eligible inmates, IDOC admission data for the period from SFY 2004 through 2008 were examined. Only those inmates who met the following criteria were included: sentenced to IDOC for a new offense (no parole violators), adult males, not convicted of murder or a sex offense, not identified as a maximum security classification, and projected to serve between 6 and 24 months in prison. This last criterion was determined by taking the court-imposed sentence and subtracting from that jail credit received and assuming the inmate would receive all the good conduct and supplemental good conduct credit they were eligible to receive. Based on these criteria, there were more than 60,000 admissions during the five year SFY 2004-2008 time period, or roughly 12,000 per year.

Table 6: Comparison of Sheridan & Overall IDOC Admissions, January 2004- June 2010

	Sheridan Admissions [1]	Admissions Meeting Sheridan Eligibility [1]
Average Age	31.8 years	31.8 years
Race		
African-American	66.4%	58.8%
White	24.4%	31.5%
Hispanic	8.9%	9.3%
Total	100.0%	100.0%
Marital Status		
Married	15.6%	15.8%
Single	84.4%	84.2%
Total	100.0%	100.0%
Children		
None	32.9%	35.2%
One or More	67.1%	64.8%
Total	100.0%	100.0%
Education Level		
No High-School Diploma or GED	56.5%	56.3%
At Least a High-School Diploma/GED	43.5%	43.7%
Total	100.0%	100.0%
Gang Member		
No	60.0%	71.5%
Yes	40.0%	28.5%
Total	100.0%	100.0%
Committing County/Region of Illinois		
Cook County/Chicago	52.3%	50.1%
Rest of Illinois	47.7%	49.9%
Total	100.0%	100.0%
Prior Prison Sentences		
None	35.7%	41.2%
One	24.5%	22.4%
2 or More	39.8%	36.4%
Total	100.0%	100.0%
Current Conviction Offense [2]		
Violent	24.3%	20.4%
Property	32.5%	35.7%
Drug-Law Violation (Including DUI)	42.3%	41.4%
Total	100.0%	100.0%
Current Offense Felony Class		
Class X Felony	6.5%	
Class 1-2 Felony	61.7%	37.4%
Class 3-4 Felony	31.8%	62.6%
Total	100.0%	100.0%

[1] Percentages may not add up to 100% due to rounding; [2] In addition, there were 0.9% admitted for "other" crimes.

Criminal & Substance Abuse History

Although traditional community-based TCs have had a long history of operation and positive impact on participants, the evolution of TCs within the prison system poses a number of challenges to the general TC model and prior rates of success. One of the most significant is the fact that those admitted to prison are generally those with the most extensive and serious criminal and substance abuse histories, and thus represent a population that has been involved in a lifestyle of drug abuse and crime for relatively long periods of time. The extant research literature on the effectiveness of substance abuse treatment has generally concluded that participants require between 3 and 9 months of treatment for long-term beneficial effects to be evident. However, much of this literature evolved from programs that were community based, and/or involved participants with less extensive patterns of drug use and criminal behavior than those housed in most state prison systems. One of the conclusions of the previously published evaluation summaries of the Sheridan program was that the population being served had very extensive and serious substance abuse and criminal histories, but relatively low prior rates of treatment participation (Olson, et al., 2004; Olson, et al., 2006). After 6 ½ years, this pattern has continued, and in some ways has revealed even more serious and extensive drug and criminal histories.

Among those participants admitted to Sheridan, there is clear evidence of an extensive prior history of involvement in criminal behavior and in the justice system, and also a criminal background that is quite varied in terms of the nature of crimes. Illustrative of this is the fact that those admitted to Sheridan had, on average (mean),[25] almost 21 prior arrest charges (Table 7), including drug-law violations, property crimes, and crimes of violence, such as robbery, battery and assault, and 94 percent of those at Sheridan had 5 or more prior arrests.

[25] Because the average, or mean, can increase due to a small number of cases with extremely high values, the median prior arrests and prison sentences are also presented. The median represents the value which separates the distribution of priors in half—one half of the participants had priors above the value for the median and one-half had priors below the median.

Table 7
Summary of Prior Criminal History of Those Admitted to Sheridan*

	Mean / Median	Percent with None / Percent with at Least One	Percent with 5 or More
Total Prior Arrests	20.5 / 17.0	0.0%/100.0%	94.1%
Prior Arrests for Drug-Law Violations	5.1 / 4.0	14.2% / 85.8%	44.6%
Prior Arrests for Property Crimes	6.3 / 3.0	15.0% / 85.0%	42.2%
Prior Arrests for Violent Crimes	3.2 / 2.0	22.5% / 77.5%	24.7%
Prior Arrests for Other Crimes [1]	6.0 / 4.0	8.9% / 91.1%	48.4%
Prior Prison Sentences	1.7 / 1.0	33.8% / 66.2%	8.8%

* For admissions through the end of SFY 2007.

[1] Other crimes include offenses such as unlawful use of a weapon, trespassing, prostitution, driving under the influence, driving on a suspended/revoked license, criminal damage to property, fleeing police, violation of an order of protection, issuance of a warrant, etc.

As seen in Table 7, almost all Sheridan participants had *at least one* prior arrest for drug-law violations (85 percent) and property crimes (85 percent), and a relatively large proportion of the participants had 5 or more prior arrests for each of these different types of crimes. Although sex offenders and murderers are excluded from Sheridan eligibility, roughly three-quarters (77 percent) of those admitted to Sheridan had at least one prior arrest for some other crime of violence. In fact, the average number of arrests for prior violent crimes was just over 3 per participant, and almost one-quarter (24.7 percent) of the participants admitted to the Sheridan Correctional Center during the period examined in this report had 5 or more prior arrests for crimes of violence.

As a result of these extensive prior criminal histories, it is not surprising that most of those admitted to Sheridan had also previously been sentenced to prison in Illinois. Of all those admitted to Sheridan during this 6 ½ year period, nearly two-thirds (64.3 percent) had previously been sentenced to the Illinois Department of Corrections (Table 7), the average number of prior prison sentences was 1.7, and nearly 9 percent of those admitted to Sheridan had been sentenced to prison 5 or more times previously. As a result of the change in the eligibility based on a projected length of time to serve at Sheridan, as well as some changes in the overall types of crimes resulting in prison sentences in Illinois and a change in the eligibility criteria for the

Southwestern Illinois Correctional Center, there have been some slight changes in the extent of prior prison sentences among those admitted to Sheridan and conviction offense types. Specifically, among those admitted to Sheridan after the eligibility criteria was changed to a minimum of 9 months to serve at the facility (from the previous 6 month minimum), the proportion of inmates with no prior prison sentences fell from 38 percent to 34 percent, while the proportion with 2 or more prior prison sentences increased from 38 percent to 41 percent. Even more substantial was the change in the nature of the current crime between those admitted when the criteria was 6-24 months versus 9-24 months. For example, among the admissions to Sheridan in 2004-2006 only about 4-5 percent were for Class X felonies, but by 2009 it was up to 8 percent and in 2010 (through June) Class X felonies accounted for 16 percent of admissions to Sheridan. Similarly, person crimes accounted for 22 percent or less of admissions from 2004-2006, but accounted for 30 percent of Sheridan admissions in 2009 and 34 percent in 2010. On the other hand, admissions to Sheridan involving Class 4 felonies fell from roughly 20 percent of admission in 2004-2006, down to 11 percent of Sheridan admissions in 2009 and 8 percent in 2010.

Similarly, the extent and nature of the participants' substance abuse history is also quite lengthy and varied, although prior exposure to substance abuse treatment is relatively limited despite extensive prior involvement in the criminal justice system. At the time of admission to Sheridan, 47 percent of the participants had never before participated in substance abuse treatment (Table 8), despite being arrested and incarcerated multiple times and despite the fact that, on average, the participants admitted to Sheridan reported using drugs for an average of 18 years**.** Among the 53 percent of Sheridan participants who had previously participated in substance abuse treatment, the time since they were last in treatment averaged 41 months prior to their admission to prison (Table 8), but varied considerably. For example, one-half of those participants who had previously participated in substance abuse treatment had done so within the 24 months prior to their admission into Sheridan, whereas one-quarter of those who had previously been in treatment completed or were discharged from that prior treatment episode more than 5 years prior to their admission to Sheridan. The length of time the Sheridan participants were enrolled in their last treatment episode averaged 129 days, with a median of 90 days.

Table 8
Extent and Nature of the Substance Abuse Histories of Those Admitted to Sheridan, SFY 2004 through 2010

	Percent of Sheridan Admissions [1]
Age at First Drug or Alcohol Use	
Under 15	59.1%
15-16	21.3%
17 or Older	19.6%
Total	100.0%
Prior Treatment Exposure	
No Prior Treatment	47.4%
One to Two Prior Treatment Admissions	35.9%
More than Two Prior Treatment Admissions	17.7%
Total	100.0%
Months Since Last Treatment (Among those with Prior TX)	41 months (Mean) 24 months (Median)
Days in Prior Treatment (Among those with Prior TX)	129 days (Mean) 90 days (Median)

[1] Percentages may not add up to 100% due to rounding.

Just as the nature of the participants' criminal history are quite varied, so too are their primary substances of abuse, with roughly 29 percent reporting marijuana, 27 percent reporting alcohol, 22 percent reporting heroin/opiates, and 17 percent indicating cocaine as their primary substance of abuse. Further, one-half (50 percent) indicated that they abuse multiple substances (including alcohol plus other drugs), and 11 percent of all Sheridan participants reported previous intravenous drug use. Despite the growing concern regarding methamphetamine production and use in Illinois, particularly in Illinois' more rural communities, Sheridan has not seen a dramatic increase in the number of admissions where this drug was cited by the participants as their primary substance of abuse. During the entire 6 ½ year period of operation, less than 2 percent reported amphetamines or methamphetamine as their primary substance of abuse. Part of this could be influenced by the fact that the majority of admissions to Sheridan are from counties where methamphetamine has not had as large of an impact as in other, more rural jurisdictions in central and southern Illinois (Bauer & Olson, 2006). Further, Illinois' Southwestern Correctional Center has a specialized methamphetamine treatment unit where many of those identified as in need of treatment for methamphetamine abuse would be sent.

Other Medical Issues

Beyond the extensive prior substance abuse history, the majority (55 percent) of Sheridan participants had also been previously hospitalized for other medical problems, and one-third (33.4 percent) of all Sheridan participants had been hospitalized multiple times. The average number of prior hospitalizations (excluding drug overdoses or drug detoxification) among all Sheridan admissions during the four year period was 2. Another characteristic that illustrates the environment and exposure to violence experienced by the participants at Sheridan is the fact that 8 percent of those admitted to Sheridan had been previously hospitalized specifically as a result of gun-shot wounds.

In addition, roughly one-quarter (27.3 percent) of those admitted to Sheridan were also identified as having a chronic medical condition, and 19 percent of all Sheridan admissions were taking prescription medications for these medical conditions. The top three most frequently cited chronic medical conditions among those admitted to Sheridan were asthma, cited by 8 percent of all those admitted to Sheridan (and 30 percent of those with a chronic medical condition), high blood pressure, cited by 4 percent of all Sheridan admissions (and 15 percent of those with a chronic medical condition) and diabetes, cited by 1.5 percent of all Sheridan admissions (and 5 percent of those with a chronic medical condition).

Current Conviction Offense & Sentence

Although many prison-based TCs in the U.S. target only those convicted of specific drug-law violations, most often drug possession, it was recognized by those involved in the development of the Sheridan eligibility criteria that considering only an inmate's conviction offense would miss a substantial portion of people in need of treatment. Further, as a result of plea bargaining and charge reduction, oftentimes what individuals were *convicted* and sentenced to prison for was not necessarily what they were originally *arrested or charged* with. Thus, the only restrictions in terms of conviction offense for Sheridan eligibility were making those sentenced to IDOC for murder and sex offenses, or those with these offenses in their criminal background, ineligible for admittance to Sheridan. As a result, the specific crimes those at Sheridan were

convicted of and sentenced to prison for have included, for example, felony-level Driving Under the Influence (DUI)[26] of drugs or alcohol, drug sale and possession, burglary and robbery and battery (Table 9). In aggregate, the largest single offense category for admissions to Sheridan was for drug-law violations (42 percent of all admissions), followed by property crimes (32 percent of all admissions) and then violent offenses (24 percent of all admissions).[27] Also summarized in Table 9 are the four most frequent specific conviction offenses within each of these general crime categories, along with the proportion of total admissions to Sheridan these specific offenses accounted for and the proportion of the crime category they comprised.

Table 9
Current Conviction Offense[1] Among Those Admitted to Sheridan and Top 4 *Specific* Offenses within Each Category, January 2004 to June 2010

	Number	Percent of Total [2]	Percent within Category[2]
Drug Law Violations	**2,826**	**42.3%**	100.0%
Sale/Delivery of a Controlled Substance	1,617	24.2%	57.2%
Possession of a Controlled Substance	813	12.2%	28.8%
Driving Under the Influence	253	3.8%	9.0%
Sale/Delivery/Production of Cannabis	121	1.8%	4.3%
Other	22	0.3%	0.8%
Property Crimes	**2,174**	**32.5%**	100.0%
Burglary	1,216	18.2%	55.9%
Theft	461	6.9%	21.2%
Motor Vehicle Theft	316	4.7%	14.5%
Forgery/Deception/Fraud	144	2.2%	6.6%
Other	37	0.6%	1.7%
Violent Crimes	**1,620**	**24.3%**	100.0%
Weapon Offenses (Primarily Firearm Possession by Convicted Felon)	446	6.7%	27.5%
Assault/Battery	405	6.1%	25.0%
Robbery	379	5.7%	23.4%
Armed Robbery	283	4.2%	17.5%
Other	107	1.6%	6.6%
Other	**60**	**0.9%**	100.0%
Total	**6,680**	**100.0%**	

[1] In cases where inmates were convicted and sentenced to prison for multiple offenses, the most serious offense, or that which carries the longest sentence, is counted as their "holding" offense or current sentence offense.
[2] Percentages may not add up to 100% due to rounding.

[26] In Illinois, a 3rd or subsequent DUI conviction elevates the crime to a felony-level offense, as is a DUI by those without a valid driver's license or liability insurance.
[27] Violent offenses included assault, battery, home invasion, robbery, and felon in possession of a firearm.

Interestingly, although the modal conviction offense category among those admitted to Sheridan was a drug-law violation, most of these individuals were actually convicted of a drug sale/delivery offense. Specifically, roughly one-quarter (26 percent) ***of all those*** admitted to Sheridan were convicted of drug sale/delivery (Controlled Substances plus Cannabis), and these offenders accounted for more than 60 percent of those at Sheridan convicted of a drug-law violation (Table 9). Still, all of these inmates convicted of drug sale/delivery were also identified during the reception and classification process, and then later through the Addiction Severity Index (ASI) at Sheridan, as in need of substance abuse treatment, which illustrates the importance of not relying exclusively on conviction offenses to identify those in need of treatment, and also the importance of having a thorough substance abuse assessment as part of program screening.[28] Thus, despite being convicted of drug selling, those incarcerated at Sheridan for these offenses were also determined through an objective, comprehensive assessment to be substance abusers in need of treatment. It is interesting to note that very few of those at Sheridan, or in IDOC in general, are convicted of *drug-law violations* that involve marijuana, as most of these crimes are misdemeanors and therefore cannot result in a prison sentence; however, marijuana was the most common primary substance of abuse among those admitted to Sheridan. The second most frequent specific conviction offense among those at Sheridan was burglary (accounting for 18.2 percent of all those admitted to Sheridan), followed by possession of a controlled substance (12.2 percent), theft (6.8 percent), weapon offenses (6.7 percent), and assault/battery (6.1 percent). No other individual crime accounted for more than 6 percent of the total admissions to Sheridan during the 6 ½ year period examined in this report.

It is also important to consider the class of the felony offense that resulted in the prison sentence, as this determines, by law in Illinois, the length of time those released from prison in Illinois are required to be supervised under Mandatory Supervised Release (MSR). In Illinois, felony offenses are grouped legislatively into one of 6 categories or levels: Murder is considered its own class of crime, followed by Class X felonies (generally the most serious offenses and those for

[28] Upon further analyses of the characteristics of those at Sheridan serving a sentence for a drug-sale versus possession offenses, it appeared that the two groups were very similar and the likely reason for their being *convicted* of different offenses are differences in the extent and nature of plea bargaining across different regions of Illinois.

which probation is not allowable),[29] and then (in order of severity and allowable sentence lengths), Class 1 through 4 felonies. Class 4 felonies are the least serious felony offenses in Illinois, and carry possible sentences of either probation (up to 42 months) or prison sentences of up to 3 years.[30]

Among those admitted to Sheridan during the 6 ½ years examined in this report, a relatively small percent (6.5 percent) were convicted of a Class X felony (Table 10), and the conviction offense for these individuals was primarily accounted for by those sentenced to prison for armed robbery (55 percent of those admitted to Sheridan for a Class X felony) or drug sale/delivery offenses involving relatively large quantities of drugs (29 percent of those admitted to Sheridan for a Class X felony). However, as noted earlier, the proportion of Sheridan admissions convicted of a Class X felony has increased over the past 6 ½ years, from less than 5 percent during SFY 2005 and 2006 to more than 15 percent during SFY 2010. Those sentenced to prison for a Class X felony are required under Illinois law to be supervised following their release from prison for 3 years. Illinois law specifies that those released from prison after serving a sentence for a Class 1 or 2 felony, the next most serious felony offense classes after Class X, must be supervised on MSR for 2 years, and 71.7 percent of those admitted to Sheridan fell into these two felony classes combined (Table 10). Finally, roughly 21.8 percent of Sheridan admissions were convicted of the lowest level felony-offense classes in Illinois (Class 3 & 4 felonies combined), and these inmates, once released, are required to have 1 year of MSR (Table 10). Again, as noted previously, the proportion of admissions convicted of Class 4 felonies has fallen over the past 6 ½ years, from 20 percent of all Sheridan admissions in SFY 2005 and 2006 to less than 10 percent of Sheridan admissions in SFY 2010.

[29] Examples of a Class X felony include the sale/delivery of 15 grams or more of cocaine or heroin, robbery with a firearm, and aggravated criminal sexual assault (an offense for which inmates are not eligible to participate at Sheridan). Illinois law requires that those convicted of a Class X felony be sentenced to prison for a minimum of 6 years up to a maximum of 30 years.

[30] Examples of a Class 4 felony include possession of less than 15 grams of cocaine or heroin and a 3rd DUI conviction.

Table 10
Conviction Offense Felony Class, Sentence Length & Time Served Among 2004 to June 2010 Sheridan Admissions/Graduates [1]

	Percent of Sheridan *Admissions* [2]	Statutory Prison Sentencing Range PLUS Mandatory Supervised Release (Months)	Average Sentence Among Sheridan *Admissions*	Average Time Served in IDOC[1] Among *Graduates*	Average Time Served at Sheridan Among Graduates
Class X	6.5%	72-360 PLUS 36 MSR	85.9 mos.	27.0 mos.	17.1 mos.
Class 1	27.4%	48-180 PLUS 24 MSR	63.1	15.6	13.3
Class 2	34.3%	36- 84 PLUS 24 MSR	56.4	14.3	12.3
Class 3	15.7%	24- 60 PLUS 12 MSR	47.7	12.8	11.9
Class 4	16.1%	12- 36 PLUS 12 MSR	43.7	12.3	11.5
Total	100.0%		56.7	14.7	12.6

[1] *Does not* include incarceration time spent in jail credited towards prison sentence.
[2] Percentages may not add up to 100% due to rounding.

The fact that the majority—roughly two-thirds-- of those admitted to Sheridan will be on mandatory supervised release (MSR) for two or three years due to the felony class of their conviction offenses has some significant implications for their post-Sheridan supervision period. First, given that individuals on MSR can be required to comply with a wide range of conditions of release, including urinalysis, participation in treatment, etc., a large number of those released from Sheridan can be required to participate in an array of aftercare services for a fairly long period of time, which has been found in prior TCs to improve long-term outcomes. Specifically, 65.6 percent of those released from Sheridan during the first 6 ½ years of operation will have two years or more of Mandatory Supervised Release because they were convicted of a Class X, Class 1 or Class 2 felony, which could potentially improve outcomes due to the fact that they will be able, or required, to access aftercare and other support services for a relatively long period of time. On the other hand, longer periods of supervision can oftentimes translate into longer periods of scrutiny and potential detection of technical violations of MSR, resulting in revocations of MSR and return to prison. Thus, these longer periods of post-prison supervision may potentially have an adverse impact on some outcome measures due to the longer period of supervision and scrutiny by parole officers. The fact that 65.6 percent of those at Sheridan will be on MSR for two or three years may have both therapeutic benefits (i.e., longer period during which aftercare can be required) but also will lead to an increased length of time during which

relapse or other violations, such as rearrests, could be detected and result in revocation and reincarceration.

Another aspect of the current sentence that is important when gauging the operation and impact of Sheridan, and also potentially useful for the larger discussion of correctional policy and practice in Illinois, is the fact that just over one-half of those admitted to Sheridan during the 6 ½ years examined in this report were eligible for Earned Good Conduct Credit,[31] which allows them to receive additional time off of their sentence by participating in this program (above and beyond the traditional day-for-day good conduct credits for which almost all inmates at Sheridan are eligible). This is important for a number of reasons, including the fact that those who were receiving EGCC for participating at Sheridan tended to have higher successful institutional-phase completion rates than did those not eligible for this time credit (after other factors were statistically controlled for), and also that this EGCC reduced the length of incarceration, thereby freeing up bed-space more quickly. Among those who graduated from Sheridan during the first six fiscal years of operation (SFY 2005 through 2010), more than 259,872 days of EGCC for Substance Abuse Treatment programming were earned, or 43,312 per year. This EGCC time is equivalent to 119 years of reduced incarceration *per fiscal year*,[32] and given the average annual cost of $23,394 to house an inmate in IDOC for 1 year, the reduced incarceration resulting from ECGG for Substance Abuse Treatment programming is *valued at $2.78 million annually, or $16.7 million* during the 6 full state fiscal years examined in this report.[33] In addition to the EGCC for participation in substance abuse treatment, 4,608 days of EGCC were also earned for participation in educational and vocational programming, saving the equivalent of nearly $300,000 in reduced incarceration costs during the time period examined in this evaluation.

[31] Under Illinois law, inmates with 2 or more prior prison sentences, or those who have previously received Earned Good Conduct Credit (EGCC) are ineligible to receive EGCC again. Further, inmates subject to Illinois' Truth-in-Sentencing law are also prohibited from receiving EGCC.
[32] Determined by taking the 43,312 days earned per year, divided by 365 days, or 119 years.
[33] Annual cost per inmate is for SFY 2008, and came from the Fiscal Impact Statement provided by IDOC to the Clerk of the Circuit Court pursuant to ICLS 5/3-2-9.

IV. SHERIDAN PROGRAM STAGES & COMPONENTS

There are a number of components to the Sheridan program, ranging from those that have been implemented "system-wide" by IDOC as a result of the Sheridan experience, to those specifically designed at Sheridan for the inmates housed there and released back to the community from the prison. Described below are the various stages or phases through which Sheridan participants progress while incarcerated at the facility. Section V describes the process and services received by Sheridan releasees once they are discharged to MSR in the community. There are 4 general phases to the prison-based part of program, and then the final phase being the reentry back into the community.

Recruitment & Screening for Eligibility (1-2 Weeks Following Admission to IDOC)

One of the first things that needed to be put into place in order for Sheridan to identify and screen eligible inmates was the utilization of an objective screening mechanism at the point where individuals were being admitted into the Illinois Department of Corrections. Within Illinois, there are 3 Reception and Classification Centers (R&C), regionally located in northern, central and southern Illinois, where adult male inmates sentenced to prison are initially transported to by local Sheriff's offices on scheduled weekdays. On the day they are admitted to the R&C, inmates go through a variety of interviews and assessments to gauge and assess risks and needs. After this day of interviews and assessments, inmates are then housed at the R&C until a determination is made as to which specific institutional placement is appropriate. Depending on the crowding at the R&C and speed with which institutional placements can be made, newly admitted inmates will spend anywhere from a week to a month at the R&C prior to being transferred to their "parent" institution. However, given the limited amount of substance abuse treatment programming prior to 2004, screening for substance abuse treatment need during the R&C process was not a priority, the methods used to assess treatment need were not clinically based, and the results generally were not used to determine an inmate's institutional placement.

Thus, when Sheridan was being designed and implemented, it became necessary to implement a consistent, objective process to screen for treatment need and also to recruit inmates interested in participating in the Sheridan program. As a result of this need, TASC received a contract to screen all inmates admitted into IDOC for substance abuse/treatment need using the Texas Christian University (TCU) Drug Screen II. During the initial phase of program implementation, this screening process was first put into place at the Stateville R&C, which, as described earlier, serves as the reception and classification center for northern Illinois. The Stateville R&C processes adult male prison admissions from Cook County (Chicago), the counties that comprise the suburbs of Chicago, and some of Illinois' other large urban population centers. In general, the majority of all prison admissions in Illinois—more than 70 percent--come through the Stateville R&C, so it was a necessity to focus on getting the screening and recruitment for Sheridan established there first. By April 2004, screening for substance abuse and treatment need was in place at all 3 of the R&Cs, and, for the first time, there was a mechanism in place to determine overall treatment needs within IDOC. For a variety of reasons, including sheer volume and the proximity of Sheridan to where many of the inmates were from, the majority (96.6 percent) of inmates admitted to Sheridan during the first 6 ½ years of the program were recruited from the Stateville R&C.

On the day the inmate is admitted to one of the IDOC's R&Cs, they are screened by TASC, and if determined to be in need of treatment and if they appear appropriate for Sheridan, TASC staff explain to the newly admitted inmate the Sheridan program, the benefits of the program, and determine, from information available at that point in time in the R&C process, if the inmate meets the other eligibility criteria (i.e., excluded offenses, projected length of time to serve, etc). For those inmates who are identified as in need of treatment (a score of at least "3" on the TCU DSII), appear to meet eligibility criteria, and volunteer to participate in the program by signing a form ("contract") indicating their desire to be transferred to Sheridan, TASC makes a recommendation that they be admitted to Sheridan. All of this generally takes place within the first couple of days the inmate is admitted into the R&C. Following the R&C process of interviews and assessments, and the collation of all the information obtained during the R&C process, IDOC's Transfer Coordinator's Office (TCO), located in Springfield, Illinois (the state capital and IDOC headquarters) reviews all of the information and makes an institutional

assignment for each inmate within a week or two. During the time the TCO is reviewing an inmate's information to determine the appropriate placement, the inmates stay within the Reception and Classification Center. During this stay TASC staff may re-interview inmates or meet with inmates who were identified for possible Sheridan placement to provide additional information about the program. Despite being recommended by TASC for Sheridan, it is possible that the Transfer Coordinator's Office will not give that institutional assignment of Sheridan due to information that became available or clarified subsequent to TASC's initial screening, such as an outstanding warrant, determination that the inmate must be placed in a maximum security facility, or if there are no beds available at Sheridan. Based on the data regarding admissions to Sheridan, it does not appear that recruitment and ultimate referral of a sufficient number of eligible inmates to Sheridan has been a problem.

As seen in Table 11, the average number of days between an inmate's admission into one of IDOC's R&Cs and their subsequent transfer to Sheridan was 18.6 days. That amount of time is primarily influenced by the relatively short period of time inmates admitted through Stateville spend in the R&C process. Because of the volume of inmates admitted into IDOC through the Stateville R&C, there is considerable pressure to move inmates through the process quickly and get them to their parent institution in order to avoid crowding problems at the Stateville R&C. The state's two other adult male R&Cs (Graham & Menard) tend to have a much lower volume of admissions, and therefore are able to house inmates in the R&C process for a longer period of time (i.e., in the case of the 74 inmates transferred to Sheridan directly from the Graham R&C, they spent an average of just over one month in the R&C stage) (Table 11).

Table 11
Number of Days Between Admissions into IDOC and Transfer to Sheridan Among Those *Admitted Directly* to Sheridan from R&Cs, by R&C, 2004 to June 2010

Reception & Classification Center	Number	Average (Mean) Days	Median Days
Stateville Reception & Classification Center – Northern Illinois	5,768	18.3	14.0
Graham Reception & Classification Center – Central Illinois	74	35.0	33.0
Menard Reception & Classification Center – Southern Illinois	27	26.8	21.0
Total	**5,869**	**18.6**	**14.0**

Transfer & Admission into Sheridan/Development of Treatment Plan (1 to 2 Weeks Following Admission to IDOC)

After inmates are transferred to Sheridan, they go through a much more extensive substance abuse assessment conducted by the treatment provider at Sheridan using the Addiction Severity Index (ASI). At that point in time, much more detailed data regarding the inmate's substance abuse problem is obtained, along with a variety of other information that is used to develop the inmate's treatment plan. In general, the more comprehensive assessment takes place within one week of the inmate's transfer to Sheridan. It is during this more comprehensive assessment that some specific issues might be identified that would result in the inmate being determined as not appropriate for the program. For example, during this more comprehensive assessment at Sheridan, there have been instances where previously undetermined mental or physical health issues have come to light and determined to be such that participation in the program would not be appropriate. In addition to an assessment by the substance abuse treatment provider, newly admitted inmates also go through a variety of other assessments, including one to gauge their level of academic ability (the Test of Adult Basic Education, or TABE), an assessment of their readiness and motivation for treatment, and an assessment by a career counselor/job coach to determine their vocational and employment skills and experience.

Orientation (First Month At Sheridan) (Phase 1)

In addition to various assessments and the development of a comprehensive, multidisciplinary treatment plan, inmates at Sheridan also go through an orientation phase during their first month at the facility. During orientation, inmates are provided with some basic drug education, discussion and learning about the TC philosophy and program rules, and other motivational activities and exercises to get them prepared for their treatment and participation in the program. During this phase, inmates will also begin to get involved in educational and vocational programming, as well as assume various job responsibilities within their individual housing unit or "family" along with more general /traditional institutional job assignments. During the orientation phase, inmates at Sheridan are housed in C25, the largest housing unit at Sheridan and referred to as C25 and described as an X-house due to the physical layout resembling an X. This housing unit is designed with a central control room where correctional officers can control

locks and doors throughout the housing unit, and from that central control room are four long "cell blocks," each containing roughly 50 cells, or a total of 200 cells in the entire building. However, 30 of these cells have been converted into office space for the treatment staff to conduct assessments and meet individually with program participants. Thus, with 170 cells for inmate housing, and with each cell housing 2 inmates, the overall capacity of this building is roughly 340 inmates. One of these wings serves—C25, A Hall--as the orientation unit for newly admitted participants and usually has around 80 inmates.

Group & Individual Treatment (Months 2 to 24 at Sheridan) (Phases 2 through 4)

Following successful completion of their orientation phase, which requires inmates to pass an exam showing that they understand the TC philosophy and basic issues regarding their drug abuse, inmates are then placed into smaller housing units and "families," where they begin their regimen of intensive, daily substance abuse treatment. Each inmate at Sheridan is required to participate in group treatment five days per week for a minimum of 15 hours per week. This programming includes didactic groups, process groups, encounter groups, cognitive restructuring program groups, aggression management and domestic violence groups, behavior management, TC structures and responsibilities, and support groups (Illinois Department of Corrections, 2006). Inmates are identified as being in either AM or PM groups, meaning that one-half of the inmates at Sheridan are participating in intensive drug treatment in the morning (generally from 8 a.m. to 11:00 a.m.), while the other half is involved in various educational, vocational, job, structured leisure, recreational and art therapy assignments. Lunch for all inmates is provided in shifts between 11:00 and 1:00, after which the groups then shift, with the group that was in treatment in the morning going to their educational, vocational, or job assignments from 1:00 to 4:00 p.m., and the other group having their drug treatment programming. The beginning and end of each day involves "family" meetings, and inmates are also provided with time in the evening to participate in recreational programming and complete school assignments or "homework" related to their treatment programming. This schedule is generally the same every day from Monday through Friday. Visitation with friends and family members is only allowed on the weekends, so there are generally less structured activities on Saturdays and Sundays.

The amount of treatment received obviously varies depending on how long the inmate is at Sheridan, and also follows a graduated schedule depending on each individual's status with respect to their treatment and recovery. For inmates who have successfully moved through the stages of intensive treatment, particularly those who are at Sheridan for 12 months or more, the intensity of the treatment regimen is reduced, and the focus on educational and vocational programming is enhanced (Phase 4). To enter Phase 4, participants are required to have completed a *minimum* of 12 months at the Sheridan Correctional Center, demonstrate leadership within their treatment group and the facility, *and* proven themselves to be active participants in the Therapeutic Community. However, despite this "graduation" within the program, these inmates do still participate in treatment sessions and often serve as mentors within the "families" and housing units with newer participants. Further, given that the entire prison is operated as a TC, "treatment" does not end after a group or individual counseling session, but rather, is reinforced throughout the entire day by all the staff and participants in the program. Upon movement into Phase 4, participants are required to participate in group treatment 3 days per week (as opposed to the 5 days through Phase 3), and still remain with the same counselor and within the same housing unit. During the 2 days Phase 4 participants are not in treatment, they are fully engaged in either work or school within Sheridan.

Changes in Participant Psychological and Social Functioning and Criminal Thinking Patterns While at Sheridan

The primary goal of the Sheridan Correctional Center TC is to reduce offender substance abuse and involvement in criminal activity through the provision of treatment that improves the psychological and social functioning of participants, reduces their criminal thinking patterns, and provides them with educational and vocational programming and experiences that will improve their chances of success once released from prison. In order to gauge the degree to which Sheridan participants changed their ways of thinking about their criminal activity, and how their psychological and social functioning changed during the course of program participation, inmates at Sheridan complete a series of self-administered surveys at each program phase change.[34] These surveys, developed by Texas Christian University's Institute for Behavioral

[34] The surveys are administered by WestCare's Research staff in group settings within a classroom. To address potential issues of illiteracy, the questions are read aloud and the inmates complete the surveys.

Research (TCU's IBR), have been used extensively in treatment programs serving criminal populations for both program evaluation purposes as well as for clinicians to monitor client progress and needs.[35] These forms include: 1) Treatment Needs and Motivation,[36] 2) Psychological Functioning, 3) Social Functioning, 4) Treatment Engagement and Process,[37] and 5) the Criminal Thinking Scales.

During the earlier phases of the Sheridan evaluation (2004-2006), the Client Evaluation of Self and Treatment (CEST) was administered to random samples of Sheridan participants exclusively to measure aggregate participant views for purposes of the evaluation, however, since 2007, these TCU forms are administered to all Sheridan participants at each phase change by WestCare staff. For purposes of the evaluation, the data collected through these forms were analyzed to determine if participants improved over the course of program participation in terms of their psychological functioning, social functioning and criminal thinking. In addition, participant views of their treatment (captured through the Treatment Engagement and Process form) were also examined and are presented below.

Changes in Psychological Functioning

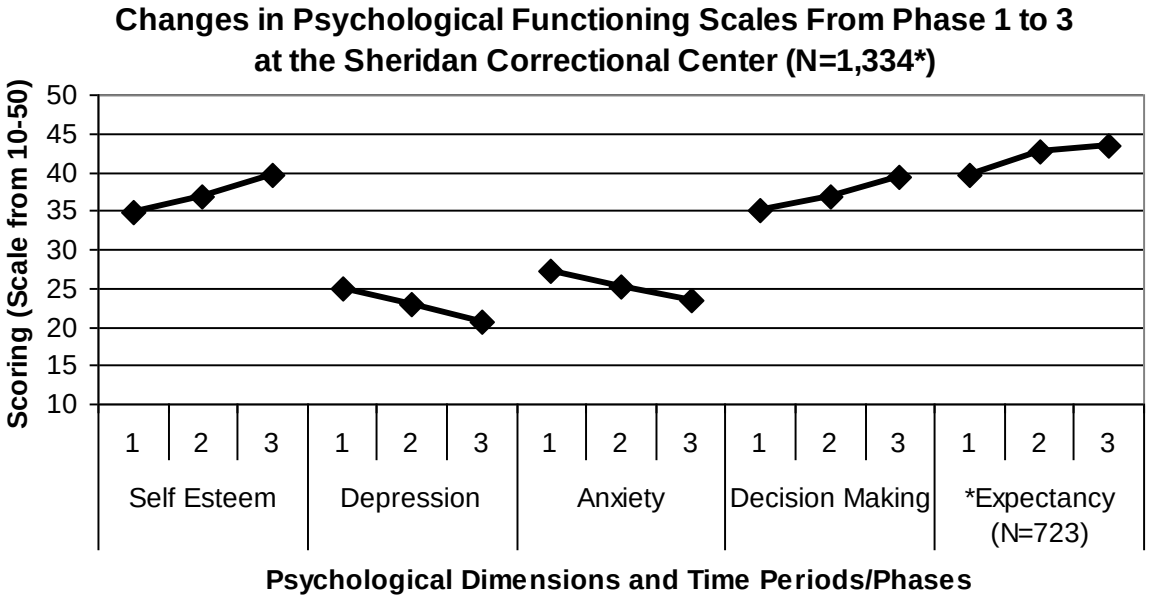
TCU's Psychological Functioning form asks respondents to indicate how strongly they agree or disagree with 33 different statements. Combining specific combinations of the responses to these statements produces a quantitative measure, or scale, of five different dimensions of psychological functioning, including: self-esteem (having a favorable impression of oneself), depression (feeling depressed, sad, lonely or hopeless), anxiety (feeling nervous, tense, sleepless or fearful), decision making (having difficulty making decisions, considering consequences, or planning ahead), and expectancy (likelihood of refraining from drug use).[38] Scores on each of these dimensions can range from a low of 10 to a high of 50, with a score above 30 indicating agreement or strong agreement with the statements that comprise the scale. For the scales

[35] For a more complete description of the forms developed by TCU's IBR, as well as the scoring of these forms, see http://www.ibr.tcu.edu/pubs/datacoll/datacoll.html
[36] Results from the Treatment Needs and Motivation form are primarily useful to describe the degree to which participants recognize their need for substance abuse treatment and motivation to participate in treatment.
[37] The Treatment Engagement and Process form is not administered to participants at the completion of Phase 1, since Phase 1 is the treatment orientation phase, but is administered at the completion of the other program phases.
[38] See http://www.ibr.tcu.edu/pubs/datacoll/cjforms.html for a detailed description of each scale.

measuring self-esteem, decision making and expectancy, a higher score indicates a more positive level of functioning. For the scales gauging levels of depression and anxiety, lower scores indicate lower (i.e., better) levels of these psychological states.

Figure 12 presents the average score on each of these five dimensions of psychological functioning across three different time period of administration—at the beginning of Phase 1, Phase 2 and Phase 3 of the program. As seen in Figure 12, as participants matriculated from Phase 1 (entering orientation) to Phase 3 of the Sheridan program, the measures of self-esteem, decision making and expectancy all improved, and levels of depression and anxiety decreased.[39] For example, the scale measuring depression decreased from an average of 25 at the beginning of Phase 1 to 20 at the beginning of Phase 3, or a 20 percent improvement. Thus, sustained participation in the Sheridan program improved the level of psychological functioning of the program participants.

Figure 12



[39] Results are presented for the 1,334 participants who completed the Psychological Functioning form at each of the three phase changes. The scale measuring expectancy was not included in the assessment until May 2008, and therefore was available for 723 of the cases. Not all Sheridan participants are in the program long enough to enter Phase 3, and thus the number of cases included in the analyses represents those who remained in the program for a substantial period of time. All of the differences between the Phase 1 and Phase 3 averages presented in Figure 12 are statistically significant at the $p<.001$ level based on a matched samples t-test. Identical analyses were performed comparing the results at Phase 1 to Phase 2 within the same matched sample, and again, statistically significant improvements at the $p<.001$ level were evident across each of the five dimensions.

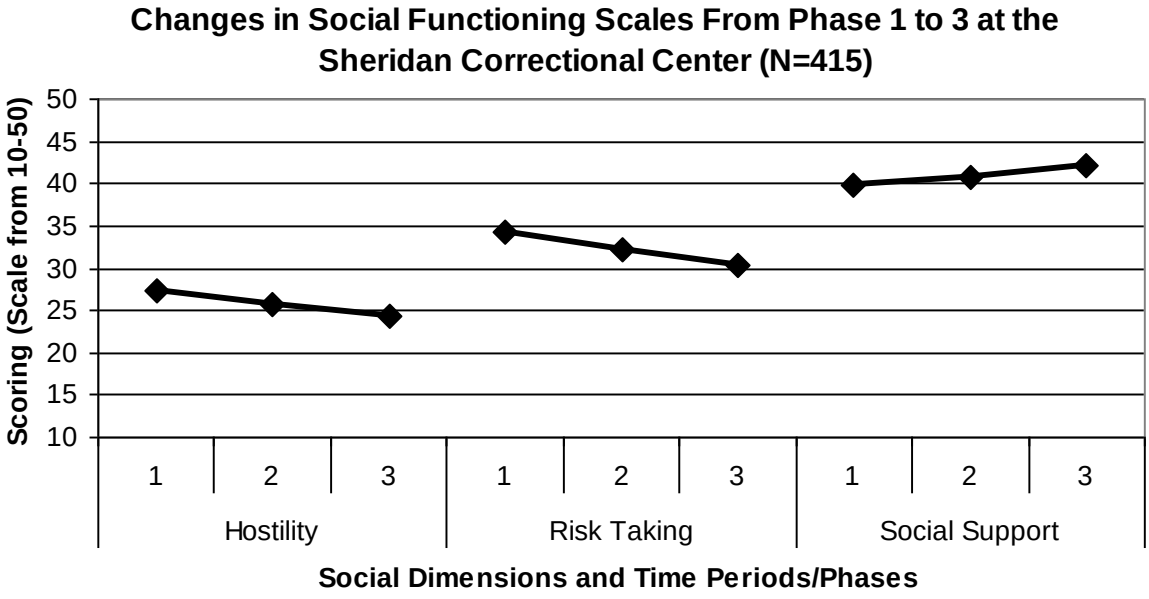
Changes in Social Functioning

The Social Functioning form asks respondents to indicate how strongly they agree or disagree with 36 different statements. Using specific combinations of the responses to these statements produces quantitative assessments of three different dimensions of social functioning, including: hostility (having a bad temper or tendency to intimidate others), risk taking (enjoys taking chances and being dangerous), and social support (having external support of family and friends). Scores on each of these dimensions can range from a low of 10 to a high of 50. For the scales measuring hostility and risk taking, a lower score indicates a lower level of these feelings, whereas higher scores for social support are indicative of a more positive level of this functioning.

Figure 13 presents the average score on each of these three dimensions of social functioning across three different time periods of administration—at admission (Phase 1), and upon entry into Phase 2 and Phase 3 of the program. As seen in Figure 13, as participants matriculated from Phase 1 to Phase 3 of the Sheridan program, the measures of hostility and risk taking were both reduced (improved), and the level of social support increased (also an improvement).[40] Thus, over time, participation in the Sheridan program improved the social functioning of inmates.

[40] Results are presented for the 415 participants who completed the Social Functioning form at each of the three phase changes and who also answered the question included as an accuracy check correctly. Not all Sheridan participants are in the program long enough to enter Phase 3, and thus the number of cases included in the analyses represents those who remained in the program for a substantial period of time. All of the differences between the Phase 1 and Phase 3 averages presented in Figure 13 are statistically significant at the $p<.001$ level based on a matched samples t-test. Identical analyses were performed comparing the results at Phase 1 to Phase 2, which included nearly 1,000 matched cases, and again, statistically significant improvements were evident across each of the three dimensions.

Figure 13



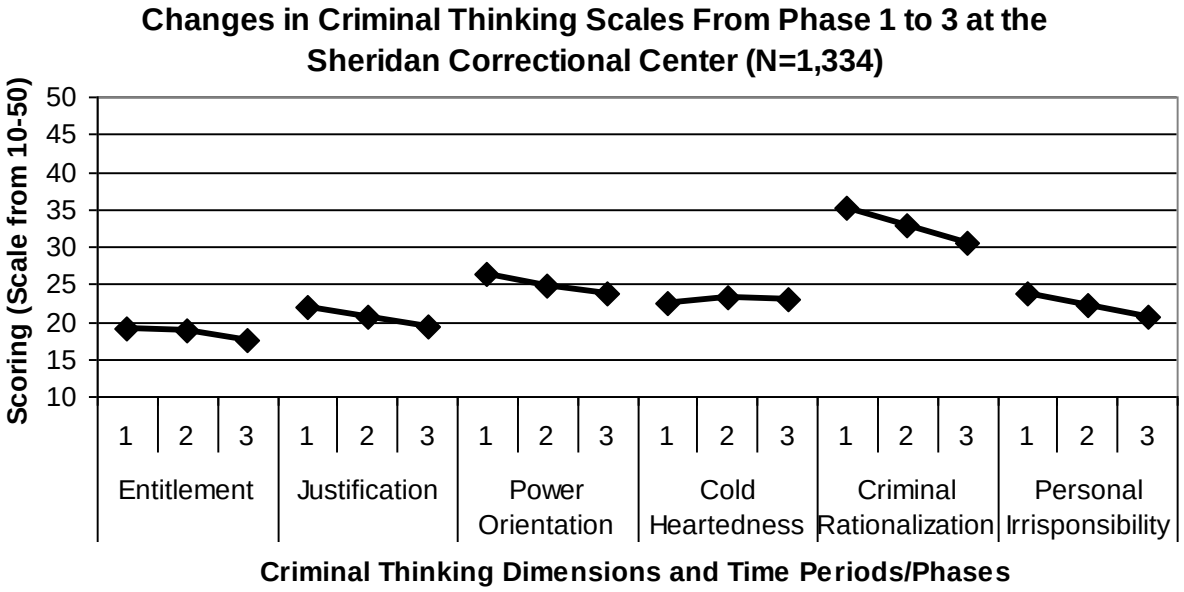
Changes in Criminal Thinking

The Criminal Thinking Scale (CTS) asks respondents to indicate how strongly they agree or disagree with 36 different statements. Using specific combinations of the responses to these statements produces quantitative assessments of six different dimensions of criminal thinking, including: entitlement (sense of ownership and privilege, misidentifying wants as needs), justification (justify actions based on external circumstances or actions of others), power orientation (need for power, control and retribution), cold heartedness (callousness and lack of emotional involvement in relationships), criminal rationalization (negative attitude toward the law and authority figures), and personal irresponsibility (unwillingness to accept ownership for criminal actions). Scores on each of these dimensions can range from a low of 10 to a high of 50, with higher scores indicting problematic criminal thinking patterns.

Figure 14 presents the average score on each of these six dimensions of criminal thinking across three different time period of administration—at admission into Phase 1, Phase 2 and Phase 3 of the program. As seen in Figure 14, as participants matriculated from Phase 1 to Phase 3 of the Sheridan program, the measures of six indicators of criminal thinking were reduced

(improved).[41] Thus, over time, participation in the Sheridan program reduced the criminal thinking patterns of the inmates enrolled in the program.

Figure 14



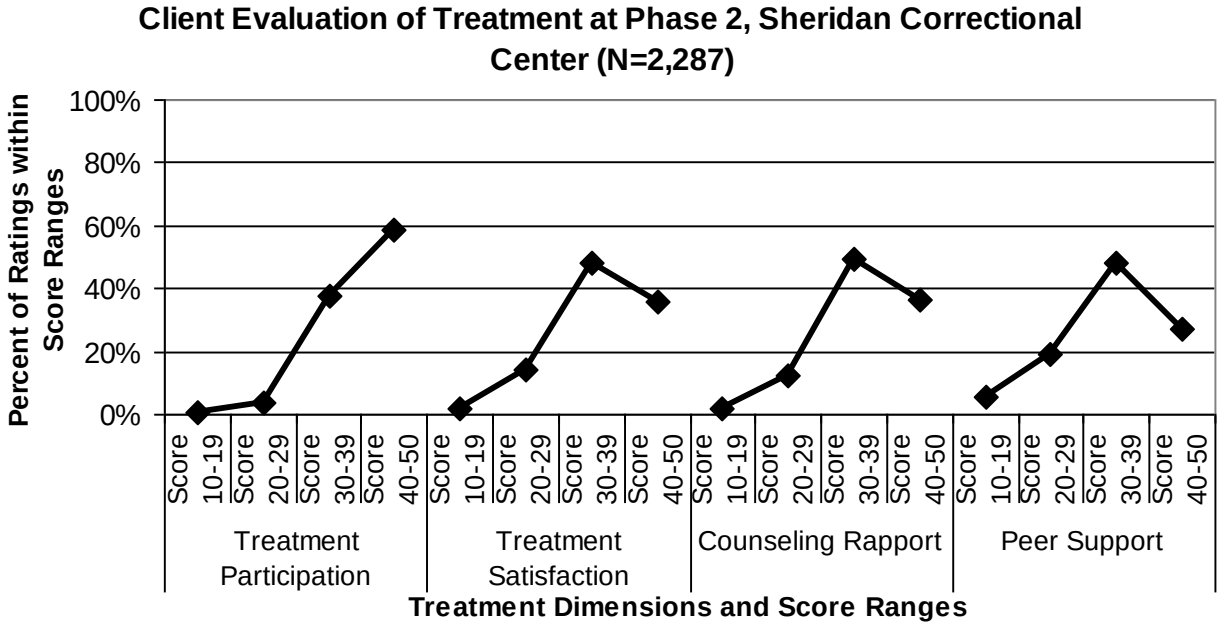
In addition to examining changes in the psychological and social functioning, and criminal thinking patterns of inmates at Sheridan as they moved through the program, information collected from participants also assessed dimensions of treatment engagement from their perspective. Specifically, through the Treatment Engagement Process form, which asks respondents to indicate how strongly they agree or disagree with 36 different statements, it is possible to construct measures of treatment participation, treatment satisfaction, counseling rapport (having a therapeutic and trusting relationship with counselor/staff), and peer support (having supportive relationships with other clients in the program). Because clients in the

[41] Results are presented for the 1,334 participants who completed the Criminal Thinking Scale form at each of the three phase changes. Not all Sheridan participants are in the program long enough to enter Phase 3, and thus the number of cases included in the analyses represents those who remained in the program for a substantial period of time. All of the differences between the Phase 1 and Phase 3 averages presented in Figure 14 are statistically significant at the $p<.001$ level based on a matched samples t-test. Identical analyses were performed comparing the results at Phase 1 to Phase 2, and again, statistically significant improvements were evident across each of the six dimensions.

orientation phase of the program (i.e., Phase 1) are not yet receiving treatment, this form is not administered until entry into the latter phases of the program (i.e., Phase 2 and beyond).

Summarized in Figure 15 is distribution of responses across each of these four dimensions of treatment engagement and satisfaction, with the scores grouped into 4 ranges—10 to 19, 20 to 29, 30 to 39 and 40 to 50. The higher the score, the better the client's perception of each of these areas of their treatment, and scores below 30 indicate less positive views. As seen in Figure 15, the majority of participants who entered Phase 2 had very positive views of their treatment participation, treatment satisfaction, counselor rapport, and peer support. For example, 48 percent of participants entering Phase 2 had a score of 30 to 39 on the treatment satisfaction scale, and an additional 36 percent had a score of 40 to 50. The mean score on the treatment satisfaction scale at the completion of Phase 2 was 36. Similarly, 85 percent of those in Phase 2 scored counselor rapport at 30 or higher, with a mean score on this scale of 36.

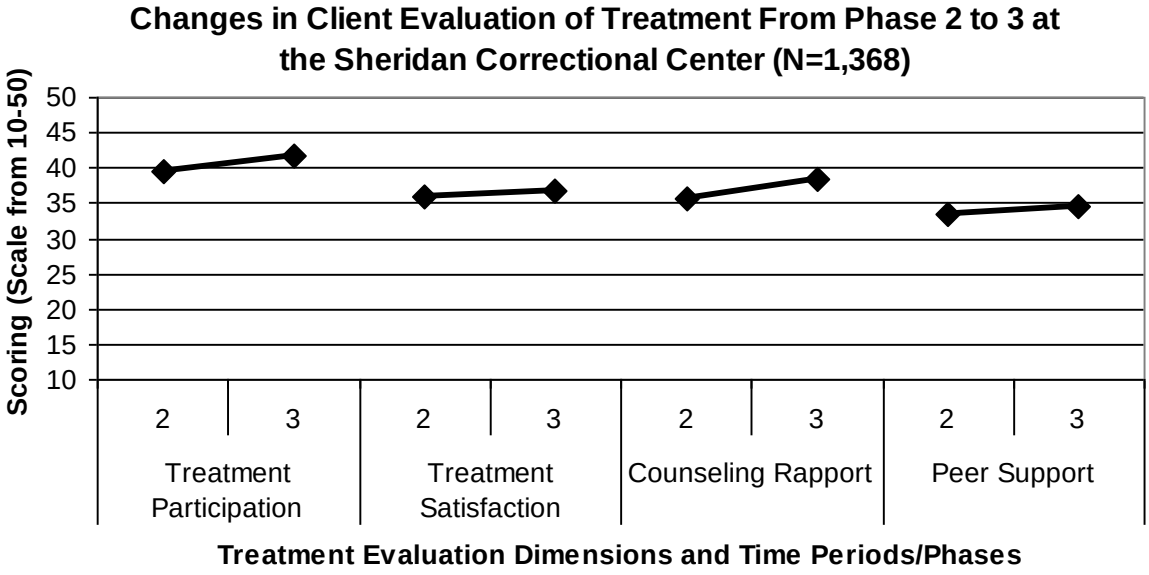
Figure 15



It is also apparent that as participants continue in the program, and move through additional phases of the Sheridan program, their already high ratings of treatment participation, treatment satisfaction, counseling rapport and peer support improved. As see in Figure 16, which compares

the mean scores across each of these four components of treatment engagement and satisfaction at entry into Phase 2 and Phase 3, improvements were seen across each of these areas. For example, the mean score for the scale measuring counselor rapport increased almost 10 percent, from an average of 35 from Phase 2 to an average of 38 during Phase 3.

Figure 16



Thus, based on self-reported information from the inmates participating in the Sheridan Correctional Center program, it is apparent that over the course of program participation improvements were seen in the psychological and social functioning of participants, there were lower levels of criminal thinking patterns, and very favorable views of the overall treatment services provided, as well as the rapport and support from both counseling staff as well as program peers.

Education

In addition to their formal participation in group and individual substance abuse treatment, inmates at Sheridan receive and participate in educational instruction through the IDOC School District. IDOC policy states that any inmate, at Sheridan or any other facility, that does not score at least a 6 on the Test of Adult Basic Education (TABE) test must attend school for at least 90

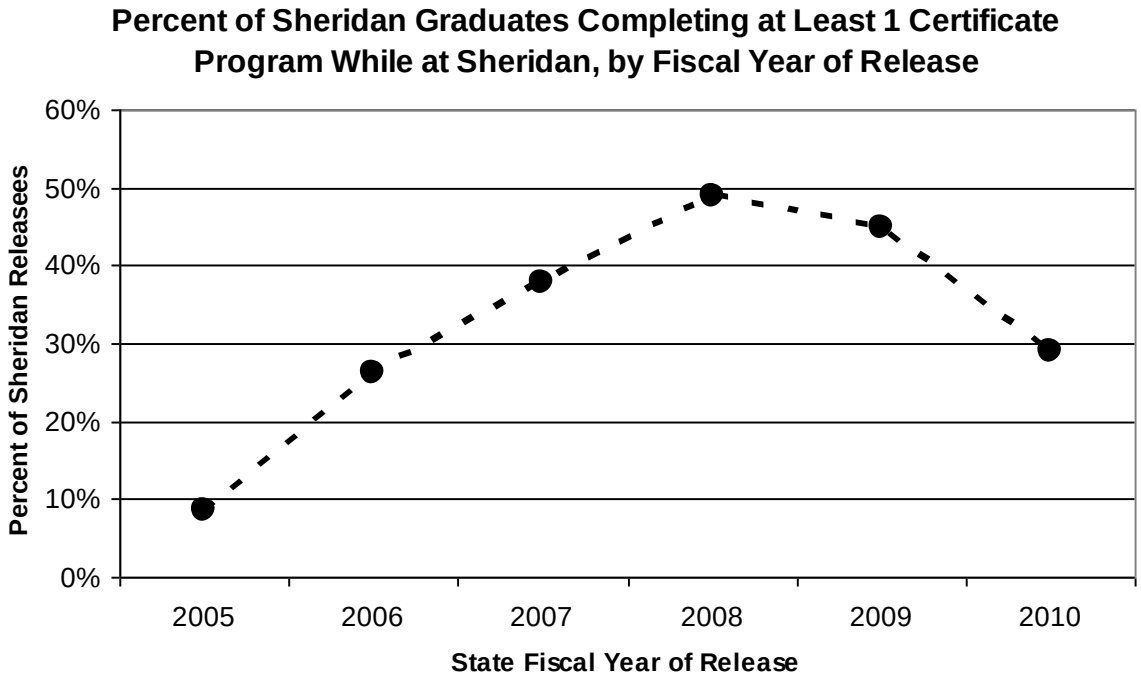
days. However, given the nature of the Sheridan program, all inmates are encouraged to participate in educational programming, including classes to prepare them to take the GED exam. As described earlier, 57 percent of those admitted to Sheridan entered prison without a high-school diploma or GED, which translates to more than 3,700 inmates during the first 6 ½ years of operation. From SFY 2004 to 2010, the first six years of program operation, a total of 504 inmates at Sheridan took the GED exam, and 86 percent of the inmates who took the GED passed the test.

Vocational Training

While at Sheridan, participants also receive a variety of services designed to enhance their vocational skills, work experience, and better prepare them to seek and obtain employment upon their release from prison. For example, inmates at Sheridan can earn certification in a number of fields, including A+ Computer/Network, specific building trades (i.e., electrical and carpentry), building maintenance, horticulture, forklift operations, commercial custodian, and warehousing. During the time period examined in this report (January 2004 through June 2010), 32 percent of the inmates who graduated from Sheridan completed at least one certification program. The most popular certificate programs that Sheridan participants completed were maintenance and repair (accounting for 17 percent of the participants that earned certificates), followed by welding (15 percent), carpentry (14 percent) and warehouse operations (14 percent), and food service (9 percent). Analyses also found specific participant characteristics predictive of their completion of at least one certificate program, the strongest of which were prior prison sentences (those with more prior prison sentences were more likely to earn a certificate), and related to this, length of time at Sheridan (the longer the inmate was at Sheridan, the more likely they were to earn a certificate). Specifically, those that earned a certificate served almost 3 months longer at Sheridan than those who did not complete or earn a certificate. As seen in Figure 17, the proportion of Sheridan graduates completing at least one certificate program at Sheridan increased considerably during the early years of program implementation—from less than 10 percent of the inmates released in SFY 2005—to a peak of 50 percent in SFY 2008. The slight decrease during SFYs 2009 and 2010 were the result of staff vacancies within the vocational and

certificate programs, which limited the number of inmates that were able to participate in these programs.

Figure 17



In addition to the certification opportunities, there is also a program at Sheridan whereby inmates working within various job assignments at Sheridan participate in a job shadowing program. Through the job shadowing program, inmates receive the types of feedback and reviews of their institutional work assignment similar to what they would experience in a traditional community-based job, including periodic performance assessment. Inmates at Sheridan are also provided with a job preparedness curriculum, during which inmates are given instruction on how to find, apply for, obtain, and retain employment upon their release. Finally, before inmates are released from Sheridan, they assemble and are provided with assistance in putting together a work portfolio, including a resume, cover letters, work appraisals from their job shadowing participation, and certificates from vocational programs they may have completed while at Sheridan.

Completion of the Institutional-Phase of the Sheridan Program

The length of time an inmate spends at Sheridan is determined exclusively by the length of the prison sentence imposed by the court that resulted in the inmate's incarceration, minus any jail credits, good conduct credits and any other statutorily defined/dictated credits towards the inmate's prison sentence. As such, an inmate can successfully complete the institutional phase of Sheridan even if from a clinical perspective their treatment has not been completed. However, because every inmate released from Sheridan after having completed their prison sentence is required to be on Mandatory Supervised Release (MSR) for a statutorily proscribed length of time, which, as described earlier, is based on the felony class of the crime for which they are in prison, those released from Sheridan are required to continue their treatment in the community at a clinically determined level of care. In fact, every inmate released from Sheridan, except those entering an Adult Transition Center (ATC), has some type of aftercare or continued treatment requirement—which as will be seen later in this report, most often involves their participation in outpatient treatment.

Prior to an inmate's release from Sheridan, an aftercare plan is developed by a multi-disciplinary team during two pre-release case staffings, one at 120 days and again at 30 days pre-release, where specific aftercare requirements are identified and discussed. Initially, inmates were not allowed to participate in the 120 day staffing, but this was later changed to increase the participants' understanding and compliance with aftercare requirements. The pre-release case staffing involves a number of different staff, which can include the inmate's substance abuse treatment counselor at Sheridan, their IDOC counselor at Sheridan, their community-based parole agent, their community-based TASC clinical case manager, and institutional/community-based Safer staff. Depending on the individual inmate's clinical, housing, employment and personal needs, these conditions include additional treatment after release (which can range from residential treatment for those who were at Sheridan for a relatively short period of time to outpatient treatment), not residing in specific neighborhoods or with specific individuals, random urinalysis, enrollment in educational or vocational training, and any other conditions deemed important for that person's post-release success. These conditions are in addition to the standard

conditions of MSR that everyone released from IDOC must abide by, including meeting with their parole agent on a regular basis, not getting arrested, etc.

These post-release aftercare services are coordinated by clinical case managers from TASC, a community-based agency that provides substance abuse assessments, referrals to treatment, and clinical case management services. The referrals to aftercare are made to ensure that they are appropriate for the inmates' particular needs and are also geographically accessible given the location where the releasee will be living. All inmates released from Sheridan are required to participate in some form of aftercare, ranging from outpatient treatment to continued residential treatment in the community. These requirements are specified by the Prisoner Review Board (PRB), an entity separate from the Illinois Department of Corrections and comprised of members appointed by the Illinois Governor. The PRB not only specifies the required conditions of Mandatory Supervised Release (PRB), with input from IDOC staff, but also conducts hearings when a parole agent files a violation of MSR and determines the sanction imposed on MSR violators. The intake assessments for these community-based aftercare referrals are ideally scheduled prior to the inmate's release, and usually take place within the first week or two following the inmate's release from Sheridan.

V. POST-RELEASE SERVICES & PROGRAMMING

Introduction

One of the factors prior research has consistently found to enhance positive outcomes of prison-based (or other intensive, residential) substance abuse treatment programs is aftercare, including additional outpatient treatment, participation in support groups, and relapse prevention programs. Given this, *all* inmates released from Sheridan are required as a condition of their Mandatory Supervised Release (MSR) to participate in some type of aftercare treatment, which, as described above, is determined from a clinical standpoint by the WestCare treatment team, and communicated to the multidisciplinary team that meets prior to the release of each inmate from Sheridan. Prior to release, TASC uses this clinical assessment of aftercare treatment need to work with the inmate to identify a treatment program that is appropriate for the inmates' particular needs and accessible from the geographic location the releasee will be residing. The intake assessments for these community-based referrals are ideally scheduled prior to the inmate's release, and are usually scheduled to take place within the first week or two following the inmate's release from Sheridan. The information presented in this section of the evaluation summarizes the types of post-Sheridan treatment/aftercare referrals given to the Sheridan participants, the timing of these referrals, and the extent to which the Sheridan releasees entered and completed these aftercare services.

To examine the Sheridan releasees' access to post-release treatment, their compliance and completion of aftercare, and the impact aftercare compliance had on post-release recidivism rates, data from TASC were examined to answer the following specific questions:

1) What is the range of treatment programs and services those released from Sheridan are being *referred* to?
2) What is the timing of these referrals relative to release from Sheridan and supervision in the community?
3) To what degree are those released from Sheridan "showing up" to treatment referrals, are they being accepted/admitted into those programs, and if not, why?
4) Of those released from Sheridan that do access post-release treatment services, how long are they in treatment and what proportion are successfully completing those treatment programs?
5) And, finally, what impact did the success or failure in post-release treatment have on subsequent recidivism patterns (discussed in Section VI)?

Given the "fluid" nature of the data being analyzed and the fact that the majority of those who have been released from Sheridan since July 2009 are still under active supervision, some of the patterns and findings from the analyses of treatment referral, entry and completion can change as those who are still in the program enter and complete (or fail in) their aftercare referrals. This potential issue is most significant and likely when examining the post-release treatment experiences of those released from Sheridan during SFY 2010, since many may have not yet been able to enter or successfully complete their aftercare. The extent to which these issues potentially influence the interpretation of the data presented below will be pointed out within each section.

Post-Sheridan Treatment Recommendations

As indicated earlier, every inmate released from Sheridan has some type of aftercare requirement and referral, ranging from the least intensive (regular outpatient counseling), to intensive outpatient treatment, to a variety of housing and residential settings, such as a half-way house, a recovery home, or the most intensive type of post-release referral, additional residential treatment. In addition, inmates released from Sheridan can be referred to different levels of care at different points during their post-release supervision period. For example, an inmate may be released and referred to a traditional outpatient program, but could be referred to residential treatment if at some point during their Mandatory Supervised Release it is determined that they need a higher level of care. Similarly, inmates released from Sheridan to a residential program can be referred to outpatient services once they complete the residential program. Thus, initial referrals are made for the 90 days immediately following an inmate's release from Sheridan, and subsequent, additional referrals to various aftercare services can take place months (or years depending on the length of MSR) after their release. During the first 6 ½ years of operation (January 2004-June 2010), data from IDOC indicate that 4,328 inmates successfully completed the institutional phase of Sheridan and were released to either Mandatory Supervised Release (i.e., "parole") or an Adult Transition Center (ATC) in the community.[42] Inmates discharged to

[42] There were a total of 4,328 inmates released from Sheridan after having completed the institutional-phase of the program, including 4,162 released directly to MSR and 166 released to an Adult Transition Center—ATC. Those inmates released to an ATC are generally not provided with aftercare referral services from TASC since they receive these through the ATC.

an ATC do not receive aftercare or TASC clinical case management services, so the total number of Sheridan releasees eligible for post-release services through June 30, 2010, was 4,162.

As summarized in Table 12, of the 4,162 releasees to MSR during the period examined, all but 64 participants--4,098--had at least one referral to some type of aftercare service. Intensive outpatient treatment accounted for the single largest category of referrals among those released from Sheridan during the first 6 ½ years of operation combined, followed by traditional outpatient, recovery home, half-way house, residential treatment and detoxification programs. As illustrated in Table 12, releasees can have multiple referrals within the same modality as well as across the different aftercare services. In some instances, referrals to services such as a recovery home will also include a referral to outpatient treatment, and generally participants who complete an intensive outpatient program will then be referred to a traditional outpatient program.

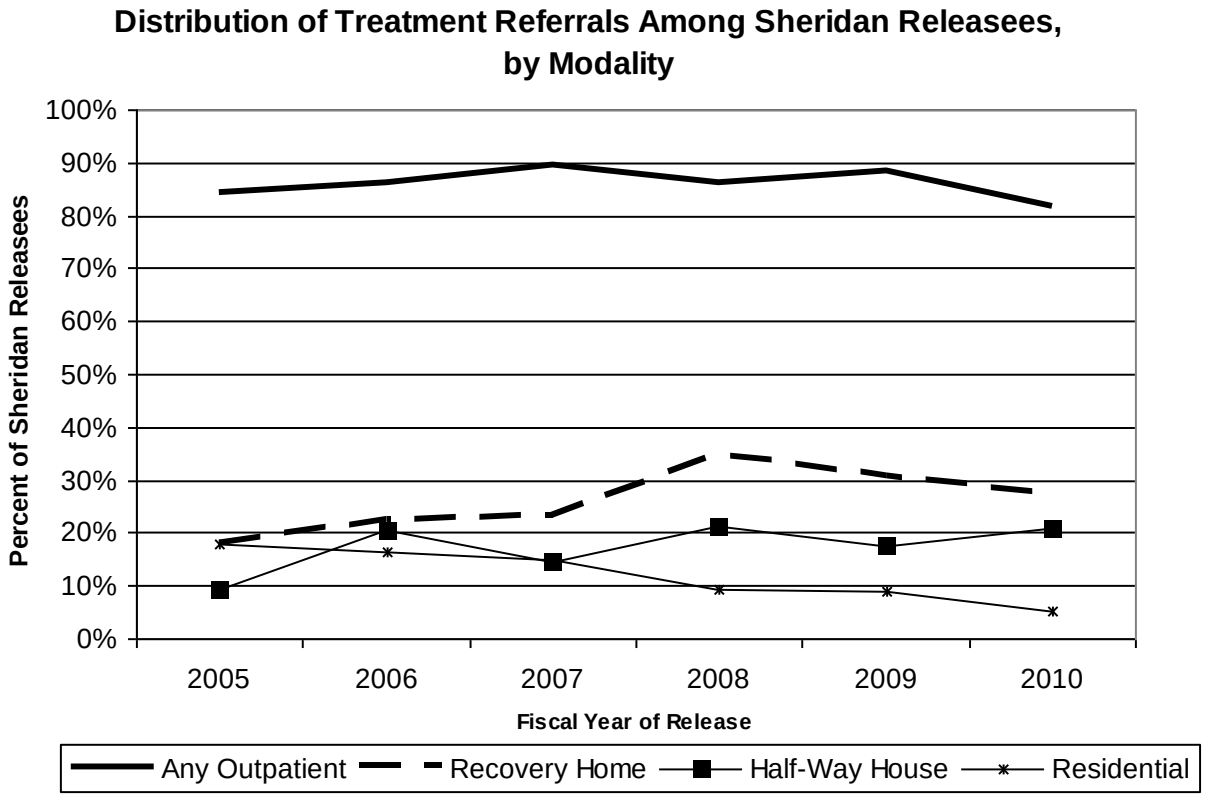
Table 12
Modality of Treatment Recommendations/Referrals & Admissions Among Sheridan Releasees, July 2004 to June 2010

	Number of Clients Referred	Number of Referrals [2]	Percent of Clients w/ at Least 1 Referral [2]
Any Outpatient [1]	3,529	5,233	84.8%
Intensive Outpatient	2,719	3,527	65.3%
Traditional Outpatient	1,328	1,706	31.9%
Residential Treatment	507	662	12.2%
Any Half-Way House, Recovery Home or Transitional Living			
Half-Way House	707	815	17.0%
Recovery Home	1,051	1,273	25.3%
Methadone Maintenance	32	34	0.8%
Detoxification	179	227	4.3%
Total Sheridan Participants Released to MSR [4]	4,162		98.5%

[1] A total of 518 clients that were referred to *both* intensive outpatient treatment and regular outpatient treatment, but not at the same time. Generally, someone referred to regular outpatient will have completed an intensive outpatient program first, although some initial referrals to regular outpatient may result in a referral to a higher level of care (i.e., intensive outpatient).
[2] Individuals can receive multiple referrals and have multiple admissions to treatment modalities so the number of referrals & admissions exceeds the number of Sheridan releasees, and the total percent exceeds 100 percent.
[3] Referrals to methadone maintenance include separate referrals for every individual methadone maintenance appointment.
[4] During the time period examined, there were 4,162 inmates released from Sheridan that did not go to an ATC. TASC data indicated referrals for 4,098 clients, thus, 64 Sheridan releasees had no referrals recorded.

As seen in Figure 18, the distribution of the types of treatment referrals given to those released from Sheridan has changed slightly during the 6 ½ years of program operation. For example, during SFY 2005 through June 2010, between 80 percent and 90 percent of all releasees from Sheridan were referred to some type of outpatient treatment. The proportion of releasees referred to a recovery home increased during the period examined in this report, from less than 20 percent among the SFY 2005 releasees to roughly 30 percent or more among those released since 2007. On the other hand, the proportion referred to residential treatment decreased from 20 percent among the SFY 2005 releasees to less than 10 percent among the SFY 2009 and 2010 releasees.

Figure 18



Referrals for Outpatient Treatment

Of the 3,504 Sheridan participants released to Mandatory Supervised Release, the majority--2,977, or 85 percent of all releasees—had at least one referral for outpatient treatment services (Table 12). The data presented in Table 12 also illustrates that individual Sheridan releasees may have multiple referrals to the same type of treatment modality, particularly when the releasee does not enter the initial referral due to failing to show up for their intake appointment or being rejected by the original treatment provider, or in instances where readmission may be required due to relapse or failure in a placement. Similarly, in the case of outpatient treatment referrals, when participants complete intensive outpatient they may then be referred to regular outpatient treatment. For example, among the 2,977 releasees with a referral to outpatient treatment (intensive and traditional combined) there were a total of 4,431 separate outpatient referrals, or an average of 1.4 outpatient referrals each.

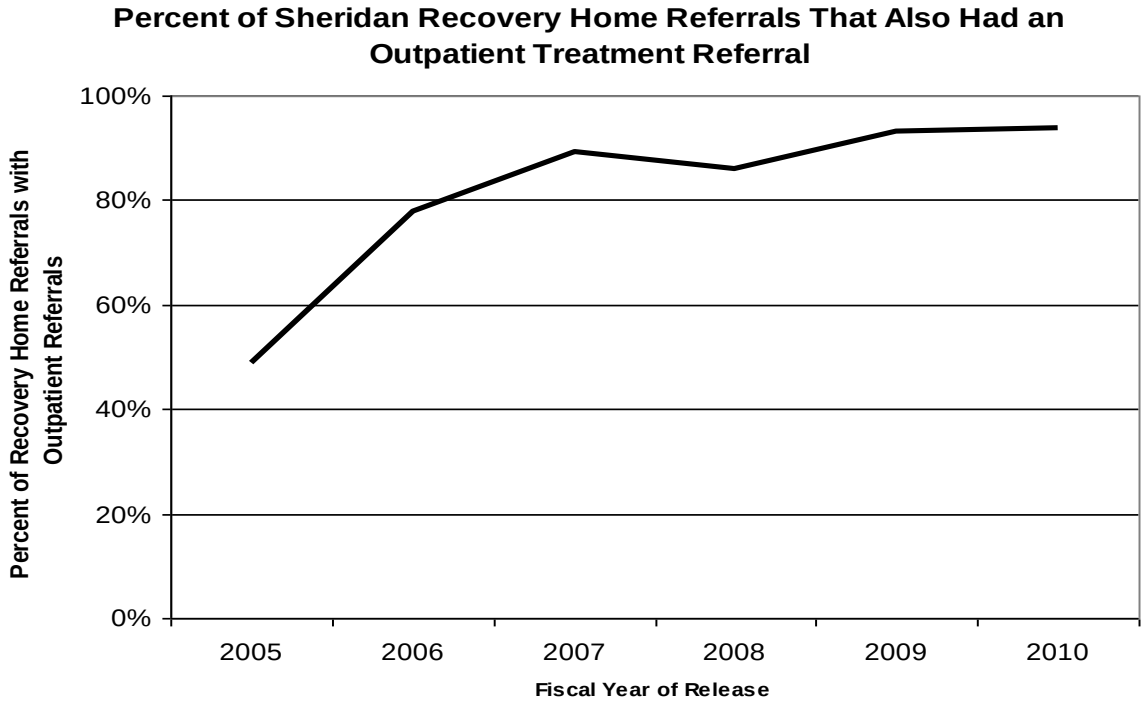
Referrals to Recovery Homes

The type of post-release referral that accounted for the second largest proportion of all referrals—involving 1,051, or 25 percent, of the releasees from Sheridan through the end of June 2010--were referrals to residential recovery homes, which are substantively different from residential substance abuse treatment programs and half-way houses in terms of the nature of aftercare services provided. Specifically, residential treatment is focused on the provision of substance abuse treatment services within a residential setting and half-way houses provide outpatient types of treatment within a setting where residents are able to leave for work or educational programming. Over the time period examined in this report (2004 through June 2010), the proportion of Sheridan releasees referred to a recovery home increased from less than 20 percent in 2004 to 30 percent by 2010 (Figure 18). Generally, recovery homes provide the resident with a sober living environment and may have self-help group meetings, however, outpatient services are not provided and these services are accessed through other community-based providers.

Since inmates released to recovery homes or transitional living may receive outpatient services through another community-based provider, it is important to examine the extent to which these

releasees were referred to and accessed outpatient treatment. Based on analyses of the TASC data, the extent to which releasees referred to a recovery home were simultaneously referred to outpatient treatment services were examined. Specifically, we examined the proportion of those referred to a recovery home that also had a referral to an outpatient treatment program, and examined how this changed over time. As a result of these analyses, we found that during the entire 6 ½ year period examined in this report, 78 percent of those referred to a recovery home also had a referral to some type (regular or intensive) of outpatient treatment program. It is also important to note that initially the likelihood of outpatient treatment referrals being made in combination with referrals to recovery homes were not being made as frequently among the first Sheridan releasee cohorts as among the more recent releasees. As summarized in Figure 19, less than 65 percent of those released during 2004 and 2005 with a referral to a recovery home also received a referral to outpatient treatment, but since 2007, the proportion of Sheridan releasees with a recovery home referrals and an outpatient referral increased substantially, to 90 percent or more per year. The same pattern was evident when *admissions* into both recovery homes and outpatient treatment were examined together.

Figure 19



Referrals to Residential Treatment & Half-way Houses

Unlike the volume of referrals for outpatient treatment and recovery homes, a smaller number and proportion—507 inmates, or 12 percent of all the Sheridan participants released through June 2010--were referred to a residential treatment program following their release from Sheridan (Table 12). Of those 507 referred to residential treatment, the average number of residential treatment referrals per Sheidan releasee was 1.3. Further, between SFY 2005 and 2010, the proportion of Sheridan releasees being referred to a residential treatment program fell from almost 20 percent in SFY 2005 to less than 5 percent of those released in SFY 2010. On the other hand, roughly 17 percent of Sheridan releasees were referred to a half-way house placement, which provides for a sober living environment, on-site outpatient treatment, and also allows the resident to leave the house to work or engage in educational or vocational programs in the community. Over the time period examined in this report, the proportion of Sheridan releasees referred to a half-way house increased from less than 10 in SFY 2005 to more than 20 percent among SFY 2010 releasees.

Referrals to Methadone Maintenance Programs & Detoxification

One of the least frequent post-release treatment referrals was for methadone maintenance, and the proportion of Sheridan releasees receiving this type of referral decreased during the period examined in this report. Overall, less than 1 percent of Sheridan releasees were referred to a methadone maintenance program (Table 12). Similarly, relatively few referrals were made for detoxification services, accounting for less than 5 percent of all those released from Sheridan through June 2010. Also, when referrals to detoxification programs were made for Sheridan releasees, they tended to occur fairly far into the releasee's period of Mandatory Supervised Release. Illustrative of this was the fact that, on average, 151 days (roughly 5 months) had elapsed between the inmate's release from Sheridan and any subsequent referrals for detoxification services.

Referrals to Recovery Support Services

In addition to referrals for specific types of substance abuse treatment services following release from Sheridan, inmates may also be referred to a variety of other recovery support services by TASC case managers, including referrals for educational, employment, health, housing or support groups. In general, these are not formal referrals to services (i.e., there is not a pre-placement referral), but there are admissions/entry into these ancillary services. Examination of the placement into these services reveals that placements into support groups, including programs such as Alcoholics/Narcotics Anonymous or the TASC-led Winner's Circle, accounted for the largest proportion—63 percent--of recovery support service placements of clients facilitated by TASC, followed by referrals for educational services—16 percent of client placements, and health-related referrals (accounting for 13 percent of all client placements in these support services). There were relatively few placements for other types of service, such as employment, since the Safer Foundation is responsible for these types of referrals. Also, the tracking of these referrals by TASC in their automated information system was not done from the beginning of the implementation of Sheridan, and thus it is difficult to examine changes in these types of referrals and placements over time. However, looking only at these placements during 2007 indicates that roughly one-third of Sheridan inmates released during this year received some type of ancillary service placement by TASC.

Overall Post-Sheridan Treatment Intakes & Admissions

In addition to examining the types of *referrals* made, it is also important to examine whether or not the Sheridan releasees actually show up for their scheduled intake interviews, if they were accepted into the program, and if they did get accepted, if they entered treatment. During the entire 6 ½ years of program operations examined in this report, 86.9 percent of the inmates released from Sheridan who were referred to treatment actually entered treatment, whereas the remaining 13.1 percent did not enter any post-release treatment program despite being referred to it. Again, every inmate released from Sheridan has some type of post-release treatment referral. It appears that the percent of Sheridan releasees entering treatment has improved over time. For example, among the first cohort released from Sheridan in SFY 2005 (July 2004 to June 2005),

only 75 percent entered treatment, compared to more than a 90 percent treatment admission rate among the cohorts released during SFYs 2008 through 2010.

Negative Outcomes of Treatment Referrals

Although the majority of Sheridan releasees entered aftercare treatment following their release, a large proportion experienced negative outcomes from referrals, which ultimately influence whether or not they were able to enter aftercare. In order to get a sense of what happens following an inmate's release from Sheridan and subsequent referral to aftercare, we examined the prevalence of negative outcomes of the referrals made for Sheridan releasees. As can be seen in Table 13, one-third (33 percent) of all Sheridan releasees had at least 1 negative intake outcome, although, as noted before, only 14 percent of all Sheridan releasees failed to enter any aftercare. Of those that experienced a negative intake outcome, the most frequent reason was that they did not show up for either their initial intake assessment or for their initial treatment session (Table 13). Specifically, 21 percent of Sheridan releasees failed to show up for at least one of their intake assessments. A smaller proportion (14 percent) of *referrals* (keeping in mind that an individual release can have multiple referrals) resulted in no-shows by the Sheridan release. The second most frequent reason for a Sheridan releasee experiencing a negative intake outcome was the released inmate refusing services at the point of referral/intake (5.8 percent of clients, or 3.1 percent of referrals), followed by the treatment provider rejected the client following the intake assessment.

Table 13
Negative Outcomes of Pre-Treatment Referrals/Intake Assessments, 2004 to June 2010

	Clients with Specific Negative Referral/Intake Outcomes Number & (Percent) [1]	**Referrals with Negative Referral/Intake Outcomes Number & (Percent)** [2]
Client Did Not Show Up for Intake	883 (21.5%)	1,159 (14.1%)
Client Refused Services	236 (5.8%)	260 (3.1%)
Treatment Provider Rejected Client	227 (5.5%)	250 (3.0%)
Any Negative Outcome [3]	1,346 (32.8%)	1,669 (20.3%)

[1] Percent based on a total of 4,098 Sheridan releasees referred to aftercare services.

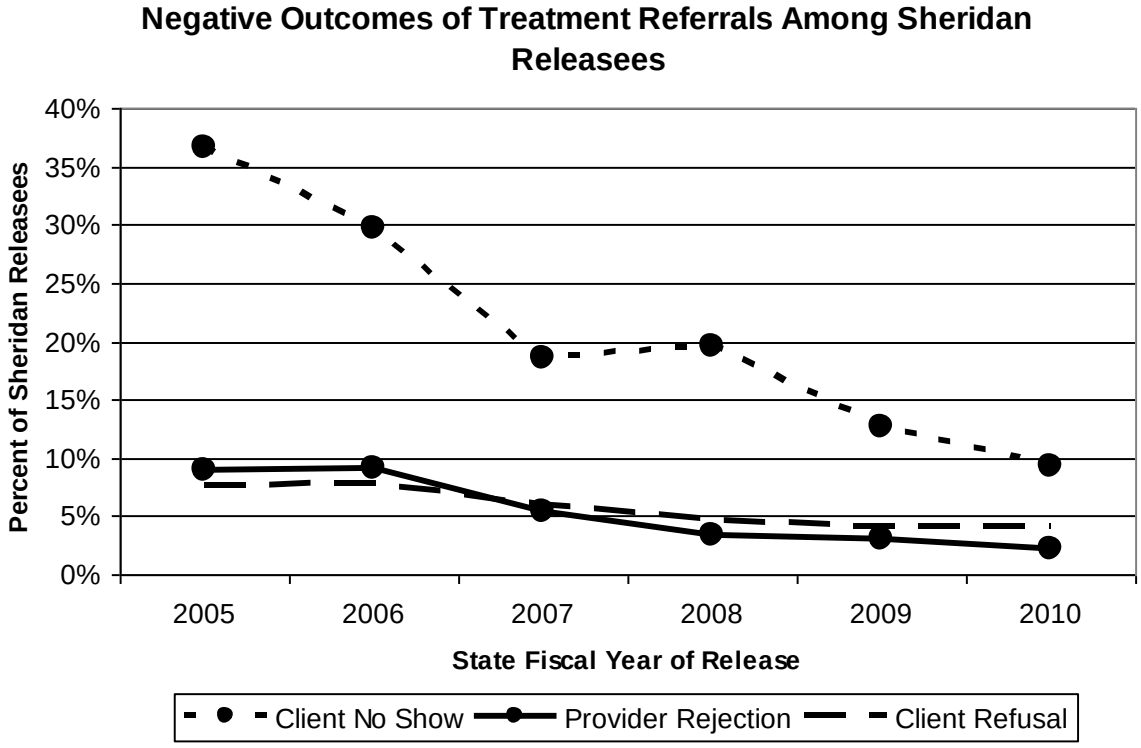
[2] Percent based on a total of more than 8,200 individual aftercare referrals.

[3] Total of these 3 categories of negative outcomes. There were also negative referral/intake outcomes resulting from the rejection of a provider by either parole or IDOC's Placement Resource Unit, but these were rare and impacted fewer than 60 referrals during the period examined.

The TASC data demonstrates that if a Sheridan releasee did not show up for their initial appointment/intake interview or if they were rejected by either the provider or IDOC, that efforts were made to make another referral and placement. For example, of the 518 Sheridan releasees who did not show up for their first intake appointment, 51 percent were ultimately accepted and placed in aftercare treatment at some point following this first unsuccessful intake. Similarly, 70 percent of those Sheridan releasees who refused their first placement were ultimately placed in an aftercare program. In most instances, a successful placement for those that had a negative outcome of their first intake was made on the second intake attempt. One of the possible consequences of client refusal or failure to show for aftercare referrals is a revocation of the individual's Mandatory Supervised Release. Thus, among those Sheridan releasees who did not enter treatment, two-thirds did not enter post-release treatment because they either failed to show up for their intake or they refused to accept the treatment program.

Examining the trends in these negative outcomes over time, however, reveals that the proportion of Sheridan releasees experiencing any of these negative intake assessment outcomes has decreased dramatically as the program has evolved (Figure 20). Specifically, during the early stages of the program—SFY 2005--a large proportion of releasees, 35 percent, failed to show up to *at least one* their treatment referrals, an additional 8 percent of the participants refused at least one of the treatment referrals, and another 10 percent of the releasees were refused service by the provider. By the SFY 2008 Sheridan releasee cohort, the no-show rate for aftercare referrals fell to 20 percent, and among those released during SFY 2010 the no-show-rate was at 10 percent. Similarly, the rate at which Sheridan releasees refused treatment or were rejected by the treatment provider also fell from SFY 2005 through SFY 2010.

Figure 20



Treatment Admission Rates Across Modality & Time

As previously indicated, roughly 86 percent of inmates released from Sheridan were accepted into an aftercare treatment program, however, this rate of successful admission has not only changed over time, but varied by the treatment modality of the referrals, with those referred to some type of residential program (including both residential treatment and residential settings like half-way houses) being more likely to enter treatment than were those referred to outpatient (Table 14). For example, 78 percent of those clients referred to outpatient were successfully admitted, and 66 percent of all those released from Sheridan were placed into this type of aftercare program (Table 14). By comparison, roughly 87 percent of those referred to residential treatment were admitted, although a relatively small proportion, only 10.5 percent, of all Sheridan releasees were admitted into residential treatment. Similarly, referrals to half-way houses and recovery homes had admission rates near 90 percent, and these high rates of admission were consistent over time. Part of this can be explained by the fact that many of the

inmates discharged from Sheridan with a residential treatment, half-way house or recovery home referral were actually picked up at Sheridan by the treatment provider and brought directly to the residential treatment facility. Additionally, nearly 90 percent of those referred to residential treatment from Sheridan entered the residential program within 7 days following their release.

Table 14
Treatment Admission Number and Rate, by Modality of Treatment Recommendations/Referrals, July 2004 to June 2010

	Number of Clients Referred	Number of Clients Admitted	Percent of Clients Referred with an Admission	Percent of Releasees w/at Least 1 Placement [2]
Any Outpatient [1]	3,529	2,758	78.2%	66.3%
Intensive Outpatient	2,719	1,995	73.4%	47.9%
Traditional Outpatient	1,328	976	73.5%	23.5%
Residential Treatment	507	439	86.6%	10.5%
Half-Way House, Transitional Living or Recover Home				
Half-Way House	707	620	87.7%	14.9%
Recovery Home	1,051	938	89.2%	22.5%
Detoxification	179	156	87.2%	3.7%
Any Treatment/Aftercare	4,098	3,615	88.2%	86.8%

[1] Clients can be admitted to both intensive and traditional outpatient, although not simultaneously, therefore the numbers included in Table 14 for "Any Outpatient" is less than the sum of "Intensive Outpatient" and "Traditional Outpatient."
[2] The total number of Sheridan participants released to MSR during time period examined was 4,162, which is the number used to calculate the percent of releasees with at least 1 placement.

Examining treatment admission rates by the fiscal year participants were released from Sheridan reveals an improvement in the rate of treatment entry over time. For example, among the first cohort released from Sheridan in SFY 2005 only 75 percent entered treatment, compared to a 90 percent or higher treatment admission rate among the SFY 2008, 2009 and 2010 releasee cohort.

Factors Improving Treatment Admission Rates Among Sheridan Releasees

In order to better understand the factors that may explain varying rates of treatment admission among the Sheridan releasees, performed multivariate regression analyses to isolate the extent to which certain participant characteristics predicted their admission into aftercare. As a result of

these analyses, a number of characteristics that were related to whether or not a Sheridan releasee entered post-release treatment, including: the number of prior prison sentences the participant had served, where the Sheridan participant was released back to, the time period (year) the inmate was released, the type of treatment referral (i.e., residential vs. outpatient), and the felony class the offender had been convicted of, which dictates the length of mandatory supervised release (See Olson, Rozhon, & Powers 2009 for a more detailed description of the analyses of post-release treatment admission). More specifically, it was found that the more prior prison sentences the Sheridan releasee had, the less likely the releasee was to enter post-release treatment. On the other hand, those released to either Cook County (Chicago) or the Collar County region (suburban Chicago) were *more likely* to enter post-release treatment than those released to other regions of Illinois. Also, those referred to some type of residential placement (residential treatment, half-way house, recovery home or transitional living) were much more likely to enter that program than were those not referred to these types of treatment modalities. It also appeared from the analyses that those inmates with longer lengths of Mandatory Supervised Release (i.e., those convicted of felony classes requiring 2 or more years of MSR) were more likely to enter aftercare than those with 1 year of MSR, which could be the result of either longer time to get the Sheridan releasee into aftercare and/or the fact that a parolee with 2 years of MSR faces much more severe consequences of non-compliance (i.e., return to prison to serve the remainder of their MSR).

In addition, it appears that there has been something of a maturation effect that has occurred over time with respect to the ability to get Sheridan inmates into aftercare treatment. After statistically controlling for a wide range of factors that could possibly explain whether or not a Sheridan releasee entered treatment, the time period the inmate was released was still found to have an independent relationship to whether or not they entered treatment. For example, compared to the first year of releasees (the cohort discharged from Sheridan between July 2004 and June 2005), those discharged from Sheridan during almost all of the subsequent 12-month time periods were more likely to enter treatment than the cohort that preceded them.

Part of this improved pattern of releasees showing up for their post-release treatment intake and fewer Sheridan releasees being rejected by the providers is likely attributed to both a maturation

of the Sheridan program as well as increased communication between the Sheridan releasee, the parole agent and the community-based aftercare provider. Specifically, in the beginning of the program's operation, the inmate was not actually involved in the pre-release case staffing that occurred 120 days prior to release. However, since state fiscal year 2006, the inmate has participated in this case staffing and not only is aware of what the post-release aftercare plans are, but can also contribute to the discussion to ensure the recommended services and actual placement are accessible and feasible.

An addition effect of the Sheridan program is a dramatic increase in the volume of inmates released from Illinois' prisons with a referral to substance abuse treatment. Prior to Sheridan a relatively small portion of inmates released from Illinois' prisons were required to access treatment services in the community, and therefore, the availability and capacity of providers in the community to serve this population had been limited. As a result, it took some time before the community-based treatment providers fully understood the population and program at Sheridan, and their appropriateness for the services they were providing. To assist in this, staff from Sheridan held a series of immersion training sessions at the facility for community-based treatment providers so that they had a better understanding of the nature of the program.

Furthermore, it took a while for those involved in the clinical case management (i.e., TASC) of the Sheridan releasees to identify appropriate programs and services for the type of offender coming out of Sheridan and the services available in parts of Illinois where TASC has not traditionally tried to place large numbers of offenders in aftercare services, in particular some of the more rural parts of the state. Because historically there had been so little systematic referral of released inmates into community-based substance abuse treatment, coupled with the fact that a relatively large proportion of inmates from Sheridan were being released back to communities with relatively few community-based treatment programs, there were some initial challenges to getting Sheridan graduates into appropriate aftercare treatment programs.

Some of the factors found *not* to be associated with whether or not Sheridan releasees entered treatment following their release from the facility included: age, race, marital status, having children, education level, gang involvement, current conviction offense, prior criminal history

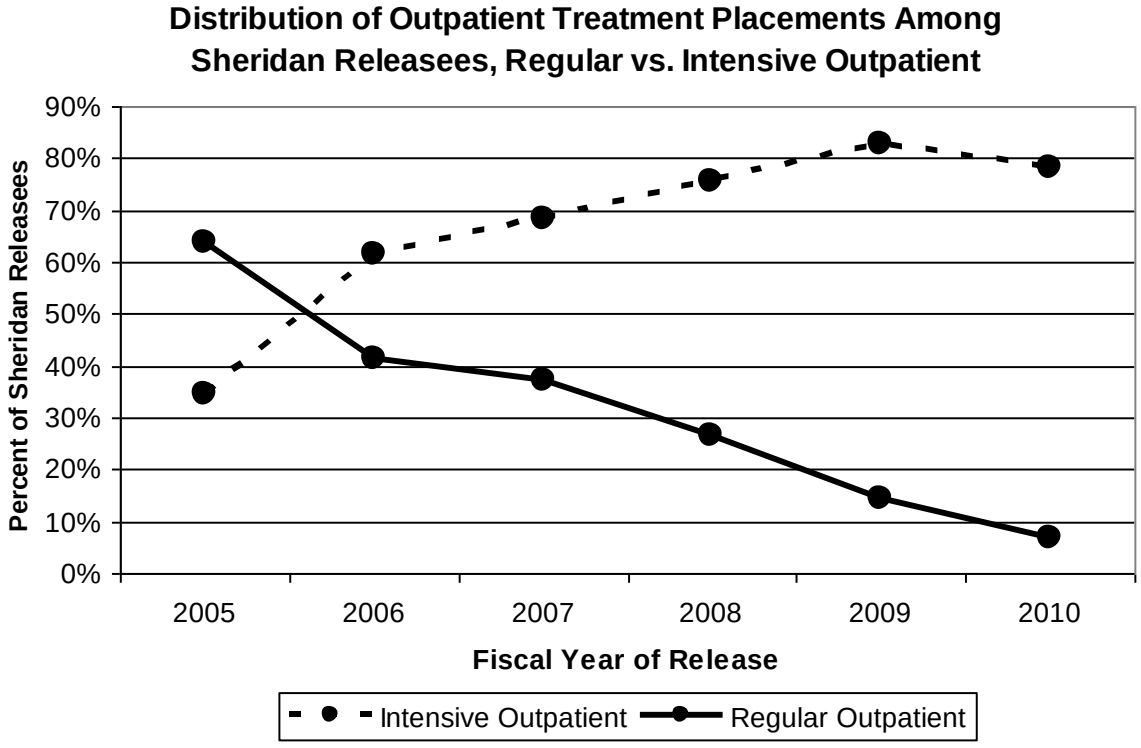
(total arrests and specific types of arrests), length of time served, prior treatment experiences, availability of a car,[43] driver's license,[44] and whether or not they earned additional time off their sentence by participating in the prison-based treatment program (Earned Good Conduct Credit).

Changes in Treatment Placement Modalities Over Time

In addition to the improved treatment admission rates over the course of program implementation, there have also been some fairly substantive changes in the treatment modalities that participants were admitted to during the 6 ½ years examined in this evaluation. As seen in Table 14, the largest proportion of Sheridan releasees were referred and admitted to outpatient treatment, in particular intensive outpatient treatment, aftercare services. Examining the percent of Sheridan releasees admitted to these two different types of outpatient treatment—regular and intensive—over time reveals a dramatic change between those released in SFY 2005 through SFY 2010. As seen in Figure 21, the proportion of Sheridan releasees admitted to regular outpatient aftercare treatment decreased, from roughly two-thirds of Sheridan releasees in SFY 2005 to less than 20 percent by SFY 2009 and below 10 percent by SFY 2010. On the other hand, the proportion of Sheridan participants admitted to *intensive* outpatient treatment following their release increased substantially, from roughly one-third of the SFY 2005 releasees from Sheridan to roughly 80 percent among the SFY 2009 and 2010 releasees (Figure 21).

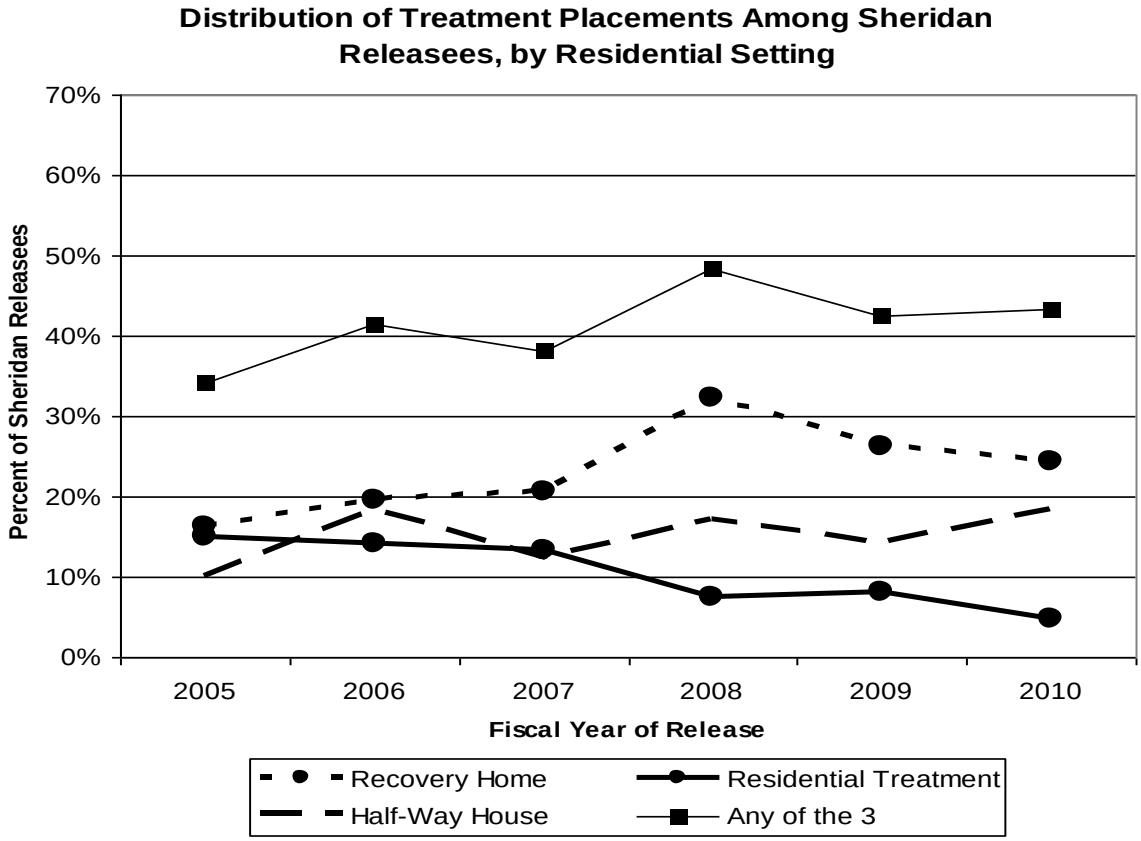
[43] Of those admitted to Sheridan, 19 percent reported having access to a car.
[44] Of those admitted to Sheridan, 25 percent reported having a driver's license.

Figure 21



Over the time period examined there were also some shifts and changes in the nature of admissions into residential-type settings for Sheridan releasees (Figure 22). In terms of admissions into traditional residential drug treatment, there was a decrease in the proportion of Sheridan releasees admitted into this form of aftercare, from roughly 15 percent in SFY 2005 to less than 5 percent during SFY 2010. On the other hand, there was a substantial increase in the proportion of Sheridan releasees admitted into recovery home settings. The proportion of Sheridan releasees admitted into recovery homes increased from less than 20 percent in SFY 2005 to more than 30 percent in SFY 2008 and more than 20 percent in SFY 2010. By 2010, more than 40 percent of those completing the institutional-phase of the Sheridan program were admitted into some type of residential setting following their release, compared to just over 30 percent among those released in 2005.

Figure 22



Post-Release Treatment Outcomes

In order to examine the post-release treatment outcomes of Sheridan participants, we grouped treatment outcomes into two categories: 1) successful completion/still enrolled, which included those Sheridan releasees who entered treatment and were successfully discharged from at least one program by the treatment provider as well as those who entered treatment and were still enrolled in the program as of June 30, 2010, and 2) unsatisfactory termination, which included those Sheridan releasees who entered treatment but were unsatisfactorily terminated from the program by the treatment provider. The reasons for unsatisfactory termination from aftercare included non-compliance by the client, clients requesting a change in aftercare provider, the client getting arrested or incarcerated, or medical/psychiatric issues limiting the ability of the client to participate in the aftercare program. The most frequent reason cited by providers for

unsatisfactory termination from aftercare was non-compliance by the client, followed by the client requesting a change in provider. [45]

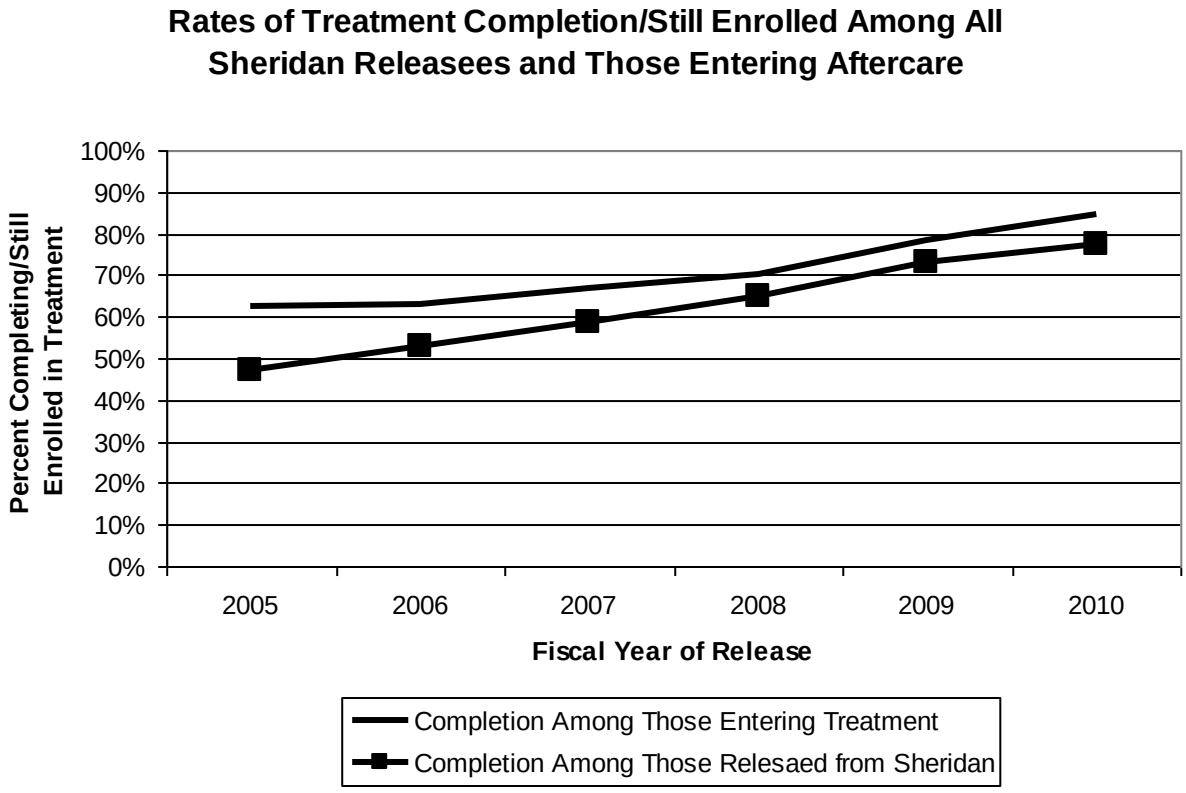
Also, when considering the outcome of the aftercare services (i.e., successful completion/still enrolled versus unsatisfactory termination) there are two different ways that this can be examined. First is the proportion of all those who were ***referred*** to an aftercare service that successfully completed or were still enrolled, and the second is the proportion of those who ***actually entered*** an aftercare program that successfully completed or were still enrolled. Although the first measure will produce a lower overall rate of aftercare completion (since it will include Sheridan releasees who did not enter the aftercare they were referred to and therefore would not be able to complete the aftercare), it is an important measure to consider when examining the overall compliance and success rates of program participants. This first rate of aftercare completion (that which includes all those referred to aftercare) revealed that since the Sheridan program's implementation, 61 percent of those released from Sherdan successfully completed or were still enrolled *in at least one* aftercare program, and 39 percent did not successfully complete any recommended aftercare. When only those Sheridan releasees who actually entered one of their recommended aftercare programs were included in the analyses (overall, roughly 87 percent of the Sheridan releasees), more than two-thirds (71 percent) successfully completed or were still enrolled in at least one aftercare program and less than one-third (29 percent) third were unsatisfactorily terminated from the treatment program.

Regardless of which rate is used to examine the likelihood of successful aftercare completion/discharge, it is clear from the analyses that the rate of successful completion has increased over time. As seen in Figure 23 (which presents both rates), the overall proportion of inmates released from Sheridan that completed or were still enrolled in at least one of their aftercare treatment programs has steadily improved over time. For example, among those inmates released from Sheridan in SFY 2005, less than 50 percent completed or were still

[45] For example, among those unsatisfactorily terminated from their first aftercare placement, 72 percent were terminated due to non-compliance and another 17 percent of clients requested a change in provider. Only about 6 percent of clients unsatisfactorily terminated from their first aftercare placement were removed due to a new arrest or being incarcerated, and only 1 percent of those unsatisfactorily terminated were removed due to medical or psychiatric issues.

enrolled in aftercare, and among those who did enter aftercare, roughly 60 percent completed or were still enrolled. On the other hand, among those released from Sheridan in 2009 and 2010, 75 to 85 percent completed or were still enrolled in aftercare.

Figure 23



However, some caution should be noted with the interpretation of the rates for the most recent time period (SFY 2010) since this includes many inmates who were still enrolled in their aftercare but who could potentially be unsatisfactorily terminated, thus reducing the treatment outcome success rate among this cohort to some degree.

When treatment completion rates were examined specifically by the type of treatment modality the Sheridan releasee was admitted into, fairly consistent completion rates were evident (Table 15). Across the entire time period examined and each individual aftercare modality, 71 percent of Sheridan releasees who entered aftercare successfully completed or were still satisfactorily enrolled in an aftercare program. Among all Sheridan releasees—including those who did and

did not enter aftercare—62 percent successfully completed or were still satisfactorily enrolled in an aftercare program. A slightly higher rate of successful discharges were evident among those admitted to residential treatment (69.5 percent), and lower rates of successful completion were seen among those admitted to half-way houses (56.5 percent).

Table 15
Treatment Referral, Admission and Completion Number and Rate, by Treatment Modality, 2004 to June 2010

	Number of Clients Referred	Number of Clients Admitted	Number of Clients Completing/Still Enrolled	Percent of Admitted Clients Completing/Still Enrolled
Any Outpatient [1]	3,529	2,758	1,783	64.6%
Intensive Outpatient	2,719	1,995	1,269	63.6%
Traditional Outpatient	1,328	976	574	58.8%
Residential Treatment	507	439	305	69.5%
Half-Way House, Transitional Living or Recover Home			874	
Half-Way House	707	620	350	56.5%
Recovery Home	1,051	938	565	60.2%
Detoxification	179	156	127	81.4%
Total Sheridan Participants Released to MSR	4,162	3,516	2,565	71.0%

[1] Clients can be admitted to both intensive and traditional outpatient, therefore the numbers included in Table 14 for "Any Outpatient" is less than the sum of "Intensive Outpatient" and "Traditional Outpatient."

When completion rates were examined over time and by treatment modality, a pattern similar to that seen in Figure 23 was evident. Across each treatment modality—outpatient, residential and the combined half-way house/recovery home—increases in positive treatment outcomes were evident between SFY 2004 and 2010. Most striking was the improved outcomes of outpatient treatment placements, which saw the proportion of Sheridan participants completing or still being enrolled in the program increase from roughly 50 percent during the first year (SFY 2005 exits) to more than 70 percent among SFY 2009 and 2010 exits. However, as mentioned before, it is important to recognize that some of those still enrolled in these programs among the SFY 2010 releasees could end up being unsatisfactorily terminated from the treatment program, which will impact the completion/still enrolled rates.

Time Between Release from Sheridan and Entry Into Aftercare Treatment

From the analyses performed for the current evaluation time period, it is apparent that the intake interviews for post-release treatment are being scheduled and, when the inmate shows up, performed shortly after release. For example, roughly 73 percent of those released from Sheridan had their intake interview for their post-release treatment *scheduled* to take place either before or within 1 week of their release, and of those that showed up, 66 percent were actually interviewed within that timeframe. However, there was also a small proportion—9 percent-- of Sheridan releasees who had their post-release aftercare intake interview ***scheduled*** for 2 or more weeks after their release from Sheridan, and 15 percent had their actual intake interview date take place 2 or more weeks after their release.

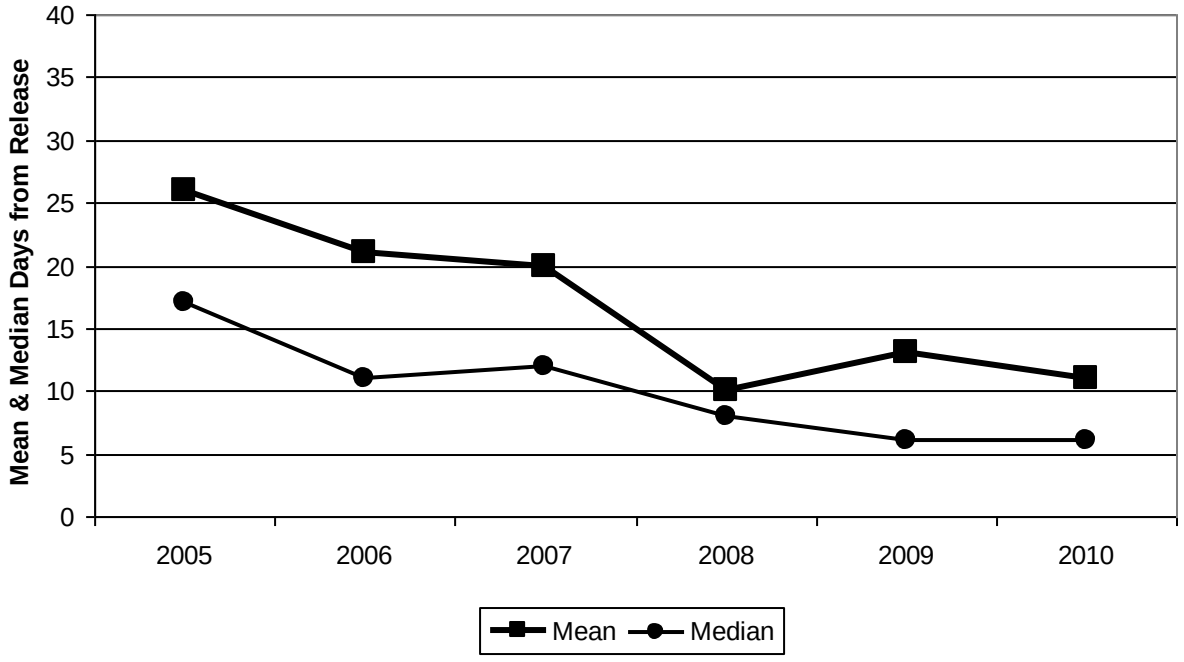
However, having an aftercare intake interview scheduled and completed shortly after release does not necessarily mean aftercare treatment services are being immediately accessed. Of those Sheridan releasees who did show up for their intake interview and were accepted into treatment, two thirds entered treatment within a week following their release. On the other hand, 20 percent of Sheridan releasees accepted into treatment did not actually enter treatment (i.e., begin receiving services) for ***2 or more weeks*** following their release from prison. Clearly, the faster admission into treatment was evident among those referred to residential, recovery home, half-way home and transitional living placements, many of whom had their intake interview conducted while they were still at Sheridan and were admitted to treatment the day of their release from prison. For example, 88 percent of the Sheridan releasees admitted into a recovery home or a half-way house entered those facilities the day they were released from Sheridan.

Those referred to outpatient treatment, which accounted for the majority of Sheridan releasees, experienced slightly longer times between release and entry into aftercare, but those times have improved (been reduced) substantially as the program and referral processes have matured. When just the admission into outpatient treatment was examined, which accounted for the majority of treatment admissions, the average number of days between release from Sheridan and entry into treatment was 19 days, or almost three weeks, whereas the median number of days

from release to treatment entry was just over one week (9 days).[46] Again, as the Sheridan program has matured and evolved, the length of time between release from the facility and entry into post-release treatment services has improved. As summarized in Figure 24, among the first cohorts of releasees (SFY 2005), the average days between release and outpatient treatment entry was 26 days, but for those released from Sheridan during SFY 2010, the average days between release and outpatient treatment entry fell to 11 days. Similarly, the median days between release and entry into outpatient aftercare fell from 17 days for those released from Sheridan in SFY 2005 to 6 days for those released in SFY 2009 and 2010.

Figure 24

Time Between Release from Sheridan and Outpatient Placement, Outpatient as First Referral



Thus, over the course of the 6 ½ years of program operation, substantial improvements and high rates of access and completion of aftercare services for those released from Sheridan have been

[46] When the mean—average--is larger than the median, it indicates relatively high values or outliers "pulling up" the average. The median is the value at which 50 percent of the cases are above that value and 50 percent of the cases are below that value.

achieved. Not only has the admission rate to aftercare improved, and the time between release and aftercare entry been shortened, but a higher proportion of Sheridan releasees are successfully completing their aftercare requirements.

Post-Release Support for Employment

In addition to providing releasees from Sheridan with referrals and access to aftercare treatment services, a component of the Sheridan program also includes support and assistance as Sheridan releasees seek employment and engage in job searches. Through the Safer Foundation, Sheridan releasees are provided with assistance in their employment search, and once employment is obtained, support so that employment can be maintained. The support Safer provides to Sheridan releasees also can take the form of public transportation cards to assist inmates in getting to job interviews and their places of employment, and in some instances, clothing and work boots needed for their jobs.

Among those released from Sheridan through June 30, 2010, more than one-half (61 percent) obtained employment (i.e., had a job start), and the majority of these positions (88 percent) were full-time jobs. The average starting pay for these job starts was just under $9.00 per hour. Among those Sheridan releasees who did find employment and start a job, over one-half (56 percent) started their employment within the first 60 days following their released from prison. However, illustrative of the challenges facing the formerly incarcerated as they seek employment following their release from prison was the fact that among those who were able to eventually find employment (the 61 percent of Sheridan releasees), one-quarter did not obtain employment until more than 4 months following their release from prison.

VI. PROGRAM OUTCOMES: POST-RELEASE RECIDIVISM

Introduction

Evaluating the impact of any program as large and complex as Sheridan is oftentimes difficult and likely to lead to a variety of conclusions. In the field of criminal justice, the most frequently used measure to gauge the impact and effectiveness of rehabilitative programs is the reduction in recidivism, or reduced involvement in criminal behavior, by those who participate in the rehabilitative program. However, accurately measuring an individual's involvement in crime is very difficult since many crimes never come to the attention of law enforcement. Thus, measuring subsequent involvement in crime in criminal justice research usually involves analyses of official criminal history information, including rearrests for new crimes or return to prison. Using these two different measures of recidivism is advantageous because they examine program impact from different perspectives. For example, rearrests for new crimes can illustrate behavior detected by police agencies that at least meet the legal threshold of probable cause necessary for police to initiate an arrest, regardless of whether or not the arrest results in prosecution or conviction.

While many might argue that *conviction* for a crime would be a better measure of recidivism (since there would have been proof beyond a reasonable doubt that a crime was committed), the limitation with this measure is that when an offender is on active parole (or MSR), the decision as to whether or not the State's Attorney's Office will actually file charges and seek a conviction would be influenced by both the seriousness of the offense and the response to the new arrest by parole agents and the Prisoner Review Board (PRB). For example, a rearrest for drug possession while on MSR can result in a revocation of MSR and the offender being returned to prison to serve the remainder of their MSR in prison as a result of the PRB hearing. In this case, a prosecutor may not file charges, and therefore not seek a conviction, because the response by the parole agent and PRB achieved the goal of punishment or incarceration. On the other hand, if the crime was more serious, or the response by the parole officer and/or PRB was not viewed by the prosecutor as sufficient, charges may be filed and a conviction sought. Thus, some arrests of parolees will result in prosecution being sought, and potentially a conviction being obtained,

whereas other cases will not result in additional formal processing. Also, if there is a differential response to how arrests while on parole are handled between Sheridan releasees versus inmates released from other facilities, this would introduce a substantial bias in the interpretation of conviction rates between the Sheridan releasees and the comparison group. Indeed, this is a strong potential since inmates released from Sheridan have a much wider array of community-based responses available for parolees who may violate the conditions of their release, including referral to various modes of substance abuse treatment and residential settings.

Return to prison is another measure of recidivism that is often used in research examining prison releasees, and can be influenced by both rearrests as well as violations of parole conditions. As described above, inmates rearrested for a new crime while on MSR in Illinois can be returned to prison because of this new arrest, and are considered to be "technical violations" as opposed to a return to prison for a new crime. Inmates returned to prison for violating the conditions of MSR other than a new arrest can be viewed as "purely" technical violators, and can include reasons such as failure to report to their parole agent, not complying with treatment requirements, testing positive for drugs during urinalysis, etc. If an inmate released from prison is rearrested, convicted and re-sentenced to IDOC as a result of this new conviction within 3 years following release, they are considered by IDOC to be "new sentence recidivists."

Selecting Comparison Groups

In order to assess the impact of the Sheridan program on post-release recidivism (operationalized as return to prison), the performance of the first 4,162 Sheridan graduates (all those who completed the institutional phase of the program from the beginning of the program through June 2010 minus those transferred to an ATC) were compared to a sample of inmates with similar characteristics and backgrounds released from other prisons in Illinois during the same time period. Specifically, in order to identify an appropriate comparison group, the sampling pool was limited to adult male inmates released from medium or minimum security-level prisons between July 2004 and June 2010, and excluded those inmates released from the Southwestern Correctional Center (the other drug treatment prison in Illinois). Further, to ensure the comparison group had similar lengths of time served in prison, and similar criminal

backgrounds, the comparison group sample was stratified to match the Sheridan graduates on their lengths of time served in prison (i.e., 6 to 11 months or 12 to 24 months) and prior numbers of prison sentences (i.e., 0, 1 or 2 or more). As a result of this selection process, a comparison group consisting of 8,078 inmates was selected. In general, this sampling technique produced a comparison group with characteristics very similar to those of the Sheridan graduates, although due to the relatively large sample size there were statistical, albeit not substantive, differences between the two groups (See Tables 16 and 17, which summarize the characteristics of the Sheridan and comparison group). [47]

As seen in Table 16, both the Sheridan graduates and the comparison group averaged 33 years old when they were released from prison, the majority of both groups were non-white, single and did not have a high-school diploma or GED. Similarly, about one-third of both groups of prison releasees did not have any children, and more than 40 percent of both groups had 2 or more children. A slightly higher proportion of Sheridan releasees were gang members than the comparison group (40 percent versus 35 percent, respectively), and a slightly higher proportion of Sheridan releasees were from Chicago/Cook County than were those releasees in the comparison group (roughly 53 percent versus 47 percent, respectively). In terms of prior arrests and prior prison sentences, the Sheridan releasees were very similar to the comparison group, with both groups having serious and extensive criminal histories. The nearly identical distribution of prior prison sentences between the two groups was achieved because this variable was specifically used to stratify the selection of the comparison group sample.

[47] The similarities and differences between the Sheridan releasees and the comparison group show a slightly different pattern than that presented in Table 6, which compared all of those *admitted* to Sheridan to all those *admitted* to IDOC that met the general criteria. The data presented in Table 16 include only those *released* from Sheridan through June 2010 who successfully completed the program, and the comparison group is comprised of exits from IDOC, not admissions.

Table 16
Comparison of Demographic, Socio-Economic and Criminal History Characteristics Among Sheridan Graduates and Comparison Group

	Sheridan N=4,152	**Comparison Group N=8,078**	**Total 12,230**
Age (Mean, Years) F=0.3, p=.58	33.4	33.4	33.4
Race	X^2 =72.8, 3df, p<.001, Phi=.08, p<.001		
White	25.3%	32.1%	29.8%
African-American	65.4%	57.6%	60.2%
Hispanic	9.3%	10.3%	10.0%
Total	100.0%	100.0%	100.0%
Marital Status	X^2 =0.5, 1df, p=.97, Phi=.00, p<.97		
Married (including Common Law)	15.8%	15.8%	15.8%
Not Married	84.1%	84.1%	84.1%
Total	100.0%	100.0%	100.0%
Education Level	X^2 =1.5, 1df, p=.46, Phi=.01, p=.46		
HS Diploma or GED	43.6%	44.1%	43.9%
No HS Diploma or GED	56.2%	55.5%	55.8%
Total	100.0%	100.0%	100.0%
Children	X^2 =22.9, 2df, p<.001, Phi=.04, p<.001		
None	32.1%	35.3%	34.2%
1	20.7%	21.9%	21.5%
2 or more	47.3%	42.8%	44.3%
Total	100.0%	100.0%	100.0%
Gang Member	X^2 =30.6, 1df, p<.001, Phi=.05, p<.001		
No	59.5%	64.6%	62.8%
Yes	40.5%	35.4%	35.4%
Total	100.0%	100.0%	100.0%
Region of Illinois	X^2 =41.2, 1df, p<.001, Phi=.06, p<.001		
Cook County/Chicago	52.7%	46.6%	48.7%
Rest of Illinois	47.3%	53.4%	51.3%
Total	100.0%	100.0%	100.0%
Total Prior Arrests (Mean) F=0.02 p=.87	19.6	19.6	19.6
Total Prior Arrests for Violent Crimes (Mean) F=6.1, p<.05	3.0	3.2	3.1
Total Prior Arrests for Property Crimes (Mean) F=0.1, p=.77	6.2	6.3	6.3
Total Prior Arrests for Drug-Law Violations (Mean) F=30.8, p<.001	4.8	4.2	4.5
Prior Prison Sentences	X^2 =1.5, 2df, p=.46, Cramer's V=.01, p=.46		
None	35.9%	36.1%	36.1%
One	25.2%	24.2%	24.6%
2 or More	38.8%	39.7%	39.4%
Total	100.0%	100.0%	100%

When the current conviction offense and length of stay in prison was examined for the Sheridan releasees and the comparison group, again, some slight differences were noted (Table 17). For example, a slightly larger proportion of the Sheridan releasees were sentenced to prison for a drug-law violation than were those in the comparison group (45 versus 39 percent, respectively), whereas a slightly larger proportion of the comparison group releasees had served time for a property offense than the Sheridan releasees (36 percent versus 32 percent, respectively) (Table 17). When the current offense felony class between the two groups was compared, differences were noted, with a higher proportion of the Sheridan releasees incarcerated for a Class 1-2 felony than the comparison group (61 percent versus 52 percent, respectively). On the other hand, a larger proportion of the comparison group had a current offense that was within the Class 3-4 felony range than the Sheridan releasees (44 percent versus 35 percent, respectively). Finally, those released from Sheridan spent slightly longer in prison, on average, than did the comparison group—an average of 446 days versus 421 days, respectively.

Table 17
Comparison of Current Conviction Offense & Length of Stay in Prison Among Sheridan Graduates and Comparison Group

	Sheridan N=3,494	**Comparison Group N=6,942**	**Total 10,436**
Current Offense Type	X^2 =70.1, 3df, p<.001, Cramer's V=.07, p<.001		
Violent	22.2%	23.5%	23.0%
Property	32.1%	36.2%	34.8%
Drug-Law Violation (Including DUI)	45.1%	38.6%	40.8%
Other	0.6%	1.7%	1.3%
Total	100.0%	100.0%	100.0%
Current Offense Felony Class	X^2 =97.5, 1df, p<.001, Phi=.08, p<.001		
Class X Felony	4.3%	3.9%	4.1%
Class 1-2 Felony	61.0%	52.1%	55.1%
Class 3-4 Felony	34.7%	43.9%	40.8%
Total	100.0%	100.0%	100.0%
Length of Stay in Prison (Mean, Days) F= 32.7, p<.001	446 days	421 days	430 days

In addition to this comparison group of inmates, a second group of inmates was also identified and compared to the Sheridan graduates in terms of their post-prison recidivism patterns. This second group of inmates consisted of those who had originally been at the Sheridan Correctional Center, but were removed due to rule violations or disciplinary problems. Although there are clearly biases in using a sample of inmates who "failed" within the program being evaluated, this technique is often used in recidivism studies of prison-based treatment programs, or community-based programs for that matter. During the time period between January 2004 and June 2010, a total of 1,069 inmates were removed from Sheridan due to rule violations or disciplinary problems, and of these**,** 892 had been released from prison as of June 2010.

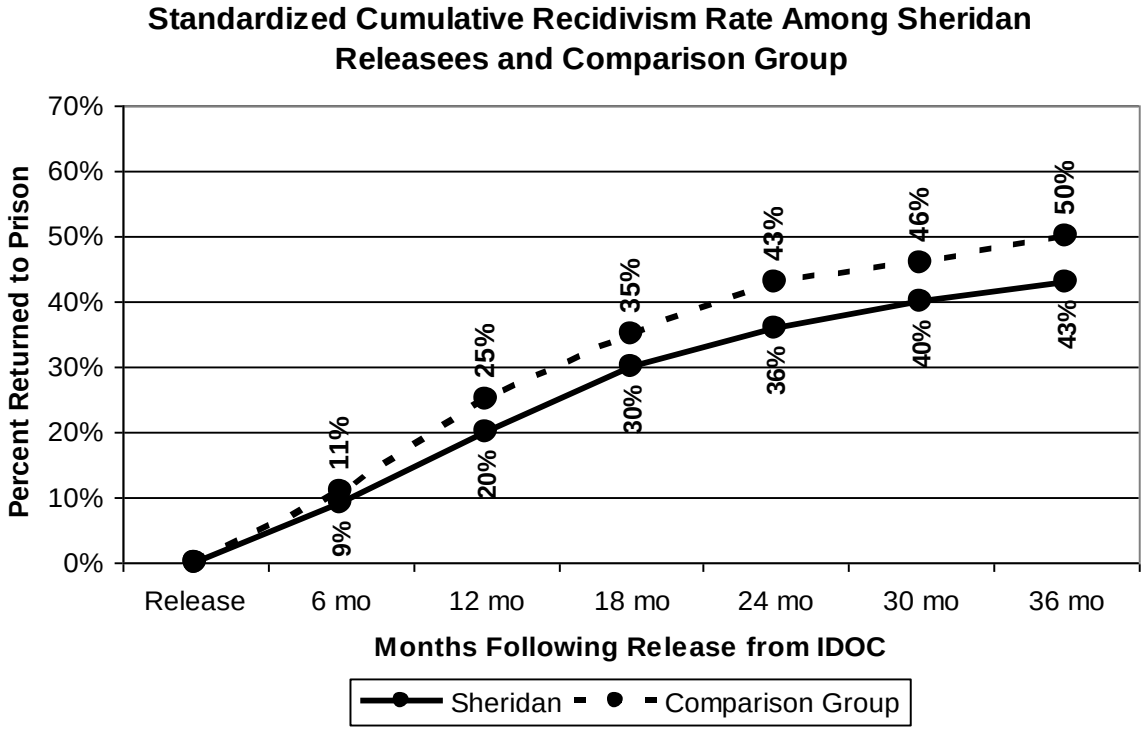
Following this identification of the Sheridan graduates and comparison groups, prison admission records were then examined to determine if the releasees in each group had been returned to prison as of June 2010. With the data that were available, we were able to examine recidivism rates (return to prison) at different points in time following release as well as among different cohorts of releasees. The length of time between release from prison and the June 30, 2010 (when returns to prison data were checked) averaged 1,125 days (roughly 3 years), with a maximum time at risk of six years and a minimum of one month. Most of the literature on recidivism, including that done previously in Illinois (Olson, Dooley & Kane, 2004), has found the first 9 to 12 months following release from prison to be the time period when recidivism is most likely to occur. Because the Sheridan graduates and inmates included in the comparison group were not exactly identical, it was necessary to perform multivariate statistical analyses in order to statistically control for the influence these differences may have on their overall recidivism rates.[48] For a more detailed and technical description of the statistical analyses used to measure the impact of the Sheridan program on recidivism, see Olson and Rozhon, 2010.

[48] Standardized rates represent the recidivism rates for the groups after statistically controlling for any differences between the groups in terms of offender age, race, marital status, education level, having children, gang membership, prior prison sentences, current conviction offense, current offense felony class, length of time served in prison, and the jurisdiction the inmate was released to. The technique used to make these statistical controls was Cox Regression (multivariate survival analyses), which not only accounts for the slight differences between the groups in terms of their characteristics but also to account for the fact that there were substantial differences in the time at risk for recidivism among the individuals included in the analyses.

Recidivism Findings

In general, the recidivism analyses found that Sheridan graduates had a lower likelihood of recidivism than did the comparison group. Overall, those inmates released from Sheridan had a 16 percent lower likelihood of being returned to prison for a new offense or a technical violation of their MSR than the comparison group. As seen in Figure 25, after statistically controlling for the characteristics of those released from Sheridan and the comparison group, at 36 months following their release from prison, 43 percent of the Sheridan releasees had been ***returned to prison***, compared to 50 percent of the comparison group.[49]

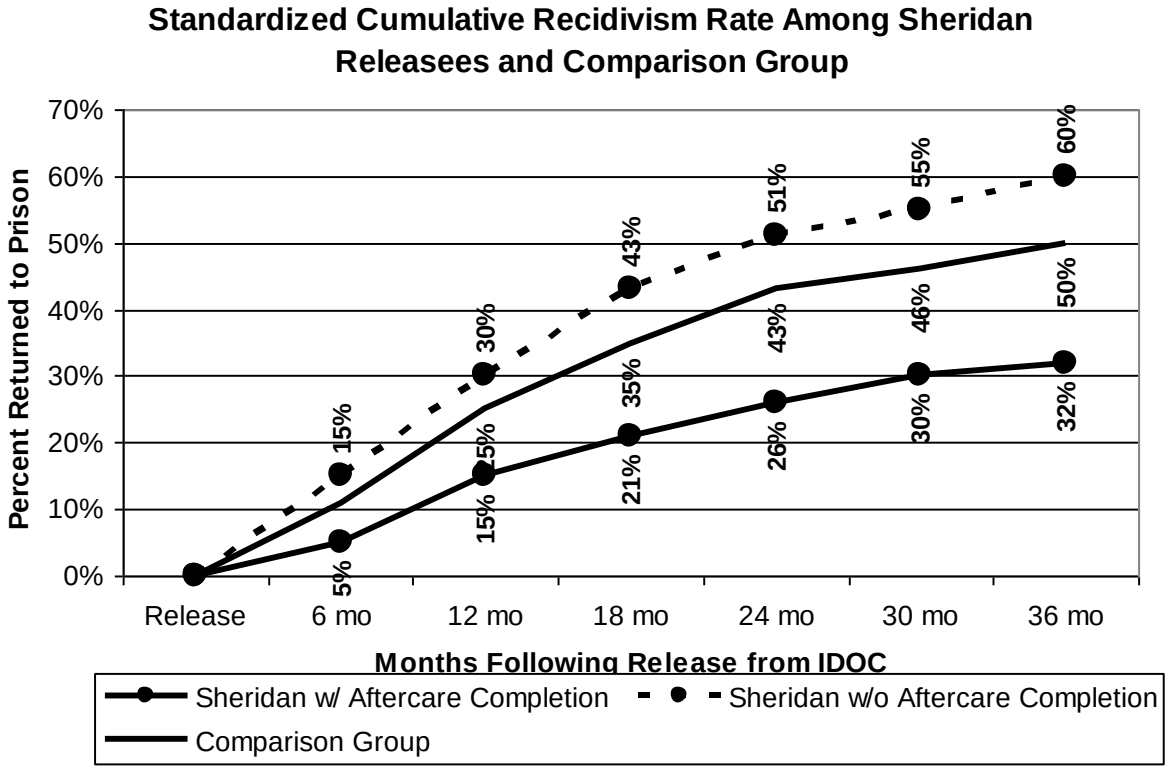
Figure 25



[49] The standardized rates represent the recidivism rates for the groups after statistically controlling for any differences between the groups in terms of offender age, race, marital status, education level, having children, gang membership, prior prison sentences, current conviction offense, current offense felony class, length of time served in prison, and the jurisdiction the inmate was released to. The technique used to make these statistical controls was Cox Regression (multivariate survival analyses), which not only accounts for the slight differences between the groups in terms of their characteristics but also to account for the fact that there were substantial differences in the time at risk for recidivism among the individuals included in the analyses. The unstandardized recidivism rates (i.e., without making statistical adjustments to account for the slight differences in the characteristics of the Sheridan and comparison group) using survival analyses/life tables were 53 percent for the comparison group and 49 percent for the Sheridan graduates at 36 months.

Further, when the Sheridan graduates were separated into those who had completed/were still enrolled in aftercare and those that did not complete aftercare, the reduction in recidivism relative to the comparison group was even more substantial. Specifically, those Sheridan participants who had completed/were still enrolled in aftercare had a recidivism rate that was 44 percent lower (i.e., almost one-half) than that of the comparison group. Again, at 36 months post-release, 32 percent of Sheridan releasees who completed/were still enrolled in aftercare had been ***returned to prison***, compared to 50 percent among the comparison group (Figure 26). On the other hand, those Sheridan releasees who ***did not*** complete aftercare were 30 percent ***more likely*** to be returned to prison than the comparison group: among Sheridan releasees who did not complete aftercare, 60 percent were returned to prison within 36 months.

Figure 26



The fact that Sheridan graduates who did not complete aftercare were substantially more likely to be returned to prison than the comparison group is primarily due to the fact that failure to comply with aftercare among the Sheridan releasees is considered a technical violation of their MSR, and

therefore increases the likelihood of return to prison relative to the comparison group, which generally does not have any mandatory treatment requirements as part of their MSR. Further, all Sheridan releasees are supervised by parole agents at "Level 1," which requires much more frequent contact and supervision than most parolees receive upon their release from prison. Finally, because Sheridan releasees are monitored for aftercare compliance by parole agents, as well as TASC and Safer staff, they are watched much more closely than typical prison releasees. Thus, many more requirements, coupled with closer scrutiny, has resulted in non-compliant Sheridan releasees to be returned to prison at a much higher rate than other prison releasees in Illinois.

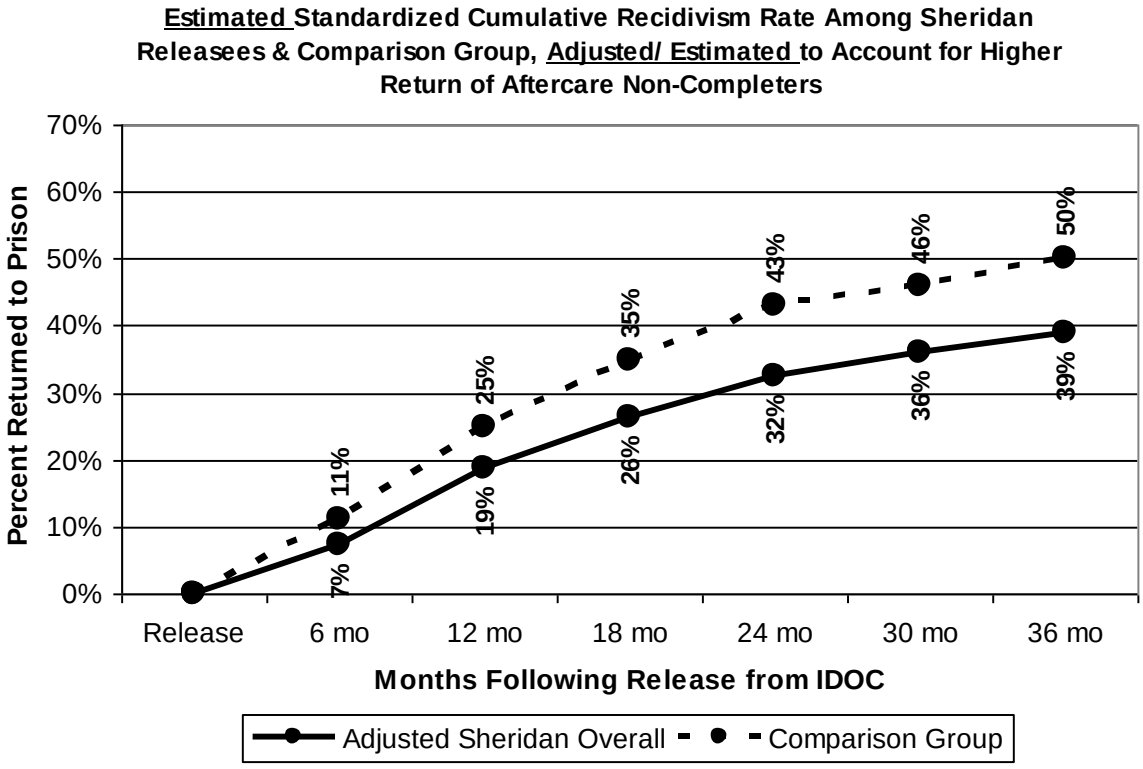
Further, this pattern appears to have changed considerably during the 6 ½ years of operations covered in this evaluation. For example, during the first couple years of Sheridan's operation and release of inmates to MSR, Sheridan releasees who failed to complete aftercare were only slightly more likely to be returned to prison than the comparison group. Among those released during SFYs 2005 and 2006, Sheridan releasees who did not enter aftercare had a 15 percent higher likelihood of being returned to IDOC than the inmates in the comparison group released during the same time period (i.e., the odds ratio of 1.15, $p<.01$). However, those released from Sheridan during SFYs 2006 through 2009 who did not enter aftercare had a 47 percent higher likelihood of being returned to IDOC than the inmates in the comparison group released during the same time period (odds ratio of 1.47, $p<.001$). In other words, it appears that the likelihood of being returned to prison among Sheridan releasees who failed to comply with aftercare requirements has increased over time.

The fact that those released from Sheridan who did not complete aftercare had a higher rate of return to prison than the comparison group illustrates how rigorously monitored and how strictly these conditions of release are enforced among the Sheridan releasees. As was described earlier, all inmates who participate in the Sheridan program are required, upon release to MSR, to participate in aftercare treatment. Most often this aftercare is in the form of intensive outpatient treatment, which includes frequent urinalysis as well as frequent appointments to participate in group and individual treatment sessions. By comparison, most inmates released from prison (i.e., the comparison group) in Illinois are not required as a condition of their MSR to participate in

intensive outpatient treatment, and as a result, have fewer conditions of MSR which they can violate. Further, if a non-Sheridan inmate is released to MSR with a requirement of substance abuse treatment in the community, oftentimes there are wait-lists or treatment services are not readily available, and thus, through no fault of their own, the releasee cannot comply with these requirements and therefore will not be considered in violation of their MSR. On the other hand, inmates released from Sheridan are referred to community-based programs that have dedicated contracts with IDOC to serve Sheridan releasees. As a result, a Sheridan releasee failing to comply with aftercare is viewed more seriously because the services were made available to them. Analyses done during earlier stages of the evaluation found that there were no statistical differences in the likelihood of rearrest when those released from Sheridan who did not complete aftercare were examined relative to the comparison group. Thus, the higher likelihood of return to prison appears to be primarily related to their failure to comply with the aftercare requirements. The data presented in Figure 27 attempts to account for this difference, and provides an ***estimate*** of what the overall recidivism rate for the Sheridan releasees ***would*** look like if those who failed in aftercare were subject to the same risk of returning to prison as the comparison group.[50] Thus, had those released from Sheridan who failed in aftercare had the same likelihood of being returned to prison as the comparison group (i.e., those inmates without the extensive MSR requirements Sheridan releasees were subject to), the overall recidivism rate for Sheridan releasees at 36 months post-release would have been 39 percent, compared to the 50 percent for the comparison group.

[50] This estimate for the Sheridan releasees was calculated by weighting the recidivism rate in terms of what proportion completed aftercare and what proportion did not complete aftercare. In the cohort of releasees examined in this report—those released through June 30, 2010—roughly 62 percent completed aftercare and 38 percent did not. Thus, the recidivism rate for the comparison group at each point in time was multipled by .38 (the weight for those that did not complete aftercare) and the recidivism rate for the Sheridan aftercare completers was multipled by .62 (the weight for those that did complete aftercare). Combining these two rates produced the estimates presented in Figure 27.

Figure 27



The last set of analyses regarding post-release recidivism of Sheridan releasees involved a comparison to those inmates who were initially admitted to Sheridan, but were subsequently removed from the program due to disciplinary reasons—primarily refusal to participate in the treatment program. Again, all of the individuals in this group (referred to as "Sheridan removals") met the program's eligibility requirements, including being in need of substance abuse treatment and volunteering for the program, but did differ from those who completed the program in terms of their age, time to serve, criminal history and the other characteristics described on pages 33 and 34. Oftentimes in evaluations of programs similar to Sheridan, this group of non-completers or "drop-outs" are used as the comparison group since they obviously met the eligibility requirements and were motivated (at least initially) to participate in the voluntary program. On the other hand, some question the appropriateness of this group as a true comparison since they obviously differed from the group that successfully completed the program in terms of their ultimate commitment and motivation to complete the program. Still, it provides another perspective from which the impact of the Sheridan program on recidivism can be examined. Using techniques similar to that described above (i.e., multivariate statistical

analyses that control for the demographic, socio-economic, criminal history, and time served differences between the two groups), results of these analyses indicated that the graduates from the institutional-phase of the Sheridan program had a 25 percent lower likelihood of recidivism than those who were removed from/dropped out of the Sheridan program and were subsequently released from another Illinois prison.

Reasons for Return to Prison

In addition to examining whether or not Sheridan releasees and those in the comparison group were returned to prison, the reasons for their return to prison were also examined and compared. From those analyses it was evident that among those returned to prison, regardless of the group, the most frequent reason was a violation or a new arrest that occurred while the releasee was still on Mandatory Supervised Release. As seen in Table 18, *among those Sheridan releasees who were returned to prison* during the follow-up period, just over one-half (53.5 percent) were returned as a result of a new conviction and sentence to prison, whereas just under one-half (45.7 percent) were returned as a result of a violation of their MSR (which can include new *arrests*, but not new convictions). Among the group of Sheridan releasees who successfully completed their aftercare requirements, which as seen before had a much lower overall recidivism rate, *but were returned to prison*, the most frequent reason—accounting for 59.1 percent of those in this group that were returned to prison--was a new conviction and sentence to IDOC. On the other hand, among those Sheridan releasees who failed to complete their required aftercare and were returned to prison, just over one-half (50.1 percent) were returned to prison due to violations of their MSR, which in most instances included not only their failure to complete aftercare but other violations as well, such as arrests for new crimes.[51] Among releasees in the comparison group who were returned to prison, technical violations of their MSR accounted for just under one-half of these returns (49.9 percent).

[51] When the nature of the returns to IDOC among the Sheridan releasees who failed to complete aftercare were examined separately for those releasees exiting prison during SFYs 2005 and 2006 versus those released during SFYs 2007 through 2009, a much higher proportion of returned inmates in the most recent cohort—2007 through 2010—were returned due to an MSR violations (59 percent) than those from the earlier cohort—2005-2006--who were returned (42 percent).

Table 18
Nature of First Return to IDOC Among Recidivists

	Sheridan			Comparison	
	Overall Sheridan	Sheridan w/Aftercare Completion	Sheridan w/o Aftercare Completion	Comparison Group	Sheridan Removals (Alternative Comparison Group)
New Conviction & Sentence to IDOC After Discharge from MSR	27.2%	36.3%	20.1%	22.1%	14.1%
New Conviction & Sentence to IDOC While on MSR	26.3%	22.8%	29.0%	26.8%	30.6%
Total New Conviction & Sentence to IDOC	53.5%	59.1%	49.1%	48.9%	44.7%
Technical violation of MSR (including new arrests)	45.7%	40.1%	50.1%	49.9%	55.0%
Other	0.8%	0.8%	0.8%	1.3%	0.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Finally, when those returned to prison specifically because of a new conviction and sentence to prison were examined to determine what crime they had been convicted of and sentenced to prison for, it was evident that among both those Sheridan releasees and those in the comparison group the majority of conviction offenses were non-violent, and the majority were either drug-law violations or property-related crimes. For example, among those released from Sheridan who ended up coming back to prison as a result of a new conviction and sentence, 13 percent had been convicted of a crime of violence, compared to 16 percent of those in the comparison group who were re-sentenced to prison. On the other hand, among those convicted and resentenced to prison, drug-law violations accounted for a higher proportion of the crimes Sheridan releasees came back to prison for than the comparison group (44 percent versus 37 percent, respectively). There were also some differences noted in the types of reconviction offenses that resulted in those being returned to prison between those Sheridan releasees who completed aftercare and those that did not. Specifically, among those Sheridan releasees who completed aftercare but were still reconvicted and sentenced to prison for a new crime, only 11 percent had been convicted of a crime of violence, compared to 16 percent of those who did not complete aftercare and were resentenced to prison. Conversely, 48 percent of those who completed aftercare but

were subsequently reconvicted and resentenced to prison were convicted of drug-law violations, compared to 41 percent of those who did not complete aftercare and were resentenced to prison.

Thus, the recidivism analyses found that overall the Sheridan releasees had better post-release outcomes than did the comparison group of inmates who were similar to those at Sheridan but that did not receive services, as well as those who had initially been accepted to participate in Sheridan but were later removed due to disciplinary problems and failure to participate in treatment. Further, those Sheridan releasees who completed their aftercare requirements had a recidivism rate that was close to one-half that of the comparison group, whereas those released from Sheridan who did not complete aftercare actually did worse than the comparison group. Part of this is likely attributed to the fact that Sheridan releasees exiting prison since 2007 who did not complete aftercare were more likely than the comparison group to be returned to prison for technical violations of their MSR, and this is most likely due to the fact that Sheridan releasees have more MSR conditions than the comparison group. Finally, when those in either the Sheridan group or the comparison group were returned to prison as a result of a new conviction, the likelihood that the new offense was violent in nature was relatively low for all groups examined, but was lower for the Sheridan releasees as a whole and those from Sheridan who completed aftercare, and most often involved drug-law violations or property-related crimes.

VII. CONCLUSIONS

The establishment of the Sheridan Correctional Center Therapeutic Community in 2004 marked a substantial change in the Illinois Department of Corrections' response to the rehabilitative and reentry needs of those offenders committed to the state's prison system. Prior to the creation of the Sheridan Correctional Center Therapeutic Community there was no process in Illinois to assess all inmates for substance abuse treatment need, no substance abuse treatment wait list to prioritize access to treatment services, and no coordinated process to refer released inmates to needed services in the community or contract for those services. Many of these glaring deficiencies were evident during the planning phase for the Sheridan program in 2003, including an inability to accurately determine how many of those admitted to Illinois' prison system were in need of treatment or would volunteer to participate in treatment if it were available. As a result of Sheridan, IDOC now assesses every inmate admitted to prison using the Texas Christian University (TCU) Drug Screen II, and maintains a system-wide treatment wait list so that those inmates identified as in need of treatment during the Reception and Classification (R&C) process but for whom treatment may not be immediately available or appropriate can potentially access services prior to being released from prison. Evidence of this can be seen by the fact that as this process was implemented, a larger proportion of inmates admitted to Sheridan were coming from this treatment wait list as opposed to exclusively from IDOC's R&C Centers. Similarly, because of the need to coordinate aftercare services for the Sheridan releasees, including additional substance abuse treatment, transitional living arrangements, and employment referrals, across the entire state and across multiple service providers the role of the Placement Resource Unit has expanded considerably.

In terms of the operation of Sheridan over the past 6 ½ years, the evaluation found that the program is serving the intended population and has implemented processes so that inmates who do not meet the eligibility criteria are generally not referred to Sheridan, and in instances when they are inappropriately admitted, they are transferred quickly. The program has also been successful at matriculating a high proportion of admitted participants through the entire institutional phase of the Sheridan Therapeutic Community. From the data presented in this report, the Sheridan program is clearly serving a population with very extensive substance abuse

and criminal histories, and a high, previously unmet need, for the kind of intensive, comprehensive treatment being provided at Sheridan.

The Sheridan Correctional Center Therapeutic Community has clearly benefitted from the political and organizational support needed to ensure that a new program as large and complex as Sheridan was implemented as intended. At various times during the first 6 ½ years of operation, new admissions into the program were scaled back to ensure the clinical integrity of the services being provided. For example, during the period when the first cohort of inmates were being released back into the community and into aftercare (the summer of 2004), no new inmates were admitted so that staff could ensure that the pre-release planning for these graduates of the institutional-phase was carried out as intended. Similarly, during a period when some of the substance abuse counseling staff went on strike (summer of 2006), and therefore reduced the number of counselors available to provide treatment, admissions were reduced. During the course of program implementation and the first 6 ½ years of operation, there was also widespread political support for inmate reentry programming and providing substance abuse treatment to those in prison. Because of the high recidivism rate in Illinois, crowding within the state's prison system, and the widespread recognition that substance abuse treatment delivered through a Therapeutic Community with aftercare can reduce recidivism, it was the convergence of a number of factors that allowed for this bold break from the traditional way Illinois' prison system responded to inmates in need of rehabilitative services and treatment.

The implementation and development of the Sheridan Correctional Center Therapeutic Community has also enhanced the capacity of IDOC as well as community-based substance abuse treatment providers to respond to the reentry needs of Illinois' prison population. Prior to Sheridan, the number of inmates leaving IDOC with dedicated access to aftercare treatment services for substance abuse, as well as the ancillary services needed to enhance successful reentry (i.e., transitional living or recover homes), was essentially non-existent. As a result of Sheridan being implemented with an eye towards evidence-based practices, and the consistent finding in research that prison-based treatment must be followed up with aftercare services upon an inmate's release, all Sheridan releasees were given referrals to aftercare services, and through the efforts of IDOC's Parole Division and Placement Resource Unit, and TASC, a network of

community-based providers able to serve this population has been identified and supported in their efforts through funding as well as immersion training at Sheridan.

Ultimately, in order for these efforts to be supported and continued they must show that they have an ultimate impact on the rate at which prison releasees return to prison—the recidivism rate. The evaluation has shown that the Sheridan program has been successful in this respect: overall, inmates released from Sheridan have a lower rate of return-to-prison than a statistically similar group of prison releasees (i.e., the comparison group), despite having a much more extensive and rigorously monitored set of requirements for their MSR. Further, among those Sheridan releasees who are effectively matriculated through the aftercare component of the program and complete their aftercare, the recidivism rate is one-half that of the comparison group. As the program has evolved, and the aftercare network in the community, and referral process by TASC and Parole, has matured and become more standardized, the likelihood that Sheridan releasees complete their aftercare has also improved. However, with that said, the evaluation also found that those inmates who graduate from the prison-phase of the program, but fail to comply or complete the aftercare requirements are returned to prison at a rate higher than the comparison group. Since the comparison group and Sheridan releasees who failed to comply with aftercare did not differ significantly in terms of new arrests, it appears that the failure to comply with the aftercare is the primary factor leading to their being returned to prison at a higher rate than the comparison group. However, since those who fail to show up for, or comply with, initial aftercare referrals are usually referred to other aftercare programs, those returned to prison for technical violations of their MSR from Sheridan usually have violated multiple conditions and failed to comply with multiple referrals to aftercare programs.

Finally, the benefit of the Sheridan program's experience and efforts has now been expanded and the model of an intensive, prison-based Therapeutic Community with dedicated and coordinated aftercare services has been implemented at the IDOC's Southwestern Illinois Correctional Center (SWICC). Although the SWICC program serves a slightly different population—it is a minimum security facility and also has a dedicated methamphetamine treatment unit—the aftercare referral process and mechanisms at SWICC have been built upon those developed as a result of the Sheridan program. As a result, among the first cohorts of inmates released from the newly

enhanced SWICC TC program (i.e., including the aftercare component) starting in 2007, treatment entry and completion rates have been substantially higher than among the first cohorts released from Sheridan in 2004 and 2005, when the aftercare referral process and network was just being implemented. As seen earlier in this report, by 2007 the rate at which Sheridan releasees were entering and completing aftercare services had improved and reached a high-level of success, which has been translated into SWICC releasees benefitting from these established and improved processes.

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