ILLINOIS BUDGETING FOR RESULTS

# Budgeting for Results

## IDOC Therapeutic Communities Program Assessment

## Introduction

The statute that created Budgeting for Results (BFR) states that in Illinois, budgets submitted and appropriations made must adhere to a method of budgeting where priorities are justified each year according to merit (Public Act 96-958). The BFR Commission, established by the same statute, has worked since 2011 to create and implement a structure for data-driven program assessment useful to decision makers.

The BFR framework utilizes the Results First benefit-cost model and the State Program Assessment Rating Tool to produce comprehensive assessments of state funded programs.

The Pew-MacArthur Results First Initiative developed a benefit-cost analysis model based on methods from the Washington State Institute for Public Policy (WSIPP). The Results First benefit-cost model can conduct analysis on programs within multiple policy domains including; adult crime, juvenile justice, substance use disorders, K-12 education, general prevention, health, higher education, mental health, and workforce development.

The State Program Assessment Rating Tool (SPART) combines both quantitative (benefit-cost results) and qualitative components in a comprehensive report. It is based on the federal Program Assessment Rating Tool (PART) developed by the President's Office of Management and Budget and has been modified for state use. The SPART provides a universal rating classification to allow policy makers and the public to more easily compare programs and their performance across results areas.

## Methods

BFR begins each assessment by modeling an Illinois program's design and assessing its implementation. Each program is then matched with an existing rigorously studied program or policy. BFR completes a comprehensive review of related program literature to inform the modeling and matching process.

Each rigorously studied program has an effect size determined from existing validated research that summarizes the extent to which a program impacts a desired outcome. The effect size is useful in understanding the impact of a program run with fidelity to best practices or core principles.

The Results First benefit-cost model uses the effect size combined with the state's unique population and resource characteristics to project the optimal return on investment that can be realized by taxpayers, victims of crime, and others in society when program goals are achieved.

The SPART contains summary program information, historical and current budgetary information, the statutory authority for the program, performance goals and performance measures. The SPART tool consists of weighted questions, which tally to give a program a numerical score of 1-100. Numerical scores are converted into qualitative assessments of program performance: effective, moderately effective, marginal and not effective.

# Section 1

# Results First Benefit-Cost Report

## Benefit-Cost Summary – IDOC Therapeutic Communities

This is the benefit-cost analysis in the Adult Crime domain of the Illinois Department of Corrections (IDOC) Therapeutic Communities program at Sheridan Correctional Center (Sheridan) and Southwestern Illinois Correctional Center (SWICC). Many offenders in IDOC custody have substance use disorder (SUD) problems. Effective treatment can help prevent people from moving on to nondrug offending. The period while in IDOC custody provides an opportunity to treat the SUD that can lead to greater recidivism. The benefit-cost analysis completed by BFR calculated that for every one dollar spent on Therapeutic Community programs by IDOC, **$1.61** of future benefits could be realized by Illinois taxpayers and crime victims.

The major takeaways from this analysis can be found in *Table 1* below. The optimal benefits are projected for programs run with fidelity to best practices or core principles. The optimal benefits are determined using a standard metric called an effect size. The real costs of a program are the sum of its direct and indirect costs. The benefit/cost ratio is the optimal return on investment (OROI) Illinois can expect from implementing the program with fidelity. BFR performs a Monte Carlo risk estimate showing the percent of time that the benefits exceed the costs when simulated 10,000 times with random variation in costs and benefits.

***Table 1:***

| Benefit-Cost Results<br>IDOC Therapeutic Communities per Participant | |
|---|---|
| Optimal Benefits | $7,052 |
| Real Cost (Net) | $4,377 |
| Benefits - Costs | $2,675 |
| Benefits/Costs (OROI) | $1.61 |
| Chance Benefits Will Exceed Costs | 91% |
| SPART Score | 70, Moderately Effective |

## Benefit-Cost Detail – IDOC Therapeutic Communities

***Program Information***

Therapeutic communities are a type of substance abuse treatment program in which program participants live together and support one another through the treatment process. IDOC runs therapeutic communities at Sheridan Correctional Center (Sheridan) and Southwestern Illinois Correctional Center (SWICC). One of the primary outcomes this program was implemented to achieve is a reduction in recidivism, since substance abuse and crime are closely related for many offenders.

Using program information gathered with IDOC, BFR matched the Illinois Therapeutic Communities program at Sheridan and SWICC with the Incarceration-based Therapeutic Communities for Adults practice profile in the *CrimeSolutions.gov* clearinghouse. The program information for Sheridan and SWICC was provided by IDOC and is described in *Table 2*.

***Table 2:***

| Program Name | Program Description |
|---|---|
| **Sheridan Correctional Center** | - Substance abuse treatment facility for adult males with 1650 dedicated beds, run by West Care Foundation<br>- Provides 15+ hours of treatment weekly, for 9-36 months |
| **Southwestern Illinois Correctional Center (SWICC)** | - Substance abuse treatment facility for adult males with 715 dedicated beds, run by the GEO Group.<br>- Includes a specialized Methamphetamine Treatment Unit<br>- Offers a program that trains offenders to become entry level service providers in the field of substance abuse. |
| - In FY2017, over 4000 in total received services at one of the two facilities, and there were 1591 successful discharges from the program.<br>- At both facilities, TASC provides pre- and post-release clinical services, oversees support groups including post-release community support groups, and helps offenders prepare for reentry into the community. | |

The clearinghouse rated this type of program as "effective" based on 2 meta-analyses of 129 studies:

> The majority of the studies included in the overall analysis were published after 1999 (60 percent) and were conducted in the United States (88 percent). Thirty studies reported on the effects of incarceration-based therapeutic communities for adults on recidivism post-release…. The results indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders after release (odds ratio = 1.38 for the treatment group). This means that if the comparison group has an

assumed recidivism rate of 35 percent, treatment group offenders have a 28 percent recidivism rate.[1]

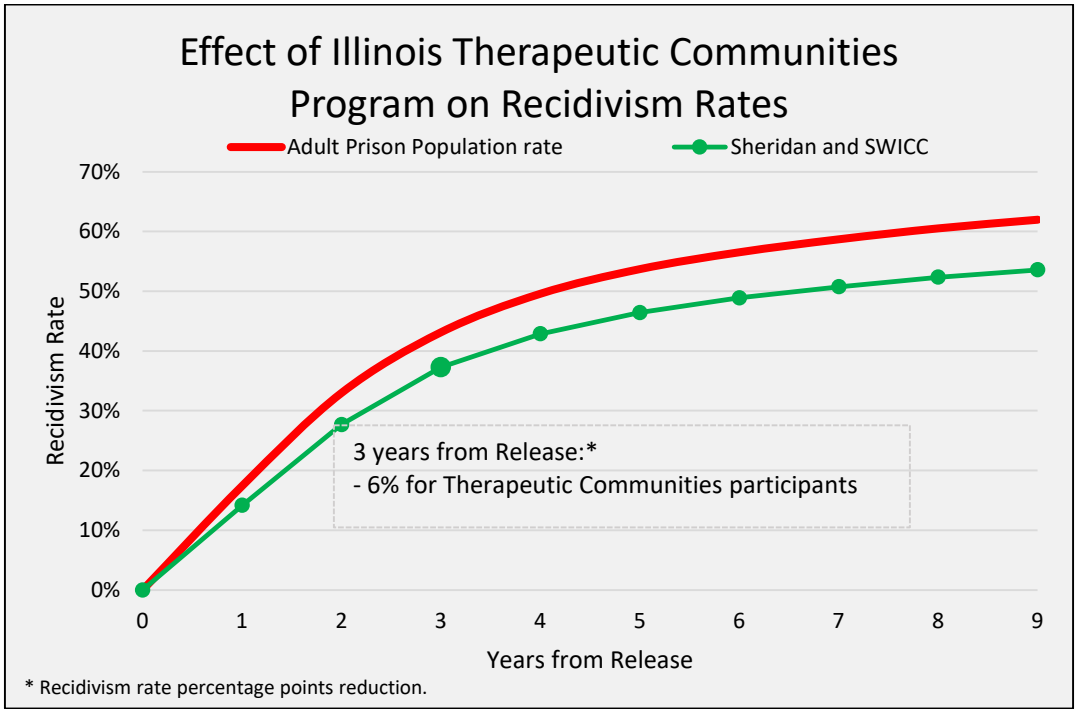
***Analysis***

A well-run substance abuse treatment program for offenders can benefit taxpayers and society in a number of ways. In particular, this analysis focuses on how such a program saves taxpayers' money over time by avoiding future criminal justice expenses. Taxpayers avoid paying for additional criminal justice system costs of arrests and processing; prosecutions, defense, and trials; and incarceration and supervision. Lower recidivism rates lead to fewer prisoners that need to be paid for by the State.

Just as importantly, decreasing recidivism saves money by avoiding private costs incurred as a result of fewer Illinois crime victims. The private victimization costs include lost property, medical bills, wage loss, and the pain and suffering experienced by crime victims.

The benefit-cost model predicts a 6% decrease in the recidivism rate[2] three years from release from IDOC custody for participants in the Therapeutic Communities program at Sheridan and SWICC, as illustrated in *Figure 1*. The model also predicts the 9-year recidivism rate for participants in the program to be 14.5% less than that of the general prison population.

***Figure 1:***

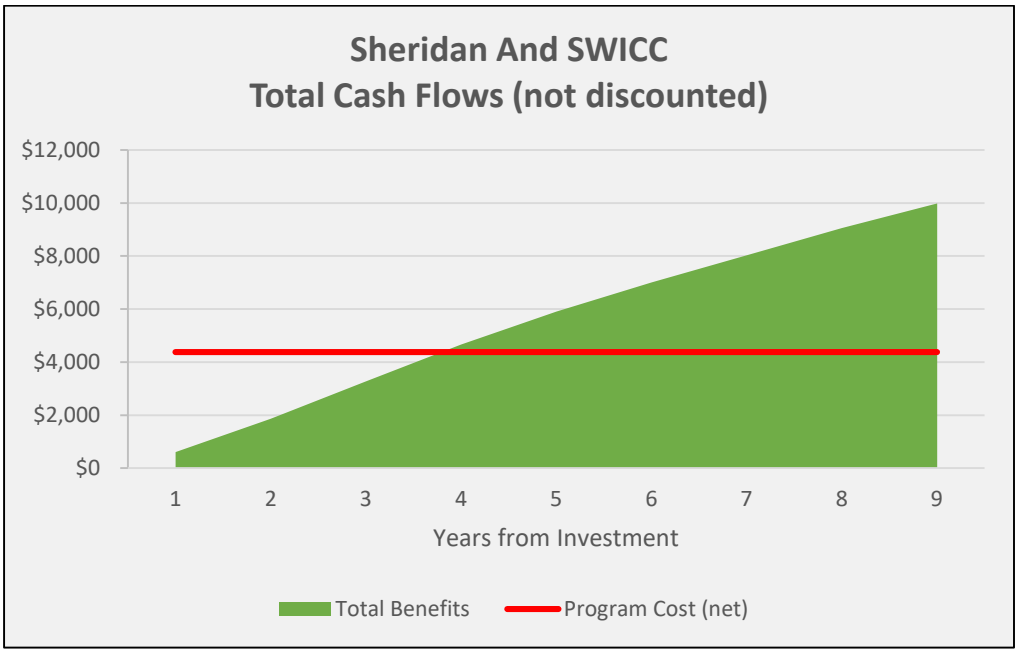



[1] Crime Solutions (https://www.crimesolutions.gov/PracticeDetails.aspx?ID=52)

[2] Recidivism is defined as reconviction after a release from prison or sentence to probation.

The average cost to the State of Illinois for providing the Therapeutic Communities program is $4,377 per participant per year. These costs are all incurred while the participant is in IDOC custody, while the benefits from reduced recidivism accumulate over time after the offender is released. This is demonstrated in *Figure 2* below. The red line depicts cumulative program costs, which are flat since all costs occur at the beginning of the period. The green area shows cumulative program benefits. As illustrated, the program benefits exceed the program costs after the third year from the initial investment.

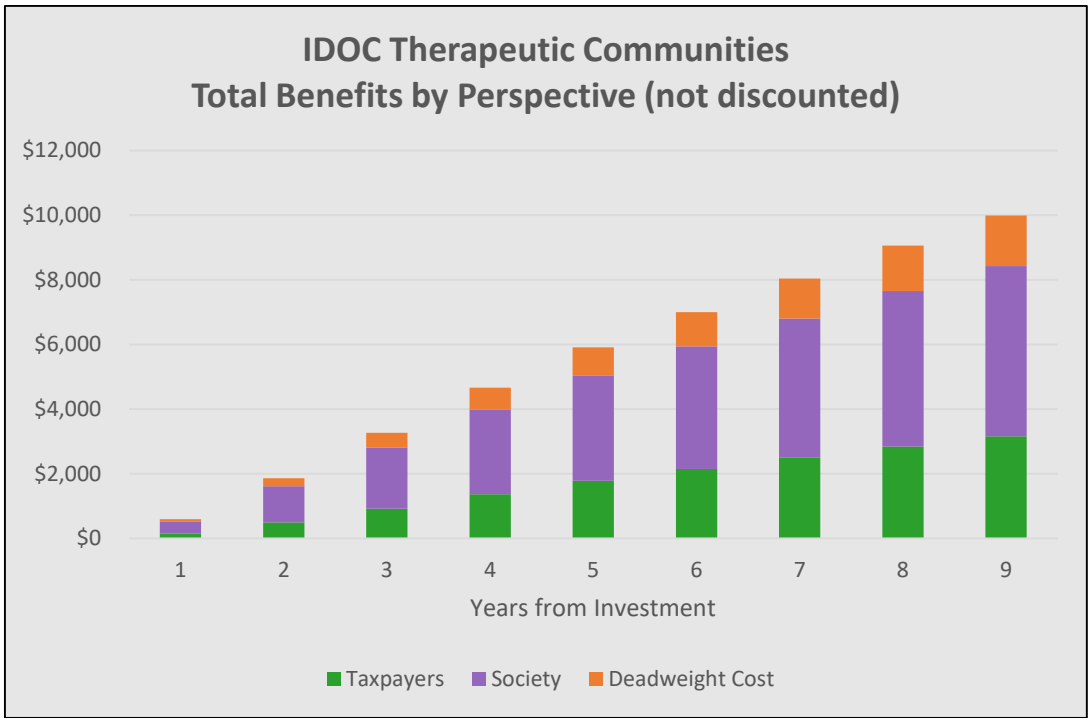
***Figure 2:***



The IDOC Therapeutic Community program at Sheridan and SWICC could optimally produce $7,052 in future lifetime benefits per average participant. Beyond the direct benefits to Illinois taxpayers and crime victims, additional indirect benefits accrue to society as well, including better use of the tax dollars that are currently raised, and future taxes that won't have to be raised to pay for avoidable costs due to recidivism. When tax revenue is spent on one program, it has an opportunity cost of revenue that cannot be spent on other beneficial programs and services like public safety or economic development. Money that is taxed is also not available for private consumption and investment. The indirect benefits of making effective, economically efficient investments to reduce criminal recidivism are quantified within the Results First model using the Deadweight Cost of Taxation.

*Figure 3* below shows how the total benefits from the Therapeutic Communities program are divided among taxpayers, crime victims, and indirect deadweight costs.

***Figure 5:***




This analysis was conducted by the BFR Unit using the Results First cost-benefit model. Please see Budget.Illinois.gov for additional benefit-cost reports and supporting information.

# Section 2

# State Program Assessment Rating Tool

**State Program Assessment Rating Tool (SPART)**
**Therapeutic Communities**
426-Illinois Department of Corrections

**This report was compiled by the Budgeting for Results Unit of the Governor's Office of Management and Budget with the support of the Illinois Department of Corrections. The SPART is an assessment of the performance of state agency programs. Points are awarded for each element of the program including: Program Design and Benefit-Cost and Performance Management/Measurement. This combined with benefit-cost analysis through Results First establishes an overall rating of the program's effectiveness, which can be found on the final page of this report.**

**Section 1: General Information**

Prior Year (PY), Current Year (CY), Fiscal Year (FY) Budget (in thousands) Appropriated___ Expended__

| PY 2013 | PY 2014 | PY 2015 | PY 2016 | CY 2017 | FY 2018 |
|---|---|---|---|---|---|
| $0 | $78.821.0 | $80.288.1 | $79,107.0 | $77,197.9 | N/A |

Is this program mandated by law? Yes__ No_x__
Identify the Origin of the law. State__ Federal_____ Other____
Statutory Cite_____
Program Continuum Classification __Treatment, Standard treatment for known disorders_

**Evaluability**

*Provide a brief narrative statement on factors that impact the evaluability of this program.*

This is a new program created by IDOC. IDOC is still determining appropriate measures and targets. Due to the program state of flux, obtaining sufficient data in a timely manner was difficult. It is expected that this obstacle will resolve as the program is more fully implemented.

| Key Performance Measure | FY 201X | FY 201X | FY 201X | Reported in IPRS Y/N |
|---|---|---|---|---|
| Illinois 3-year Recidivism Rate | 46.9% | 45.5% | 43.9% | Y |
| Sheridan Correctional Center and Southwestern Illinois Correctional Center 3-year recidivism rate | N/A | 37% | 37% | Y |
| | | | | |

**Section 2: Program Design and Benefit-Cost** **Total Points Available: 60**

Total Points Awarded: 40

| Question | Points Available | Yes/Partial/No | Points Awarded |
|---|---|---|---|
| 2.1 Is the Program:<br>Evidence Based 25pts<br>Theory Informed 15 pts<br>Unknown Effect 0 pts<br>Negative Effect -5 pts<br>What are the program's core principles? | 25 | Yes | 25 |

**Explanation:**

Incarceration based Therapeutic Communities (TC) for Adults are a specific type of drug treatment program targeted at offenders who are assessed to be higher risk and in need of higher intensity treatment. There a several core principles that appear to be important components of a TC program. For instance, inmates in therapeutic communities are usually housed in separate living and treatment areas away from non-participating residents. Groups and interventions in a TC are attended collectively to promote inmate participation in the full residential community. Sheridan Correctional Center and Southwestern Illinois Correctional Center are purpose built to separately house and treat higher need drug offenders.

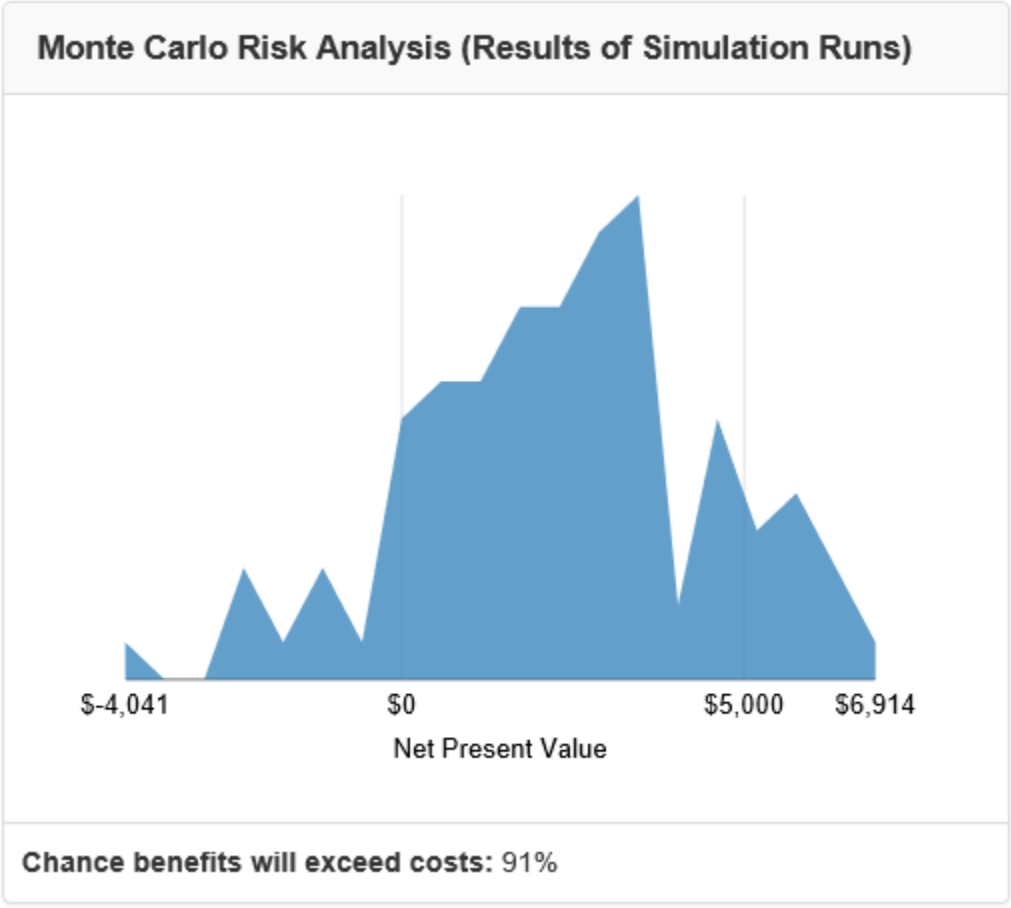
| Question | Points Available | Yes/Partial/No | Points Awarded |
|---|---|---|---|
| 2.2 Is the Program implemented and run with fidelity to the program design? | 25 | Partial | 10 |

**Explanation:**

The IDOC TC program at Sheridan Correctional Center has undergone an independent evaluation by Southern Illinois University. The evaluation focused on treatment fidelity and effectiveness within a Risk Needs, Responsivity framework. The evaluation concluded that, "The referral criteria for the Sheridan programming was inappropriate. This results in a waste of treatment resources, in addition precluding the treating of appropriate offenders in a timely fashion. Although the Sheridan programming is labelled as cognitive behavioral treatment, the techniques used in the sessions provide only limited support. This lack of treatment fidelity may contribute to facility treated offenders having substance abuse issues in the community ". The report is attached at the end of this document. IDOC is currently working to improve the risk assessment, referral process and fidelity to core practices.

| Question | Points Available | Yes/Partial/No | Points Awarded |
|---|---|---|---|
| 2.3 If the program achieved full credit in question 2.2, can we expect the Optimal Return on Investment (OROI) for this program to be equal to or greater than $1 for each $1 spent? | 10 | Partial | 5 |

**Explanation:**
BFR performed a Monte Carlo risk estimate on the IDOC TC program showing the percent of time that the optimal benefits exceed the costs when simulated 10,000 times with random variation in costs and benefits. 91% of the time the OROI was greater than $1, with an average of $1.61. The IDOC is working on improving the implementation of this program to better ensure fidelity to core principles and best practices.



**Section 3: Performance Management/Measurement** **Total Points Available: 40**

Total Points Awarded: 30

| Question | Points Available | Yes/Partial/No | Points Awarded |
|---|---|---|---|
| 3.1 Does the program regularly collect timely and credible performance measures? | 10 | Partial | 5 |

**Explanation:**
Although performance measures are collected by DOC for their annual reports (see attached) the measure data is not easily accessible.

| Question | Points Available | Yes/Partial/No | Points Awarded |
|---|---|---|---|
| 3.2 Do the performance measures focus on outcomes? | 10 | Partial | 5 |

**Explanation:**
The measure identified above indicates the program's impact on recidivism, which is the primary goal of the program. See attached IPRS report. The TC program was implemented to reduce SUD in order to decrease recidivism, tracking SUD among participants needs to be improved.

| Question | Points Available | Yes/Partial/No | Points Awarded |
|---|---|---|---|
| 3.3 Are independent and thorough evaluations of the program conducted on a regular basis or as needed to support program improvements and evaluate effectiveness? | 10 | Yes | 10 |

**Explanation:**
This program does have an independent evaluation. See attached report.

| Question | Points Available | Yes/Partial/No | Points Awarded |
|---|---|---|---|
| 3.4 Does the Agency use performance information (including that collected from program partners) to adjust program priorities, allocate resources, or take other appropriate management actions? | 10 | Yes | 10 |

**Explanation:**
The IDOC uses performance information to help determine staffing levels, as well as prisoner transfer and location dispositions.

**Concluding Comments**

The at the Sheridan and South Western Illinois (SWIC) Correctional Centers utilize a Therapeutic Communities (TC) substance use disorder (SUD) treatment program. The TC program has been shown through research to be highly effective in reducing recidivism among groups with high a need of SUD treatment. However, an independent evaluation of the program conducted by Southern Illinois University showed that a sample of inmates at Sheridan and SWIC reported a level of substance abuse generally lower than a sample of IDOC general population inmates. Consequently, treatment may be delivered to inmates without a truly established SUD, which would have the potential of skewing outcome effectiveness measures.

The independent evaluation also noted that many of the interventions within the IDOC TC program do not have fidelity to core principles and best practices. It is recommended that IDOC reexamine evaluation, referral and treatment criteria and make any necessary adjustments. In addition, it is further recommended that IDOC continue to establish annual performance targets.

**Final Program Score and Rating**

| Final Score | Program Rating |
|---|---|
| 70/100 | Moderately Effective |

**SPART Ratings**
**Programs that are <u>PERFORMING</u> have ratings of Effective, Moderately Effective, or Adequate.**

- <u>Effective.</u> This is the highest rating a program can achieve. Programs rated Effective set ambitious goals, achieve results, are well-managed and improve efficiency. Score 75-100
- <u>Moderately Effective.</u> In general, a program rated Moderately Effective has set ambitious goals and is well-managed. Moderately Effective programs likely need to improve their efficiency or address other problems in the programs' design or management in order to achieve better results. Score 50-74
- <u>Marginal.</u> This rating describes a program that needs to set more ambitious goals, achieve better results, improve accountability or strengthen its management practices. Score 25-49

**Programs categorized as <u>NOT PERFORMING</u> have ratings of Ineffective or Results Not Demonstrated.**

- <u>Ineffective.</u> Programs receiving this rating are not using your tax dollars effectively. Ineffective programs have been unable to achieve results due to a lack of clarity regarding the program's purpose or goals, poor management, or some other significant weakness. Score 0-24
- <u>Results Not Demonstrated.</u> A rating of Results Not Demonstrated (RND) indicates that a program has not been able to develop acceptable performance goals or collect data to determine whether it is performing.

## Glossary

**Best Practices:** Policies or activities that have been identified through evidence-based policymaking to be most effective in achieving positive outcomes.

**Evidence-Based:** Systematic use of multiple, rigorous studies and evaluations which demonstrate the efficacy of the program's theory of change and theory of action.

**Illinois Performance Reporting System (IPRS):** The state's web-based database for collecting program performance data. The IPRS database allows agencies to report programmatic level data to the Governor's Office of Management and Budget on a regular basis.

**Optimal Return on Investment (OROI):** A dollar amount that expresses the present value of program benefits net of program costs that can be expected if a program is implemented with fidelity to core principles or best practices.

**Outcome Measures:** Outcomes describe the intended result of carrying out a program or activity. They define an event or condition that is external to the program or activity and that is of direct importance to the intended beneficiaries and/or the general public. For example, one outcome measure of a program aimed to prevent the acquisition and transmission of HIV infection is the number (reduction) of new HIV infections in the state.

**Output Measures:** Outputs describe the level of activity that will be provided over a period of time, including a description of the characteristics (e.g., timeliness) established as standards for the activity. Outputs refer to the internal activities of a program (i.e., the products and services delivered). For example, an output could be the percentage of warnings that occur more than 20 minutes before a tornado forms.

**Results First Clearinghouse Database:** One-stop online resource providing policymakers with an easy way to find information on the effectiveness of various interventions as rated by eight nation research clearinghouses which conduct systematic research reviews to identify which policies and interventions work.

**Target:** A quantifiable metric established by program managers or the funding entity established as a minimum threshold of performance (outcome or output) the program should attain within a specified timeframe. Program results are evaluated against the program target.

**Theory Informed:** A program where a lesser amount of evidence and/or rigor exists to validate the efficacy of the program's theory of change and theory of action than an evidence-based program.

**Theory of Change:** The central processes or drives by which a change comes about for individuals, groups and communities

**Theory of Action:** How programs or other interventions are constructed to activate theories of change.

# Practice Profile

## Incarceration-based Therapeutic Communities for Adults

**Evidence Ratings for Outcomes:**

Crime & Delinquency - Multiple crime/offense types

### Practice Description

**Practice Goals/Target Population**
Incarceration-based therapeutic communities (TCs) are separate residential drug treatment programs in prisons or jails for treating substance-abusing and addicted offenders. The defining feature of TCs is the emphasis on participation by all members of the program in the overall goal of reducing substance use and recidivism.

**Practice Theory**
The TC theory proposes that recovery from substance abuse involves rehabilitation to learn healthy behaviors and habilitation to integrate those healthy behaviors into a routine (NIDA 2015). TCs differ from other models of treatment by their focus on recovery, overall lifestyle changes, and the use of the "community" as the key instrument for that change (De Leon and Wexler 2009; NIDA 2015; Welsh 2007; Vanderplasschen et al. 2012). The community includes inmate peers and facility staff. TCs use a stepping-stone model in which participants progress through several levels of treatment. As they progress through each treatment level, their level of responsibility also increases. TCs are implemented in a residential setting to help inmates adjust to the idea of a community working together toward a common goal (Welsh 2007). Treatment includes aftercare and reentry services as a means of providing continued support and relapse prevention after leaving the community (NIDA 2015)

**Practice Components**
Residents of TCs progress through treatment in three stages 1) induction and early treatment, 2) primary treatment, and 3) reentry. The first stage provides the resident with an introduction to the TC rules and procedures, staff, and community members. During this stage, residents begin TC model treatment and are integrated into the community. The second stage is the main treatment phase, which focuses on changing attitudes and behavior related to substance use as well as addressing other needs. Common treatment approaches include cognitive behavioral therapy and motivational interviewing. Other treatment services provide assistance with social, familial, medical, and mental health needs. The third stage prepares the residents for their transition from the program and includes aftercare services. During this final stage, resident discharge planning provides referrals for reentry services available in the community once the participants are released (NIDA 2002; 2015).

Specific treatment interventions vary by facility, but there are several common components of TCs. Residents of TCs are housed separately from other inmates in order to establish and maintain a drug-free, rehabilitative, prosocial environment. Residents must follow strict community rules and norms, reinforced with set rewards or punishments, as a way to facilitate self-control and responsibility. Routines are established to teach goal planning and accountability. Residents must participate in TC-related roles, as assigned, based on a hierarchy of increasing responsibilities and privileges. Residents must also participate in TC-related activities such as community meetings, individual and group counseling, games, and role playing (NIDA 2002; 2015). These roles include chores and jobs for maintaining the community and its daily operations. All activities, aside from individual counseling, occur in group formats (CSAT 1999). In addition to their assigned community-related work, residents typically participate in 4 to 5 hours of treatment a week (NIDA 2015).

### Meta-Analysis Outcomes

**Crime & Delinquency - Multiple crime/offense types**
Mitchell, Wilson, and MacKenzie (2012) synthesized results from 30 studies that examined the effectiveness of incarceration-based therapeutic communities for adults on recidivism post-release. The results indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders after release (odds ratio = 1.38 for the treatment group). This means that if the comparison group has an assumed recidivism rate of 35 percent, treatment group offenders have a 28 percent recidivism rate. Drake (2012) analyzed 18 effect sizes on the effectiveness of incarceration-based therapeutic communities for adults on recidivism. The results indicated that treatment group offenders were significantly less likely to recidivate than comparison group offenders (effect size = –0.12).

### Meta-Analysis Methodology

| Meta-Analysis Snapshot | | | |
|---|---|---|---|
| | Literature Coverage Dates | Number of Studies | Number of Study Participants |
| **Meta-Analysis 1** | 1980 - 2011 | 30 | 0 |
| **Meta-Analysis 2** | 1990 - 2011 | 18 | 0 |

**Meta-Analysis 1**
Mitchell, Wilson, and MacKenzie (2012) synthesized results from 74 independent effect sizes on the effectiveness of incarceration-based drug treatment programs on recidivism and drug use post-release. For inclusion in the analysis, studies had to have been conducted between 1980 and 2011, assessed the effectiveness of prison- or jail-based drug treatment programs, specifically

**Practice Snapshot**

**Age:** 18+

**Gender:** Both

**Targeted Population:** Alcohol and Other Drug (AOD) Offenders, Prisoners

**Settings:** Correctional

**Practice Type:** Aftercare/Reentry, Alcohol and Drug Prevention, Alcohol and Drug Therapy/Treatment, Cognitive Behavioral Treatment, Group Therapy, Individual Therapy, Motivational Interviewing, Residential Treatment Center, Therapeutic Communities

**Unit of Analysis:** Persons

targeted substance users, used a random or quasi-experimental design with a no-treatment or minimal-treatment comparison group, and measured recidivism or drug use post-release.

The majority of the studies included in the overall analysis were published after 1999 (60 percent) and were conducted in the United States (88 percent). Thirty studies reported on the effects of incarceration-based therapeutic communities for adults on recidivism post-release. Of the included studies, 6 percent used an experimental design, 31 percent used a rigorous quasi-experimental design, 43 percent used a standard quasi-experiment design, and 20 percent used a weak quasi-experimental design. Offenders in the treatment group were residents of therapeutic communities while incarcerated; offenders in the comparison group received no treatment or treatment-as-usual while incarcerated.

Odds-ratio effect sizes were calculated and analyzed using the random-effects inverse-variance weight method.

**Meta-Analysis 2**
Drake (2012) analyzed 55 studies on the effectiveness of chemical dependency treatment on reducing crime and substance use in juvenile and criminal justice systems. For inclusion in the analysis, studies had to assess the effectiveness of a therapeutic community, intensive outpatient, or outpatient chemical dependency treatment program in either the adult criminal or juvenile justice system, use a random or rigorous quasi-experimental design with a control or comparison group, provide sufficient information to calculate an effect size, and report on measures of recidivism. Studies were excluded if their treatment groups consisted of program completers only.

The analysis included 45 studies with adults and 10 studies with juveniles. Eighteen effect sizes were synthesized on the effectiveness of incarceration-based therapeutic communities for adults in the criminal justice system. The average age of program participants was 30. No information was reported on the gender and race/ethnicity of program participants. Offenders in the treatment group were residents of therapeutic communities while incarcerated or under community supervision; offenders in the comparison group received no treatment or treatment-as-usual.

The analysis reported results using mean-difference effect sizes. The mean-difference effect sizes of studies with small samples were adjusted using the Hedges' g correction factor. A random-effects model was used to calculate the weighted average effect size.

## Cost

After conducting a cost–benefit analysis on studies on the effectiveness of chemical dependency treatment programs in the criminal justice system, Drake (2012) found that for every $1 spent, adult therapeutic communities produced a benefit of $2.59, or a 23 percent return on investment. Adult therapeutic communities also produced an average savings of $11,075 in recidivism-related costs, when crime was avoided. The analysis was based on 2011 treatment costs.

## Other Information

Mitchell, Wilson, and MacKenzie (2012) conducted a moderator analysis of treatment characteristics of the therapeutic communities. Treatment characteristics included mandatory aftercare, location of intervention (jail or prison), length of treatment program maturity, nature of participation (voluntary or at least partially mandatory), and average number of participants. The results showed that programs with voluntary participation in therapeutic communities had significantly larger effect sizes than programs in which participation was partially mandatory. No significant effects were detected for the other treatment characteristics.

## Evidence-Base (Meta-Analyses Reviewed)

These sources were used in the development of the practice profile:

**Meta-Analysis 1**
Mitchell, Ojmarrh, David B. Wilson, and Doris L. MacKenzie. 2012. "The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior: A Systematic Review." *Campbell Systematic Reviews* 18.
http://www.campbellcollaboration.org/lib/project/20/

**Meta-Analysis 2**
Drake, Elizabeth. 2012. *Chemical Dependency Treatment for Offenders: A Review of the Evidence and Benefit-Cost Findings.* Olympia, Wash.: Washington State Institute for Public Policy.
http://www.wsipp.wa.gov/ReportFile/1112/Wsipp_Chemical-Dependency-Treatment-for-Offenders-A-Review-of-the-Evidence-and-Benefit-Cost-Findings_Full-Report.pdf

## Additional References

These sources were used in the development of the practice profile:

Center for Substance Abuse Treatment (CSAT). 1999. "Therapeutic Communities." *Treatment of Adolescents with Substance Use Disorders: Treatment Improvement Protocol (TIP) Series No. 32.* Rockville, Md.: Substance Abuse and Mental Health Services Administration.
http://adaiclearinghouse.org/downloads/TIP-32-Treatment-of-Adolescents-with-Substance-Use-Disorders-62.pdf

De Leon, George, and Harry K. Wexler. 2009. "The Therapeutic Community for Addictions: An Evolving Knowledge Base." *Journal of Drug I*ssues 39:167–78.

Holloway, Katy R., Trevor H. Bennett, and David P. Farrington. 2006. "The Effectiveness of Drug Treatment Programs in Reducing Criminal Behavior: A Meta-Analysis." *Psicothema* 18(3):620–29.

Mitchell, Ojmarrh, David B. Wilson, and Doris L. MacKenzie. 2006. "The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior." *Campbell Systematic Reviews* 11.

Vanderplasschen, Wouter, Kathy Colpaert, Mieke Autrique, Richard Charles Rapp, Steve Pearce, Eric Broekaert, and Stijn Vandevelde. 2013. "Therapeutic Communities for Addictions: A Review of Their Effectiveness From a Recovery-Oriented Perspective." *The Scientific World Journal*. doi:10.1155/2013/427817

National Institute on Drug Abuse (NIDA). 2002. *Therapeutic Community*. Research Report Series. Bethesda, MD: National Institute

on Drug Abuse.
http://archives.drugabuse.gov/pdf/RRTherapeutic.pdf

National Institute on Drug Abuse (NIDA). 2015. *Therapeutic Community*. Research Report Series. Bethesda, MD: National Institute on Drug Abuse.
https://www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-are-therapeutic-communities

Welsh, Wayne N. 2007. "A Multisite Evaluation of Prison-Based Therapeutic Community Drug Treatment." *Criminal Justice and Behavior* 34(11):1481–98.

## Related Programs

Following are CrimeSolutions.gov-rated programs that are related to this practice:

**Forever Free**
The first comprehensive, in-prison, residential substance abuse treatment program designed for incarcerated women. The program is rated Promising. The intervention group reported fewer arrests during parole, less drug use and were employed more at follow-up than the comparison group.

**Amity In-Prison Therapeutic Community**
Provides intensive treatment to male inmates with substance abuse problems during the last 9 to 12 months of their prison term. The volunteer participants must reside in a dedicated program housing unit during treatment. The program is rated Promising. Overall, participants had lower levels of reincarceration rates compared to the control groups.

**Delaware KEY/Crest Substance Abuse Programs**
A prison-based therapeutic community for offenders with a history of substance abuse and a residential work release center that allows offenders to continue their treatment as they transition to the community. The program is rated Promising. Program completers and aftercare recipients were less likely to be arrested or use drugs. Also, the treatment group did better at follow-up in remaining arrest and drug-free.

**Modified Therapeutic Community for Offenders with Mental Illness and Chemical Abuse (MICA) Disorders**
An adaptation of the therapeutic community models for use with offenders who have both drug abuse problems and mental health disorders. This modified version uses a more flexible, more personalized, and less intense program that targets reductions in substance use and recidivism. The program is rated Promising. Participants in the treatment group were less likely to abuse substances; and if they did start, it was later than the control group.

**Minnesota Prison-based Chemical Dependency Treatment**
Prison-based treatment for offenders who are chemically abusive or dependent. The program is rated Promising. Offenders who received treatment had significantly lower rates of reoffending. Completing treatment reduced the hazard for rearrest by 22 percent, for reconviction by 20 percent, and for incarceration by 27 percent. Increased treatment time was also found to have some impact on recidivism.

**InnerChange Freedom Initiative (Minnesota)**
A voluntary, faith-based prisoner reentry program that attempts to prepare inmates for reintegration into the community, employment, family, and other significant relationships through educational, values-based programming. The program is rated Promising. Participants were rearrested, reconvicted, and reincarcerated less than the comparison group. There was no statistically significant impact on revocations for a technical violation between the groups.

**Pennsylvania Department of Corrections (PADOC) Therapeutic Community**
A prison-based drug treatment program based on the principles of therapeutic communities with the overall goal of reducing offenders' risk of drug relapse and recidivism once they return to the community. The program is rated No Effects. The program did not significantly impact participants' rates of rearrests or drug relapse, and only had a small effect on reincarceration rates.

# State Recidivism Reduction Project

## Final Report
Spring 2017

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*“To serve justice in Illinois and increase public safety by promoting positive change in offender behavior, operating successful reentry programs and reducing victimization.”*

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## Executive Summary

- This report catalogues interventions and evaluates current treatment programs for the purpose of reducing recidivism. The evaluation focuses on treatment fidelity and effectiveness within a Risk Needs, Responsivity framework. The recommendations (Strategic Intervention Plan) are based on the evaluative data.

- Cataloguing efforts began February 2016 and evaluation efforts began June 2016. During this time, 28 IDOC correctional centers were visited. While 9 IDOC facilities were revisited at least once, 2 IDOC Impact Incarceration Programs (IIPs) facilities were revisited. In addition, 2 Adult Transition Centers (ATCs) were visited. A total of 150 IDOC staff were interviewed, with additional contact after the interviews. Both institutional and community offenders were surveyed (N = 1,597). A total of 305 interventions were evaluated.

- 1, 452 interventions were catalogued. A portion of these interventions had risk-reduction intentions, which became the focus of the evaluation. The interventions that are not evidenced based are recommended for removal.

- Program procedures of a lack of integration of homework, inappropriate use of peer facilitators, lack of admission criteria, and the underutilization of treatment manuals resulted in poor treatment fidelity.

- Treatment processes focused on the programs at Sheridan and Pinckneyville Correctional Centers. The use of therapeutic process in the treatment session was a strength, but the lack of cognitive behavioral techniques and the lack of optimizing treatment time impede optimal intervention results.

- The treatment of offenders with mental illness should integrate criminogenic need areas into treatment efforts. This will not only reduce recidivism, but also contribute to safer institutions.

- The Strategic Intervention Plan provides three key strategies for recidivism reduction programming. First, increase the evidence based components of current treatment programs and eliminate programs that have limited evidenced based support; Second, increase evidenced based treatment engagement; Third, increase treatment dosage.

- Central to this Strategic Intervention Plan is the development and application of the Intervention Demonstration Assessment Tool (IDAT) and System Logic Model. The IDAT incorporates empirically-derived and contemporary factors regarding effective correctional programming. Utilizing the results of the IDAT, the System Logic Model provides a roadmap to ensure IDOC matches offenders to program opportunities, appropriately allocating resources to maximize efficiency and effectiveness.

# Introduction

Southern Illinois University-Carbondale entered into agreement with the Illinois Department of Corrections (IDOC) to assist in response to the increasing number of adults returning to IDOC after release from incarceration. The IDOC is currently underway transforming how and which offender interventions are utilized to combat the high rate of recidivism in Illinois. The evaluation process began with cataloging efforts to determine what interventions were suitable for evaluation. The evaluation proceeded with a thorough data-driven assessment of intervention strategies aimed at increasing positive outcomes related to offender behavior and/or reducing recidivism.

Broadly, the goals for the evaluation of interventions were to examine both treatment fidelity and treatment effectiveness. Efforts to evaluate fidelity and effectiveness included, but were not limited to, assessing the appropriateness of referrals, the ability of programs to match needs of the offenders, attendance, activities reinforcing treatment goals, offender progress, and offender satisfaction.

## *Key Terms*

**Intervention**- A group-based or individual session that promotes the progression of offenders through considering their needs.

**Program**- A group-based session that is offered two or more times per week and addresses criminogenic needs. The purpose is to reduce potential recidivism.

**Service**-A group-based session that is offered less than two time per week and addresses criminogenic needs.

**Treatment**- The targeting of criminogenic needs through the utilization of both programs and services.

**RNR**- A treatment model that highlights the need to adhere to risk, needs, and responsivity principles. The model states that only high-risk offenders should be targeted by intense treatment, and the treatment should target criminogenic needs, and occur in an environment that is conducive to the offender's learning style.

**Dosage**- The amount of intervention an offender receives in front of intervention staff.

**Evidence-Based**- Policies and practices that rely on sound theory, are informed by scientific research, and are deemed to be effective.

**Clinical intervention-** An intervention (program or service) offered through the Clinical department at an IDOC facility.

## Scope and Overview

The purpose of this evaluation was to: a) catalog and assess inmate programs and b) develop an evaluative system for assessment, continuation, modification, and adoption of IDOC intervention programs. These efforts will address strategies related to recidivism reduction and public safety enhancement.

Researchers used a brief interview tool to catalog basic intervention data such as mode of change, dosage, activities to reinforce change, demographics, success rates, and facilitator data.

The evaluation phase proceeded to assess interventions in the IDOC. Only risk reduction interventions were included in this phase. This excluded interventions classified as religious education and development, mandated services, and core education.

For the purpose of this evaluation, interventions included both services and programs. Some services were provided infrequently, but still had the intent to create a positive outcome or reduce recidivism.

During this period, researchers utilized the Best Practices Survey to collect more extensive data pertaining to intervention strategies such as activity purposes and use of peer facilitators. Further, self-report offender data was collected to assess risk factors, criminogenic needs, progress towards desistance, and mental health barriers.

### *Data Collection*

Catalog data was collected at all 28 IDOC correctional centers. All 28 IDOC correctional centers were also visited for the evaluation phase, in addition to two Impact Incarceration Programs, two Adult Transition Centers, and one Life Skills Reentry Center. See Appendix A for a reference list of facilities visited and the data collected gathered from each facility included in the report.

The Catalog Protocol was created to gather general information relevant to interventions. This basic intervention data contained dosage, treatment practices, facilitator qualifications, and other broad items to better understand what interventions in the IDOC look like. This data was used to inform the Best Practices Survey used in the evaluation.

The Best Practices Survey was developed to evaluate interventions within IDOC. The survey consisted of 5 sections addressing administrative information, program development and evaluation, program descriptions, best practices, and facilitator information. The Best Practices Survey provides information on the process of program delivery including information on referrals, dosage, content, curricula, as well as other areas.

The Perceived Risk Inventory (PRI) is a 35-item self-report measure used to assess offenders' criminogenic risk levels. Offenders are asked to compare their risk levels with others. See Appendix B for a list of items.

The Transition Inventory (TI) is a self-report measure intended to assess an offender's perceptions of transition difficulty (Kroner, 2012). The TI consists of 64 agree/disagree items that cover the areas of impulsivity, social pressure, substance abuse, financial/employment, leisure, negative affect, interpersonal and family concerns and reentry potential. All items are future-oriented and offenders are asked to predict their behaviors. These subscales are used to predict the likelihood of reoffending. See Appendix C for a list of items.

The CRiminal Attribution Inventory (CRAI) is a 60-item questionnaire designed to measure criminal blame, which are central to criminal and antisocial behavior (Kroner & Mills, 2003). The instrument was designed to be used in both practitioner-based and research settings. There are six scales, each consisting of ten items. The six scales include: Psychopathology, Personal, Victim, Alcohol Abuse, Societal and Random. See Appendix D for a list of items.

### *Report Overview*

This report contains 5 main sections. Each section describes the data collection process and context and then presents results and summaries of key findings.

Linkage between evaluation and recommendations is an integral part of the report, notably the Strategic Intervention Plan. This linkage between the collected data and the Strategic Intervention Plan reflects the empirical and evidenced based components of the recommendations. Recommendations that directly support a point in the Strategic Intervention Plan will be identified by a "STRAT: A1," referring to a specific recommendation.

*Section 1.1* presents the system evaluation. The system evaluation provided a catalog of all interventions in IDOC.

*Section 1.2* presents the program evaluation. Evaluation of intervention strategies shall inform about trends in implementation and delivery of interventions along several relevant factors that are intrinsic to recidivism reduction.

*Section 1.3* presents the treatment process evaluation. This section presents analysis of interventions at Correctional Centers in Pinckneyville and Sheridan. Pinckneyville and Sheridan were selected for additional analysis by IDOC to specifically investigate intervention efforts aimed at moderate- to high-risk offenders. Further analysis of the referral process at was conducted based on self-report offender surveys. Offender surveys were also collected from a community sample to identify gaps in treatment.

*Section 1.4* presents information on mental health interventions. Mental health interventions were of interest due to an increasing demand for care centered around offenders with varying degrees of special care. Evaluative efforts focused on appropriate dosage of interventions, as well as intervention process strategies.

*1.5* provides the Strategic Intervention Plan.

# Evaluation Process

## 1.1 System Evaluation

### *Risk-Need-Responsivity Principles*

The RNR is a model of offender treatment that contains three components in an effort to reduce recidivism. The three components include risk, needs, and responsivity. Before offenders ever begin the treatment process, it is imperative that they are assessed for programming using a tool that has an abundance of predictive components, and investigates a variety of different criminogenic needs (Andrews & Bonta, 2006). Offenders who are deemed to be of higher risk should be targeted by high intensity treatment because they generally have the most deficiencies that could be improved upon. Low-risk offenders should not be targeted by intense treatment because they would be exposed to high-risk

offenders, which can be detrimental to treatment (Smith, Gendreau, & Swartz, 2009).

The second component of the RNR model is offender needs. Offenders possess both dynamic risk factors (Criminogenic needs), as well as static risk factors such as criminal history that are unable to be changed. Dynamic risk factors should be the primary treatment because they are things that an individual can change. These factors could include antisocial attitudes, peer groups, and substance abuse. Criminogenic needs should be reevaluated periodically. Because offenders change over time, their treatment should always be tailored specifically to their situation (Gendreau, Little, & Goggin, 1996).

The final component of the RNR model is Responsivity. It has been noted that cognitive-behavioral and social learning techniques are the most effective at reducing recidivism. For treatment to be considered highly effective, offenders need to be matched to specific programs and facilitators based on personal characteristics such as their drive to improve themselves, as well as what cognitive deficiencies they possess. It makes sense to classify offenders based on their overall drive to succeed and their basic deficiencies, because as previously stated, if an individual is enrolled in a specific program that doesn't meet their needs, then they may end up regressing. If treatment providers take steps to ensure that all three components of the RNR model are included in the assessment and implementation of treatment, then they should begin to see reductions in recidivism (Smith et al., 2009).

### *Cataloging Procedures*

In the first phase of the evaluation cataloging was completed of all IDOC programs. Cataloging started in February of 2016 and was completed in May of 2016. The cataloging process visited 28 IDOC facilities. Of this total, 24 facilities were visited at least twice, and of that total 7 were visited 3 times. A total of 250 IDOC staff were interviewed, with additional contact after the interviews. A total of 1,452 interventions were cataloged. The complete listing of the 1,452 interventions is found in Appendix F.

The catalog interview protocol utilized during this phase determined what interventions were in use at each IDOC facility. This cataloguing phase helped to develop a list of possible interventions to evaluate. The scope of the cataloguing phases was designed to inform the data collection during the evaluation phase. This catalog interview focused on dosage, intervention processes, and facilitator qualifications.

A concrete criterion was developed for the purposes of this report, which distinguished between program and service interventions. Interventions that meet more than once a week were designated as programs, and all other interventions were described as services. This criterion highlighted the necessity for increased focus on dosage of interventions across the system.

### *Catalog Summary*

Based on the cataloguing process of all IDOC interventions, there were 431 programs delivered for 27,121 offenders. There were 1,015 services for 86,846 offenders in the past 6 months.

Table 1 summarizes the cataloging of programs and services into broad categories. Note that women and family services, substance abuse treatment, and sex offender treatment interventions were categorized as clinical.

Table 2 presents information on programs and services based on the type of offender. Note that the Dual Diagnosis interventions at Logan were classified as General-Female due to their substance abuse element. However, the interventions offered under Dual Diagnosis qualify them for the Mental Health-Female category as well.

Table 1: Number of Programs and Services according to Broad Categories

| Category | Programs | Services |
|---|---|---|
| Education | 189 | 4 |
| Clinical | 158 | 249 |
| Mental Health | 11 | 174 |
| Religious | 53 | 514 |
| TRAC 1 / Parole School / Orientation | 19 | 73 |

Table 2: Number of Programs and Services according to Type of Offender

| Type of Offender | Programs | Services |
|---|---|---|
| General - Male | 386 | 739 |
| General - Female | 34 | 102 |
| Mental Health-Male | 11 | 128 |

| | | |
|---|---|---|
| Mental Health-Female | 1 | 46 |

Education had the greatest number of programs. It should be noted that there are approximately one and one-half times more services than programs under Clinical interventions. It should also be noted that there are 15 times more mental health services than programs. It is recognized that some services are necessary or mandated, but the high ratio of services for Clinical interventions (Table 1) and Mental Health interventions (Table 2) may suggest some disjointedness in the delivery of interventions.

### *Programming and Recidivism*

Through the cataloging process, many of the programming efforts were void of considering the IDOC's mission statement inclusion to reduce recidivism. One concern is the differences in quality of interventions available to offenders. This is evident by the comparison between psychoeducational and therapeutic processes utilized in programs. For example, using the provided definition of a program, an intervention at one facility is considered a program while at another facility it is being implemented as a service. The evaluation phase focused on interventions that had a goal of reducing recidivism.

## 1.2 Program Evaluation

### *Program Evaluation Procedures*

Evaluation efforts began June 16, 2016. During this time, visits were made to 28 IDOC Correctional Centers, 1 Reentry Facility, 2 Impact Incarceration Programs (IIP), and 1 Adult Transition Centers (ATC). Approximately 150 IDOC associates were interviewed, with additional contact after the interviews. A total of 305 correctional center interventions were evaluated using the Best Practices Survey (see Appendix G for a list of interventions). Due to limitations of access, not all interventions were evaluated. Facility lock downs and staff absences were the primary reasons for this.

The IDOC correctional centers that were included in the data collection for this evaluation include: Big Muddy River, Centralia, Danville, Decatur, Dixon, East Moline, Graham, Hill, Illinois River, Jacksonville, Lawrence, Lincoln, Logan, Menard (Proper and MSU), Pinckneyville, Pontiac (Proper and MSU), Robinson,

Shawnee, Sheridan, Southwestern IL, Stateville (Proper and MSU), Taylorville, Vandalia, Vienna, and Western IL Correctional Centers. Data was also collected at Kewanee Life Skills Reentry Center, Impact Incarceration Programs (IIP) at Dixon Springs and DuQuoin, and Adult Transition Centers (ATC) at Peoria.

### *Intervention Practices: Programs and Services*

Rationale and Background: Previous research has shown that programs tailored to an offender's needs are more effective than criminal sanctioning. Optimal implementation of programs that adhere to the Risk, Needs, and Responsivity principles (Andrews et al., 1990). The RNR model recommends that offenders should be classified and placed in programs based on their overall risk, their criminogenic needs, and what program environments are most conducive for change (Wooditch et al., 2014).

An effective treatment plan will involve offender risk and need assessments because these are factors associated with offenders that can be changed by programming, and ultimately reduce recidivism (Bergeron & Miller, 2013). It is also imperative that the intensity level of a treatment program should be matched to the risk level of an offender. Research has shown that high-risk offenders tend to benefit more from highly intense programs, whereas low-risk offenders benefit from programs that are deemed less intense in nature (Kennedy et al., 2000).

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To assess how interventions are implemented, several comparisons are presented on the delivery of programs and services across IDOC.

Current programs incorporate the treatment of offense/crime cycle, arousal reduction (anger), and victim awareness targets, as compared to services. Services tend to incorporate the treatment of problem solving, assertiveness, substance abuse, arousal reduction (general emotions), communication skills, empathy, cognitive distortion, and relapse prevention (Table 3). Programs and services share somewhat similar response numbers among the remaining categories. In Table 3, "Other" is listed and a rather large difference exists between programs and services. This is attributed to the number of services that report successful reentry and interpersonal relations as their treatment targets.

Programs and services within IDOC address an array of criminogenic needs, but more depth is needed. Most intervention methods seem to cover a plethora of

needs at the surface, where it would be more beneficial to go in depth and target a few (STRAT: B2).

Table 3: Number of Intervention Treatment Targets

| Category | Programs | Services |
|---|---|---|
| Problem definition | 19 | 42 |
| Problem solving | 31 | 66 |
| Assertiveness | 12 | 33 |
| Offense/crime cycle | 19 | 23 |
| Substance abuse | 24 | 52 |
| Arousal reduction (Anger) | 20 | 28 |
| Arousal reduction (General emotions) | 20 | 53 |
| Social competence | 21 | 41 |
| Communication skills | 27 | 65 |
| Empathy | 24 | 50 |
| Cognitive distortion | 29 | 62 |
| Victim awareness | 21 | 25 |
| Offender victimization | 15 | 24 |
| Relapse prevention | 16 | 40 |
| Other | 19 | 50 |

Most programs and services offered throughout IDOC are fixed, and have specified end dates. Very few interventions are offered on a continuous basis (Table 4).

Table 4: Type of Entry into Intervention

| Type of Entry | Continuous | Fixed |
|---|---|---|
| Programs | 12 | 70 |
| Services | 27 | 193 |

## *Intervention Delivery: Staff Training and Admission Criteria*

Rationale and Background: Although risk assessment is often used to measure the risk to reoffend once an offender is released, it is also highly effective when it comes to developing a well-tailored treatment plan. Treating low-risk offenders can be counterproductive; at times increasing recidivism rates. Research has also found that effective interventions tend to target criminogenic needs such as dynamic risk factors, or factors pertaining to an offender that can ultimately be

modified, because they produce the greatest reductions in recidivism (Bonta, 2000; Andrews & Bonta, 1998).

Cognitive behavioral therapy is the predominant treatment method that has consistently and effectively shown to address the needs of higher risk offenders. In a survey of practitioners who had an abundance of experience and education, the majority could not identify the four most prominent predictors of future delinquency. This is problematic, being these practitioners facilitate offender treatment. It is argued that the overall philosophy and integrity of treatment programs and services could be improved if practitioners received more adequate training regarding effective implementation of treatment (Lowenkamp et al., 2010).

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Table 5 shows that psychoeducational interventions were the most prominent intervention types. Across programs and services, the number of cognitive-behavioral interventions were less than half of the total interventions available. Modifying interventions to include more CBT components into interventions should contribute to lower recidivism (STRAT: A1, A2).

Table 5: Models of Change Utilized by Intervention Type

| Category | Programs | Services |
|---|---|---|
| Cognitive-Behavioral | 22 | 39 |
| Psychoeducational | 50 | 120 |
| Educational | 4 | 16 |
| Informational | 3 | 26 |

Table 6 provides a list of intervention methods devised to effect change in offender behavior. Information sharing was most common for both intervention types. This was followed by education and homework, respectively. Note that one intervention may have reported more than one of the change components listed (STRAT: B5).

Table 6: Methods of Change Utilized by Intervention Type

| Category | Programs | Services |
|---|---|---|
| Education | 57 | 132 |
| Information Sharing | 65 | 158 |
| Skills Acquisition | 38 | 82 |
| Disclosure | 26 | 51 |
| Autobiography | 12 | 25 |

| | | |
|---|---|---|
| Homework | 46 | 84 |

As presented in Table 7, staff reported receiving some specialized training according to several categories. Some of this training was received by facilitators working for vendor services and was necessary to implement interventions (i.e., substance abuse staff requiring a CADC). Of note, risk assessment training was not provided. "Other" training refers to safety and other on-the-job training. Other types of specialized training (not reported) include on the job and train the trainer.

Table 7: Staff Specialized Training for Interventions

| Category | Programs | Services |
|---|---|---|
| Diagnosis/assessment | 0 | 0 |
| Risk assessment | 0 | 0 |
| Dealing with resistant clients | 0 | 1 |
| Cognitive-Behavioral therapy | 4 | 6 |
| Content specific | 3 | 8 |
| Other | 19 | 32 |

Programs had more wait lists than services. More services than programs make use of both treatment and participant manuals as part of the intervention delivery process. This comparison is reported in Table 8. Risk/need assessment is a key component of effective treatment, because it places offenders into appropriate treatment groups.

Table 8: Number of Wait Lists and Manuals Used

| Category | Programs | Services |
|---|---|---|
| Waiting list | 43 | 97 |

Services had twice as many wait lists than programs. Wait lists are important when adhering to RNR principles, because they allow an offender to eventually have access to proper treatment.

Interventions reported an array of admission criteria. Most interventions report not using explicit admission criteria when the intervention was not mandatory. Therefore, most interventions do not have explicit admission criteria so anyone

who signs up may be chosen to participate. Of those interventions that reported explicit admission criteria, both programs and services included nature of offense, criminal history, interviews, pre-testing, and successful participation in other programs as criteria for admission. Some programs included number of prior convictions as admission criteria. Specialized assessment referred to the Texas Christian University drug screen. "Other" primarily included mandatory interventions or specific offender statuses such as being parents, nearest release date, etc. These mainly impact services offered in the institutions.

Table 9: Explicit Admission Criteria for Interventions

| Category | Programs | Services |
|---|---|---|
| Nature of offense | 5 | 2 |
| Number or prior convictions | 1 | 2 |
| Criminal history | 2 | 5 |
| Interviews | 3 | 5 |
| Pre-testing | 1 | 4 |
| Verbal aggression | 1 | 1 |
| Institutional aggression | 3 | 1 |
| Successful participation in other programs | 3 | 1 |
| Pre-treatment test | 1 | 2 |
| Specialized assessment | 5 | 5 |
| Other | 34 | 115 |

### *Intervention Delivery: Supplemental Material, Homework, and Peer Facilitators*

The delivery of intervention has been met with inconsistencies and a lack of continuity of care across the system. Many facilitators noted that their interventions do include treatment manuals, but they tend to disregard them more so than use them. After examining the lack of utility pertaining to treatment manuals, it is quite apparent that many practitioners are resorting to supplemental materials to develop a day-to-day group treatment plan.

This is problematic in two ways. First, most supplemental material incorporated throughout the IDOC does not require approval prior to being introduced to the offenders. Second, additional material contributes to the prevalence of inconsistency. Since two facilitators within one facility could be running the exact

same intervention, the interventions look different from each other regarding content. This is due to having no need for approval of supplemental material.

The SIU team noted on several occasions how manuals were present within group sessions, but supplemental materials were utilized throughout the entirety of the program, without much adherence to a specific manual. The most common response to this line of questioning was that facilitators to keep content relevant and relatable for the participants via bringing outside content to either supplement or replace materials.

Table 10: Number of Treatment and Participant Manuals Used

| Category | Programs | Services |
|---|---|---|
| Treatment Manual | 72 | 154 |
| Participant Manual | 62 | 148 |

Services use both participant and treatment manuals twice as much as programs (Table 10). This could potentially be problematic because offenders receive more face time with a facilitator during programs as opposed to services. This means that offenders are receiving treatment that is not guided by a manual.

Programs utilize more supplemental materials than services. As noted in Table 11, the most frequent type of supplement material came from other programs, but supplemental materials also included videos, internet materials, and materials developed by the program staff. "Other" represents materials from magazine articles, activities, and supplemental brochures that were found.

Table 11: Number of Types of Supplemental Materials Used

| Category | Programs | Services |
|---|---|---|
| Self-developed | 4 | 14 |
| Material from another program | 8 | 22 |
| Internet | 12 | 19 |
| Videos/Movies | 13 | 21 |
| Other | 10 | 0 |

Services utilized supplemental materials more so than programs. They tended to utilize materials from other programs the most, followed videos/movies and Internet. Programs tended to utilize videos and movies the most, followed by the Internet.

Regarding supplemental materials, it was also important to assess how these materials were incorporated into the sessions outside material. Outside material refers to materials that are not part of the intervention curriculum. There is a disparity between needing approval for bringing in outside content to interventions (Table 12). Most interventions do not require consent to change content, with programs relying more on outside sources for content than services.

Table 12: Number of Interventions Needing Approval for Outside Material

| Category | Programs | Services |
|---|---|---|
| Yes | 10 | 32 |
| No | 19 | 47 |

Rationale and Background: Treatment-related homework is a common and essential component of cognitive-behavioral therapy and effective treatment engagement. Several studies have indicated that homework completion is predictive of positive treatment outcomes as it allows the offender to practice skills they acquire in therapy sessions (Smith, Huey, & McDaniel, 2015). Further, an offender who consistently completes homework in full indicates a high motivation to change (Smith et al., 2015).

Optimal outcomes occur when the homework targets behavior modification and skill development (McDonald & Morgan, 2013). Facilitators should elaborate with offenders when developing homework assignments, and assign, collect and review them in a consistent manner (McDonald & Morgan, 2013). To increase completion compliance and foster accountability, facilitators should encourage the offenders to publicly commit to the group that they will follow through with the assignment (McDonald & Morgan, 2013). Finally, optimal treatment outcomes are most likely when the offenders believe that the homework tasks are within their ability and will lead to desired treatment outcomes (McDonald & Morgan, 2013).

The process of program-delivery also includes assignments completed outside of the program time. Programs report greater use of homework assignments than services. However, more programs reported not assigning homework than programs that do (Table 13).

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Homework was a variable of interest because it represents a way for offenders to practice the skills that are taught during group sessions. The utilization of homework represents the responsivity principle of RNR. Consistently assigning homework should be emphasized in program delivery.

Table 13: Number of Interventions Utilizing Homework

| Category | Programs | Services |
|---|---|---|
| Yes | 29 | 57 |
| No | 14 | 44 |

Beyond the assessment of whether homework is used within an intervention-delivery, frequency of homework assignments was also assessed. As noted in Table 14, programs assigned homework more frequently than services, usually on a weekly or every other week frequency. Of the services that assigned homework, homework was most frequently assigned on a weekly basis.

Not only is frequency important in assigning homework, based on how often the intervention meets, but also consistency. For example, for an intervention that meets twice per week, it is not effective to assign homework to offenders twice one week and not at all the next. Avoiding falling into this will help to create continuity of homework use in interventions.

Table 14: Frequency of Homework Assignments

| Category | Programs | Services |
|---|---|---|
| Weekly | 20 | 24 |
| Every other week | 1 | 11 |
| Monthly | 2 | 0 |
| Once or twice | 2 | 11 |
| Other | 2 | 5 |

The types of homework assignments were also assessed. Worksheets are the most common homework assignment among programs, but other homework assignments included journaling, problem-solving scenarios, and assigned reading (Table 15). Services assigned fewer homework assignments, but the distribution of types of homework was relatively evenly split between journaling, worksheets, problem-solving, and reading. "Other" referred to "thinking activities" such as recalling relevant situations or writing/phoning family members.

To address a specific RNR principle with the use of homework, facilitators may find it beneficial to match the offenders' criminogenic need to the type of

homework assigned. As an example, substance abuse interventions would benefit from the use of journaling so that offenders can write out responses, but also share them and receive feedback.

Table 15: Types of Homework Assignments

| Category | Programs | Services |
|---|---|---|
| Journaling | 14 | 28 |
| Worksheets | 22 | 37 |
| Problem solving scenarios | 13 | 15 |
| Reading | 8 | 14 |
| Other | 4 | 12 |

After homework is completed it is primarily used for discussion for both intervention types. Few interventions "grade" assignments. Homework is collected in only a few interventions suggesting little accountability regarding participation in intervention processes (see Table 16). This also suggests that homework is not integrated into program delivery. However, several interventions allow offenders to keep their assignments for future reference.

Interventions would benefit from both regular collection and stronger integration into the sessions. To meet the responsivity principle of RNR involves collecting and evaluating the homework of offenders. Without these steps, the spirit of the responsivity principle is not realized in the use of homework in interventions.

Table 16: Frequency of Steps Taken after Homework Completed

| Category | Programs | Services |
|---|---|---|
| Collected | 10 | 11 |
| Discussed | 26 | 49 |
| Evaluated | 4 | 1 |
| Feedback given | 14 | 17 |
| Offenders keep it | 14 | 28 |
| None | 1 | 4 |
| Other | 3 | 1 |

The use of peers is important to the overall success of intervention delivery. How this should be accomplished needs to be standardized across interventions and facilities.

Table 17: Number of Interventions using Peer Facilitators

| Category | Programs | Services |
|---|---|---|
| Yes | 22 | 44 |
| No | 21 | 55 |

Table 18: Selection Criteria for Choosing Peer Facilitators

| Category | Programs | Services |
|---|---|---|
| Successful program completion | 6 | 11 |
| No institutional misbehavior | 3 | 5 |
| Nature of offense | 1 | 2 |
| Evaluation of program content | 1 | 0 |
| Length of time served in facility | 2 | 2 |
| Other | 11 | 26 |
| No criteria | 6 | 5 |

An additional component of intervention delivery is the use of peer facilitators. The intention is to have someone who the group can relate to and have similar experiences. Table 17 reports how many interventions reported using peer facilitators, while Table 18 reports how peer facilitators are selected. More programs utilize peer facilitators than services. Programs utilize selection criteria more often than services. The most frequent criteria used for peer facilitator selection was successful program completion. For instance, an offender who successfully completed the Lifestyle Redirection program might be selected as a peer facilitator for another program offered at the facility. "Other" represents mock delivery to assess program knowledge and communication skills.

Peer facilities have a varied role in intervention delivery. As shown in Table 19, peer facilitators most frequently had the role of aiding intervention delivery when prompted by staff facilitators. Some programs had peer facilitators who could

run the group independently of treatment staff while no services had peer facilitators in the role of independent intervention deliverer.

Table 19: Roles of Peer Facilitators in Intervention Delivery

| Category | Programs | Services |
|---|---|---|
| Run group independently | 3 | 8 |
| Run as co-facilitator | 5 | 5 |
| Aid when prompted | 10 | 22 |
| Recruit offenders | 2 | 2 |
| Assist in grading/prepping | 0 | 3 |
| Keeping records | 0 | 1 |
| Other | 4 | 10 |

### *Treatment Gain*

The Best Practices Survey also assessed how intervention staff measured treatment gain. While measures of treatment gain appear to be used evenly across interventions, most of these responses are from vendor services such as substance abuse treatment and mental health providers. In addition, “other” primarily represents informal feedback from offenders, either as a group or 1-on-1, during the last session of an intervention (Table 20).

Table 20: Treatment Gain for Interventions

| Category | Programs | Services |
|---|---|---|
| Offender satisfaction rating | 13 | 39 |
| Role play, skills performance | 9 | 4 |
| Knowledge questionnaire | 6 | 0 |
| Behavioral rating by clinical staff | 7 | 18 |
| Independent rating | 3 | 3 |
| Institutional performance | 5 | 15 |
| Institutional charges | 4 | 13 |
| Interaction with others | 9 | 46 |

| | | |
|---|---|---|
| Pre/post-treatment test | 17 | 13 |
| Other | 25 | 74 |

### *Summary of Program Evaluation*

IDOC interventions are independent of each other and are delivered at the discretion of the facilitator. Most interventions were primarily psychoeducational in nature. Most interventions are fixed between 8-12 weeks or they are continuous in duration. Waitlists are very common, as there seems to be more eager offenders than there are groups to join. The most common screening criteria for group access is time before release.

Most psychoeducational groups utilize treatment manuals/curricula. However, a lot of these "manuals" are compilations of hand-me-down packets from previous facilitators who were unsatisfied with the actual treatment manual. It should be noted that many facilitators incorporate supplemental material without need for approval. Most groups incorporate homework assignments but over half are assigned irregularly. Worksheets are the most common type of homework assignments. There is no accounting for participation, whether in-class or homework.

The use of peer facilitators is common. However, practices are not standardized or monitored for success. Some facilities require successful completion of a particular group before becoming a peer facilitator for a different intervention, while other programs choose offenders who exhibit model behavior. All programs tend to hold group confidentiality in high regards. Some have formal written policies and others discuss it with the groups. The use of peer facilitators requires strict IDOC guidelines, as there is evidence of negative long-term consequences for peer facilitated groups.

Treatment gains are assessed informally through question and answer sessions held after conclusion of treatment groups. Many of these assessments are through informal tracking of disciplinary actions or "tickets" that offenders receive after the treatment group has finished. None of these assessments are formal or linked to intervention successes methodically. Certificates are distributed to all offenders who completed the intervention, which means only those who were removed or quit are not given a certificate. Certificates serve a positive reinforcement for offenders but do not indicate any measurable gain achieved during the intervention (STRAT: A2).

### *Impact Incarceration Programs*

The evaluation process also examined Impact Incarceration Programs (IIPs). IIPs are also referred to as "boot camps." The Illinois Impact Incarceration Program operates in accordance with 730 ILCS 5/5-8-1.1 and 730 ILCS 5/5-8-1.2. Courts may sentence eligible offenders to the IIP.
The eligibility criteria are as follows:

- Ages 17 to 35.
- Not previously served a sentence in an IIP and not previously served more than one felony sentence in an adult correctional facility.
- Not currently or previously convicted of a Class X felony first or second-degree murder, armed violence, aggravated kidnapping, criminal sexual assault, aggravated criminal sexual abuse or a subsequent conviction for criminal sexual abuse, forcible detention, or arson.
- Not sentenced to a term of more than 8 years.
- Physically able to participate in strenuous physical labor and activities.
- Not have any mental disorder/disability that would hinder participation.
- Recommended/approved for placement in IIP by the Sherriff and consented to the terms and conditions of participating in the program in writing.

Corrections officials and researchers question the ability of boot camps to successfully reduce recidivism, combat prison overcrowding, and reduce operating costs. Kempinen and Kurlychek (2003) examined the Pennsylvania boot camp and found that cadets who were serving time in the boot camp were actually more likely to recidivate than similar inmates serving time in the traditional correctional institution. Boot camp completers had a 44% chance of reoffending, while correctional institution inmates had a 39% chance of reoffending. In a systematic review of 43 experimental and quasi-experimental high-quality studies of boot camps around the nation, 88% found either an undesirable effect or no effect (Welsh & Rocque, 2014). Four studies indicated a desirable effect, noting that cadets recidivated at a significantly lower rate than traditional correctional inmates. Thirty-four studies found a null effect. Cadets' recidivism rates were not significantly different from inmates. Five studies reported that boot camps had an undesirable effect. In fact, cadets in these studies actually had a higher recidivism rate than inmates (Welsh & Rocque, 2014). In another systematic review, 43 high quality studies of boot camp/comparison samples were examined (Wilson, MacKenzie, & Mitchell, 2008). Results indicate that the likelihood of boot camp cadets recidivating was equal to the likelihood of a comparison group of correctional institution inmates

recidivating. The overwhelming majority of studies found no differences between groups, but some indicated that comparison groups of inmates fared better than cadets and some indicated that cadets fared better than inmates (Wilson et al., 2008). Boot camp programs are often not designed with effective evidence-based therapeutic practices that target risk factors, nor are they delivered by counselors who are properly trained (Bottcher & Ezell, 2005). Potential problems also arise when inappropriate offenders are sent to boot camps. Oftentimes judges send offenders who are too high risk or otherwise not suited for the boot camp model (Stinchcomb & Terry, 2001).

IIPs include mandatory physical training and labor, military formation and drills, regimented activities, uniformity of dress and appearance, education/counseling (including drug counseling). The duration of the program is 120 to 180 days followed by a mandatory monitored release of 8 to 12 months supervised by the Sherriff. Failure to successfully complete the program violates the IIP sentence and the offender will be transferred to a correctional facility

The Dixon Springs IIP and DuQuoin IIP were the sites of data collection that included the Best Practices Survey and the offender survey. It is acknowledged that an Impact Incarceration Program (IIP) is considered a "program" by the Illinois Department of Corrections (IDOC). However, for the purpose of this report, a separate distinction is made between programs and services for interventions offered at the IIPs. IIPs in the IDOC range from four to six months in duration for offenders.

As noted in Tables 21 and 22, there were 12 programs delivered for 3,755 offenders, while there were 10 services for 4,372 offenders in the between July 2015 through June 2016 at 2 facilities. A list of IIP interventions can be found in Appendix H.

Table 21: Number of Programs and Services at IIPs

| Category | Programs | Services |
|---|---|---|
| Number of Interventions | 12 | 10 |

Table 22: Number of Offenders in Interventions at IIPs

| Number of Participants | Programs | Services |
|---|---|---|
| Past 12 months | 3,755 | 4,372 |

Interventions at the IIPs were classified into three broad categories: educational, clinical, and orientation. Most programs at the IIPs were clinical but some were educational (Table 23). It should be noted that WestCare's substance abuse treatment interventions were categorized as clinical. Services at the IIPs were split between clinical and orientation.

Table 23: Categories of Interventions at IIPs

| Category | Programs | Services |
|---|---|---|
| Education | 4 | 0 |
| Clinical | 8 | 5 |
| Orientation / Parole School | 0 | 5 |

In comparing across the two IIP locations of DuQuoin and Dixon Springs, the number and type of interventions offered was fairly equivalent (Table 24). Dixon Springs is a co-ed facility, so it offers both a Motherhood and Fatherhood program.

Table 24: Location of IIP Programs and Services

| Location of IIP | Programs | Services |
|---|---|---|
| Du Quoin | 6 | 4 |
| Dixon Springs | 6 | 6 |

Intervention processes assessed areas that are known to impact treatment efficacy. Because of the nature of IIPs, offenders cannot take homework out of the classroom. In a similar thread, because IIPs are a diversionary sentence in IDOC, additional "good time" is not available to offenders.

Table 25: Type of Intervention Entry at IIPs

| Type of Entry | Continuous | Fixed |
|---|---|---|
| Programs | 10 | 2 |
| Services | 5 | 5 |

### *IIP Summary*

The IIPs report operating 12 programs and 10 services for the offenders at the two facilities (see Table 25). Most of these interventions were categorized as clinical (including WestCare's substance abuse interventions). Most of the programs available were delivered on a continuous basis, while half of the services available are continuous and half have a fixed duration. The DuQuoin and Dixon Springs IIPs offered comparable types of interventions to offenders.

A sample of offender outcomes was requested for further examination. The SIU team requested recidivism data for this population. The sample data examined showed that 46% of the sample returned to the IDOC within 3 years. It is recommended to cease and desist Impact Incarceration Programs. A summary of this sample can be found in Appendix H.

### *Community Interventions*

An additional component of this evaluation examined interventions to offenders upon release. The community programs were selected from GEO Reentry Services (GEO). This stage of data collection included the Best Practices Survey with GEO staff. In total 25 GEO programs were cataloged. The GEO sites included in this evaluation were Chatham, Chicago Heights, Decatur, East St. Louis, and West Fulton.

GEO Reentry Services (GEO) was selected for several reasons. First, GEO works closely with parole services as GEO services can be incorporated into an offender's parole plan. In addition, parole services utilize GEO services as a disciplinary sanction for more challenging paroled offenders to reduce violations of parole prematurely. Third, GEO would provide a source of moderate- and high-risk offenders to include in the treatment process portion of the evaluation. GEO utilizes the LSI-R to determine risk level of their clients.

There are 6 GEO day reporting centers located in Illinois. Locations include Rockford, Decatur, East St. Louis, and three inner city locations in Chicago. Appendix J provides a list of interventions offered at GEO. Services offered at GEO include individual counseling and case management, Moral Reconation Therapy (MRT), Anger Management, Substance Abuse Education, Employment Services, Domestic Violence (only at 1 location), and Civil World (computer-simulated parole). In addition to these services, GEO allows parolees access to computer labs for employment searches, as well as submitting applications,

resume building, and contacting potential employers. All groups are psychoeducational, except for MRT. MRT is GEO's primary cognitive-behavioral intervention strategy.

### *Community Intervention Evaluation*

GEO Reentry Services (GEO) reports several group intervention strategies attempting to reduce recidivism. Most interventions are run as services. However, Substance Abuse Education requirements of the clients are higher than others based on parole board demands. Thus, Substance Abuse Education would be classified as a program for some clients and only services for other clients.

GEO operates in all three of the IDOC regions. They have four sites in the Northern region (Chatham, Chicago Heights, Rockford, and West Fulton), one in the Central region (Decatur), and one in the Southern region (East St. Louis).

Having more offenders entering and returning from IDOC from the Northern region (i.e., Chicago areas), GEO strategically locates their sites to be most accessible to its clients. There are four times as many interventions available in the Northern region compared to the other two regions, which is representative of the number of offenders supervised (Tables 26 and 27).

Table 26: Number of Community Interventions per Region

| Category | Northern | Central | Southern |
|---|---|---|---|
| Number of Interventions | 25 | 6 | 6 |

Table 27: Number of Offenders in Community Programs and Services per Region

| Number of Participants | Northern | Central | Southern |
|---|---|---|---|
| Past 12 months | 1,181 | 294 | 199 |

### *Community Intervention Practices*

The interventions offered at GEO sites are identical at each facility (Table 28). Across region, this allows for services to be offered in a more standardized manner. Interventions at GEO are guided by the paroled offenders' level of risks/needs. Thus, the parolees are guided through services at GEO based on LSI-R scores. The primary target groups of interventions are standardized

across regions and are not simply accessed via a “request slip,” as they are inside IDOC facilities. The only exception to this standard practice is Domestic Violence. It is a new service offered only at the Rockford site until some pilot data is collected.

Table 28: Community Interventions Targets per Region

| Category | Northern | Central | Southern |
|---|---|---|---|
| Criminal History | 4 | 1 | 1 |
| Response to supervision | | | |
| Aggression | 1 | | |
| Substance use/abuse | 4 | 1 | 1 |
| Social & peer networks | 4 | 1 | 1 |
| Lack of pro-social family relations | 4 | 1 | 1 |
| Employment & education | 4 | 1 | 1 |
| Attitudes that support crime | 4 | 1 | 1 |
| Adaptive skills | | | |
| Stability | | | |
| Medical & Mental Health | | | |
| Impulsivity/Low self-control | 4 | 1 | 1 |
| Poor thinking skills | | | |
| Lack of recreation/leisure | 4 | 1 | 1 |

### *Community Intervention Delivery*

Intervention delivery was assessed at GEO sites. Staff training and intervention admission criteria were of importance. Case workers were responsible for administering LSI-R scores, but all staff received training regarding risk assessment and dealing with resistant clients (Table 29). Staff were also trained in the delivery cognitive-behavioral treatment, as well as other content specific areas, as this was a primary component of the GEO treatment process.

Table 29: Staff Specialized Training for Community Interventions per Region

| Category | Northern | Central | Southern |
|---|---|---|---|
| Diagnosis/assessment | 0 | 0 | 0 |
| Risk assessment | 20 | 5 | 5 |
| Dealing with resistant clients | 20 | 5 | 5 |
| Cognitive-Behavioral therapy | 20 | 5 | 5 |
| Content specific | 20 | 5 | 5 |
| Other | 20 | 5 | 5 |

Waitlists are not used at GEO. Instead they have caseload maximums, which allows for proper placement of clients into appropriate classrooms. Capacity usually is not an issue, as attendance is never 100%. To account for this, most classrooms begin with a roster larger than capacity to account for no-shows.

Treatment manuals are used in each group. In addition, clients are provided "carry guides" which serve as client workbooks. Again, all interventions provide these carry guides to clients.

### *Summary of Community Programs*

A broad variety of interventions were offered across the community. The programs used manuals and were informed by risk scores, which is in adherence with RNR principles.

## 1.3 Treatment Process Evaluation

### *Intervention Dosage & Integrity*

Intervention programs among offenders are central to efforts in promoting safety. Appropriate offender interventions can reduce general recidivism (Lipsey & Cullen, 2007; Morgan & Flora, 2002; Tong & Farrington, 2008), with the typical general recidivism decrease between 10 to 27% (measured by effect sizes, Bourgon & Armstrong, 2005; Prendergast, Hall, Wexler, Melnick, & Cao, 2004). Offenders do not receive maximum treatment dosage miss the opportunity to benefit from these interventions. Facilitating full participation in an effective treatment intervention is, therefore, a public safety issue. In fact, offenders who dropout typically re-offend at a higher rate than those who complete treatment (Berman, 2005; Hepburn, 2005) and re-offend more quickly (Prendergast et al., 2004; Serin, Gobeil, & Preston, 2009).

In addition to public safety, positive effects of treatment dosage occur for offenders and correctional systems. For the offender, opportunities to promote change, a sense of accomplishment, and improving quality of life can occur. From a management perspective, increasing offenders' time in programs has greater efficiency in the dispersing of limited resources. Loss in intervention efficiencies can include inadequate care for clients, fewer treatment opportunities for others, increased monetary expenditures, and an overall increase in treatment failure rates. Evidence has suggested a relationship between treatment dosage and prison misconduct (Olver, Stockdale, & Wormith, 2011; Serin et al., 2009).

Furthermore, the costs of not having offenders complete treatment programs are more noticeable within a structured treatment context. Delivering treatment below maximum capacity may unduly increase the monetary cost to the treatment provider. The lack of completion also leaves a treatment position vacant, which may remain empty within closed admission programs. Within the criminal justice system, this inefficiency is of particular importance as offenders' window of opportunity for treatment can be limited (i.e., approaching release dates). These low dosage costs are further exacerbated by the substantial percentage of offenders who dropout of treatment (27%-46%; Hepburn, 2005; Hiller, Knight, Saum, & Simpson, 2006; Serin et al., 2009), which can consume a substantial proportion of treatment budgets. There are strong benefits for maximizing the dosage time, which includes keeping offenders in treatment programs. The benefit of a general and progressive orientation towards engagement in factors reducing the likelihood of crime-related activities.

Treatment programs with sufficient "dosage" and treatment integrity have an increased likelihood of reducing recidivism (Andrews & Bonta, 2010; Andrews & Dowden, 2005). In the risk-needs-responsivity framework, the risk principle suggests that matching offenders to an adequate dosage level of treatment is important, which is supported by the evidence that sufficient dosage is related to reductions in recidivism (Bourgon & Armstrong, 2005; Kroner & Takahashi, 2012; Kroner, Power, Takahashi, & Harris,2014).

### *Treatment Process Procedures*

To assess treatment progress, two sites were selected for more focused evaluation. Treatment progress was assessed via several sources of information including interviews with staff using the Best Practices Survey, observations of interventions using the Process Evaluation Tool, and self-report surveys from offenders at Pinckneyville (PNK) and Sheridan (SHE) Correctional Centers. Interviews were conducted with facilitators at both facilities and information was collected on all treatment interventions regarding: models of change, appropriateness of referrals, use of homework, and continuity of care. This data was obtained through staff interviews using the Best Practices Survey. Treatment delivery data was collected through observations of several interventions.

All treatment delivery data was gathered at SHE, except for *Thinking for a Change* at PNK, due to the greater number of interventions delivered at any given time. The Process Evaluation Tool (PET) was incorporated into the evaluation to assess a range of treatment components relating treatment processes. The PET allowed observers to discern actual dosage compared to the maximum capacity if fully implemented, while also observing the ability of the facilitators to effectively provide therapeutic treatment to their clients. The PET assessed therapeutic treatment along two major constructs: cognitive-behavioral and therapeutic process.

The treatment process evaluation also included data collection from a sample of high-risk offenders at Pinckneyville and Sheridan and a community sample of offenders who had been released. Self-report data was also collected from offenders across IDOC facilities in order to provide a comparison on treatment progress. The offender survey data provide information on level of need and progress.

The self-report offender survey included measures assessing three broad categories: risk levels, need levels, criminal perceptions.

### *Treatment Progress: Interventions at Sheridan and Pinckneyville*

Interventions at Sheridan and Pinckneyville correctional facilities includes both programs and services. Appendix C provides a list of interventions at Sheridan and Pinckneyville.

To assess treatment progress, interventions were classified by theoretical basis. Cognitive-behavioral therapy (CBT) is one of the most empirically tested and effective forms of therapy. CBT is associated with the largest recidivism reduction of any therapeutic model (Smith, Gendreau, & Swartz, 2009). Targeting criminogenic needs with a CBT approach will produce optimal treatment outcomes (Smith et al., 2009). Treatment is further enhanced if delivered to high-risk offenders.

CBT is present-focused, structured, and problem-solving oriented. The goal of this therapy is to emphasize the link between cognitions and behaviors. Proper CBT interventions consist of three phases: preparation, action, and follow-up (Walters, 2013). Further, hallmarks of the intervention include identifying disordered thinking, modifying thinking patterns, and modifying behaviors.

Psychoeducational interventions utilize several techniques and activities depending on the specific topic of the intervention. These interventions include providing group participants with information on the topic including symptoms, treatments, resources and other services, and problem-solving strategies (Peters, LeVasseur, & Chandler, 2004). However, psychoeducational interventions are not considered therapeutic treatment.

As shown in Table 30, the model of change utilized by most interventions was psychoeducational in nature. Cognitive-behavioral interventions and informational interventions were the second most common intervention utilized, requiring advanced education and specialized skills to deliver. These were especially prevalent for programs. Two interventions were educational (STRAT: B3).

Table 30: Models of Change Utilized by Intervention Type at SHE and PNK

| Category | Programs | Services |
|---|---|---|
| Cognitive-Behavioral | 5 | 2 |
| Psychoeducational | 6 | 4 |
| Educational | 0 | 2 |
| Informational | 0 | 7 |

Program content of interventions at Sheridan and Pinckneyville was also assessed. A wide breadth of evidence indicates that offenders who actively

participate and are highly involved in the intervention process experience greater treatment outcomes than those who do not. Skills teaching/skills acquisition should be the primary components of the intervention (e.g., coping skills, problem solving skills, relapse prevention, etc.; Wong, Gordon, & Gu, 2007). Homework is an essential component of any treatment program and it provides the offender an opportunity to practice the skills they acquire during the intervention periods (Smith, Huey, & McDaniel, 2015). Role playing and modeling of these skills are effective methods of change and indicate lower offender recidivism rates than offenders who do not participate in interventions with these components. Offenders tend to find these methods very useful in applying skills to their home lives.

The methods of change utilized by most interventions were information sharing and education followed by education and homework (Table 31). Skills acquisition and disclosure were utilized in a small sample of interventions. Autobiography was not used by any of the interventions.

Table 31: Methods of Change Utilized by Intervention Type at SHE and PNK

| Category | Programs | Services |
|---|---|---|
| Education | 6 | 7 |
| Information Sharing | 7 | 10 |
| Skills Acquisition | 4 | 2 |
| Disclosure | 2 | 0 |
| Autobiography | 0 | 0 |
| Homework | 8 | 5 |

There is not currently a standardized assessment tool being implemented statewide to inform intervention referrals. The Service Planning Instrument (SPIn) risk assessment tool is utilized at only a few IDOC facilities and with a small caseload. Instead, courts, social workers, or any staff member may refer an offender into whichever intervention they see fit (Table 32). Further, offenders can often act as their own referral source. These methods are not risk or need based. Referral sources should be from staff members who are properly trained in risk assessments after an assessment is completed.

Table 32: Acceptable Referral Sources by Intervention Type at SHE and PNK

| Category | Programs | Services |
|---|---|---|
| Psychologist, Psychiatrist | 0 | 1 |
| Lawyer, Courts | 2 | 2 |

| | | |
|---|---|---|
| Social Worker | 5 | 2 |
| Offender Request | 3 | 8 |
| Security | 0 | 0 |
| Any Staff | 0 | 1 |
| Mandatory Group | 1 | 3 |
| Other | 4 | 7 |

For the interventions at Sheridan and Pinckneyville, programs report greater use of homework assignments than services (Table 33). More programs report including homework as an intervention process than programs that do not.

Table 33: Number of Interventions Utilizing Homework at SHE and PNK

| Category | Programs | Services |
|---|---|---|
| Yes | 7 | 4 |
| No | 1 | 8 |

Beyond the assessment of whether homework is used within an intervention-delivery, frequency of homework assignments was also assessed. Optimally, homework should be assigned to 90% of the sessions. Programs assigned homework more frequently than services, usually on a weekly or every other week frequency (Table 34). Of the services that assigned homework, homework was most frequently assigned on a weekly basis.

Table 34: Frequency of Homework Assignments at SHE and PNK

| Category | Programs | Services |
|---|---|---|
| Weekly | 7 | 3 |
| Every other week | 0 | 1 |
| Monthly | 0 | 0 |
| Once or twice | 0 | 0 |
| Other | 0 | 0 |
| None | 0 | 0 |

The types of homework assignments were also assessed. Worksheets are the most common homework assignments among programs, but other homework assignments included journaling, problem solving scenarios, and assigned reading (Table 35). Services assigned fewer homework assignments, but journaling was common. “Other” referred to “thinking activities” such as recalling relevant situations or writing/phoning family members and the use of other forms.

Table 35: Types of Homework Assignments at SHE and PNK

Commented [EW1]: FORMAT table

| Category | Programs | Services |
|---|---|---|
| Journaling | 2 | 3 |
| Worksheets | 6 | 2 |
| Problem solving scenarios | 2 | 1 |
| Reading | 1 | 1 |
| Other | 0 | 3 |

After homework is completed it is primarily used for discussion, feedback is given, and offenders keep the assignment. Only one intervention "grades" assignments, and only a few collect completed work (Table 36). This suggests little accountability regarding participation in intervention processes. However, several interventions allow offenders to keep their assignments for future reference.

Table 36: Steps Taken after Homework at SHE and PNK

| Category | Programs | Services |
|---|---|---|
| Collected | 2 | 4 |
| Discussed | 7 | 4 |
| Evaluated | 1 | 0 |
| Feedback given | 7 | 4 |
| Offenders keep it | 7 | 4 |
| None | 0 | 0 |
| Other | 0 | 0 |

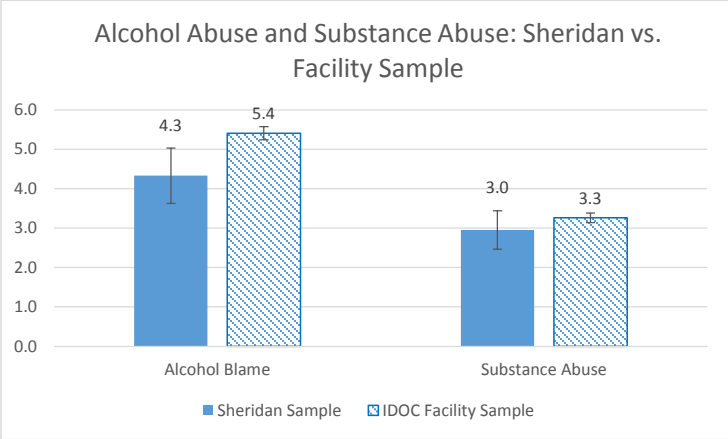
Intervention attendance is tracked by facilitators in individual files and done so inconsistently. Most facilitators maintain attendance electronically, some prefer pen and paper, while a few facilitators use assisting offenders to do this in paper format. Most notably, attendance records are maintained for accountability. None of the attendance data is collected in the Offender 360 management system. This limitation did not allow for measurement of attendance rates. Offenders who miss three scheduled group times are removed from of the intervention. They are eventually allowed to return; however, they are moved to the bottom of the waitlist in most circumstances. This management style puts the burden on the offender to seek out and continue treatment, as opposed to a more prescriptive approach.

There are no interventions being administered that require any formal follow-up, such as maintenance sessions, as part of continued offender care. However, informally, facilitators of some interventions reported "checking in" on offenders when they see former group members around their facilities.

### *Substance Abuse Referral Criteria: Sheridan*

In order to further assess the program referral criteria for those participating in the substance abuse program at Sheridan Correctional Center, results from the offender self-report survey pertaining to Substance Abuse and Alcohol Abuse scales were analyzed. Inappropriate referral criterial would be reflected by Sheridan treatment participants having lower substance abuse needs than the typical IDOC offender. Figure 1 presents average needs for the Sheridan treatment sample compared to the IDOC facility sample. The Sheridan treatment sample consisted of 72 offenders. The IDOC facility sample consisted of 832 offenders. As noted in Figure 1, Alcohol and Substance Abuse levels for the Sheridan sample were below the IDOC Facility Sample, with Alcohol Abuse being substantially lower.

Figure 1: Alcohol Abuse and Substance Abuse: Sheridan Treatment Sample and IDOC Facility Sample




These lower levels could occur for two reasons. First, Sheridan offenders could have a greater occurrence of lower substance abuse needs, as compared to the typical offender. Second, Sheridan offenders could have less occurrence of a higher number of substance abuse issues, as compared to the typical offender. Splitting the scale responses into quartiles assists in this type of assessment. Figure 2 presents the percent of the items endorsed at each quartile. The sets bars for the 1st and 2nd quartiles on the left in Figure 2, indicate a greater percentage of Sheridan offenders having lower substance abuse needs. The sets

of bars for the 3rd and 4th quartiles on the right indicate fewer number of Sheridan inmates having higher substance misuse needs.

Figure 2: Substance Abuse Profiles: Sheridan Treatment Sample and IDOC Facility Sample

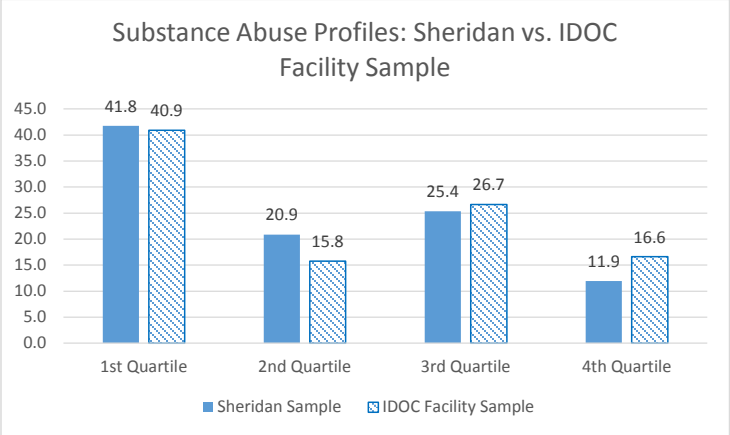



Figure 3 present as summary table of these data, and it can clearly be seen that Sheridan offenders have lower substance abuse needs, and that contributing to this are a greater number of lower need offenders and fewer high substance abuse need offenders.

Figure 3: Substance Abuse Summary: Sheridan Treatment Sample and IDOC Facility Sample

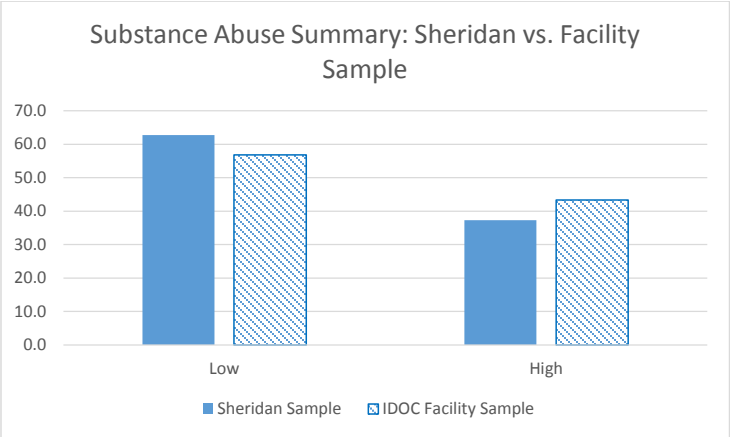
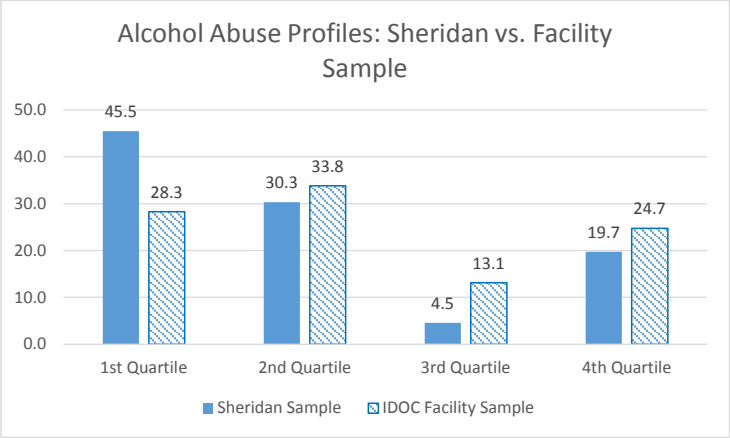


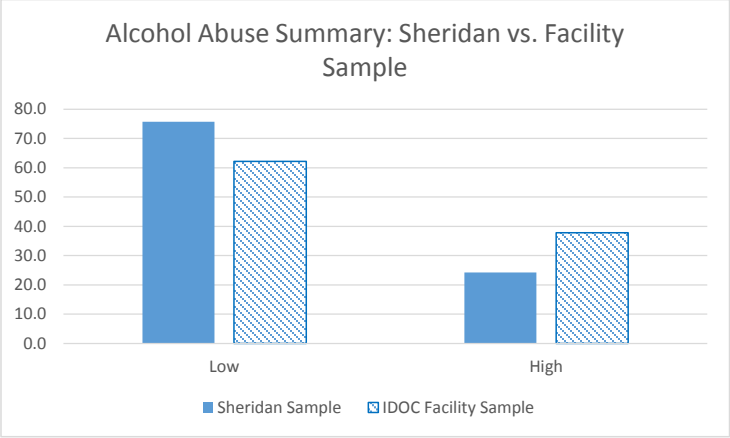

Figure 4: Alcohol Abuse Profiles: Sheridan Treatment Sample and IDOC Facility Sample




This same quartile analysis was conducted with the Alcohol Abuse scale. In Figure 4, the same pattern occurred, although there is some exception for the 2nd quartile. The set of bars for the 1st quartile on the left in Figure 4 indicate a greater percentage of Sheridan inmates having less alcohol blame. The sets of bars for the 3rd and 4th quartiles on the right indicate fewer number of Sheridan inmates having greater alcohol abuse.

Figure 5 provides a summary of these data, and it can clearly be seen that Sheridan offenders have lower alcohol abuse, and that contributing to this is a greater number of low alcohol abuse inmates and fewer high alcohol abuse offenders.

Figure 5: Alcohol Abuse Summary: Sheridan Treatment Sample and IDOC Facility Sample

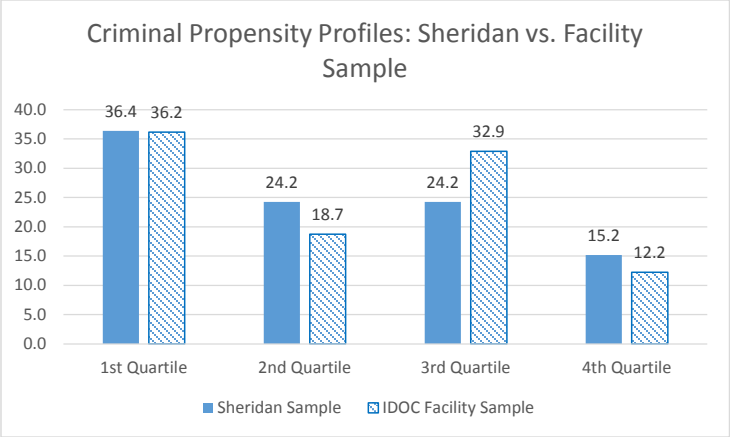



The conclusion of inappropriate referral criteria is made stronger with the use of two scales measuring different aspects of substance/alcohol needs. These two scales were minimally related to each other (r = .13), yet the same pattern for the Sheridan sample was observed.

It might be that referrals focus on substance use without regard to related criminogenic risk or need levels, which would lead to an inappropriate referral. To assess for this, the Criminal Propensity scale and a perceived risk scale provide additional information on levels of risk.

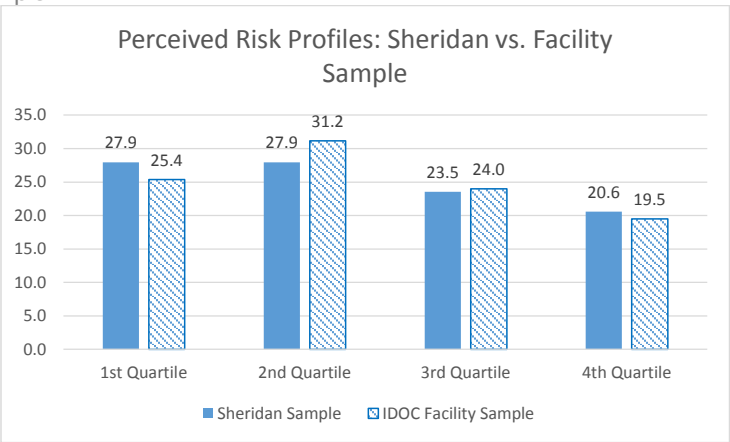
For the Criminal Propensity scale, the lower risk quartiles reflected the same or a greater percentage of lower risk offenders participating in substance abuse treatment at Sheridan (Figure 6). In the upper risk levels, the Sheridan sample was lower risk in the third quartile, but slightly higher in the fourth quartile. Thus, at the upper risk level, there were appropriately placed offenders; but for the most part, Sheridan has lower risk offenders.

Figure 6: Criminal Propensity Profiles: Sheridan Treatment Sample and IDOC Facility Sample




The Perceived Risk Scale also indicates that Sheridan offenders may have risk levels that are more similar to other offenders from facilities throughout the IDOC (Figure 7).

Figure 7: Perceived Risk Profile: Sheridan Treatment Sample and IDOC Facility Sample



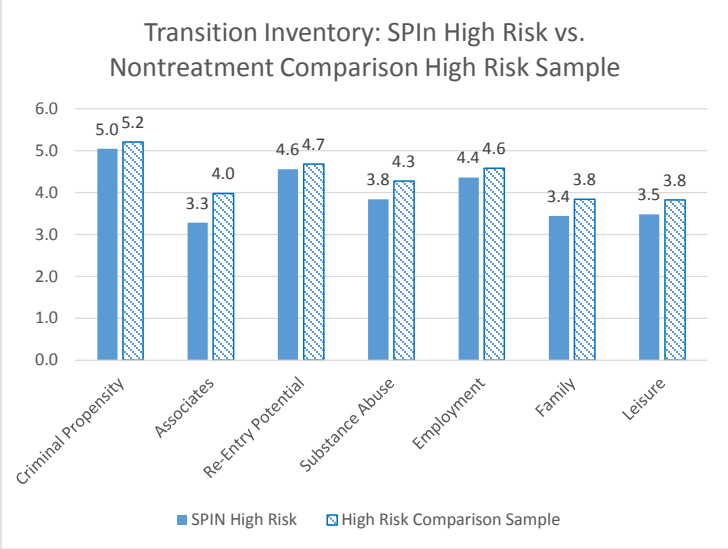

From past reviews of the Sheridan Correctional Center (Olson, 2011), the evidence suggests that the program is reducing recidivism. The current

evaluation presents evidence that these offenders are of lower need and potentially of lower risk. In accordance with the Risk principle of RNR, the current results suggest a lack of appropriate matching of offender risk level and treatment. The change of the referral criteria will result in a greater impact of treatment efforts. The referral criteria should be set by the Chief of Programs and Support Services, removing it from the vendor (see STRAT: C3).

Solely changing the cut point on a single referral substance abuse measure may still result in the lack of optimal referrals. This would result in offenders participating in substance abuse programming who had predominantly substance abuse needs, but exclude those offenders who had other related needs. Given that substance abuse programming attempts to address some of these related needs, an overly narrow referral criterion would result in an utilization of treatment resources.

To test for this, a high-risk Sheridan treatment group was compared to a high risk general offender group. The high-risk group was created for the Sheridan sample and a non-treatment comparison sample. The non-treatment comparison sample included offenders from facilities that were women's facilities, maximum-security facilities (and respective MSUs), and Adult Transition/Life Skills Reentry Centers. Based on the HighNorm scale scores from the Perceived Risk Inventory, a high-risk group included the highest one-third of the sample. It is expected that needs areas of the Sheridan group should be equivalent or greater than the need areas of the general offender group.

Figure 8: Transition Inventory SPIn High-Risk and Non-Treatment Comparison High-Risk Sample

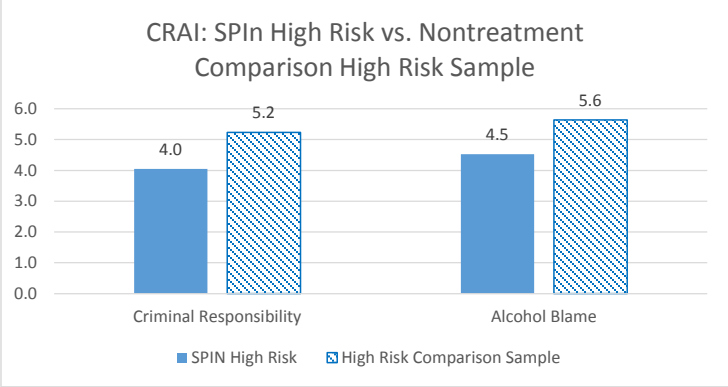



As can be seen in Figure 8, the General Criminal propensity, Associates, Re-entry Potential, Substance Abuse, Employment, Family, and Leisure scales for the Sheridan sample were lower than for the general offender group.

This same trend occurred for criminal responsibility and Alcohol Abuse scales as presented in Figure 9.

Figure 9: CRAI SPIn High Risk and Non-Treatment Comparison High Risk Sample

**Commented [EW2]:** Check with Daryl that "Criminal Responsibility" is the CR_Vict variable. CR_Alc was previously called "Alcohol Blame" so that same label is used in this table but not in the text.




The trend of the Sheridan group having lower need areas across all the scales suggests that the referral criteria could be further refined. Recommended is using the SPIn substance abuse scale and an additional scale to make the referrals to the Sheridan programs. The programing does addresses other criminogenic need areas. Better referral criteria will result in a better utilization of treatment resources (STRAT: C3).

### *Treatment Processes*

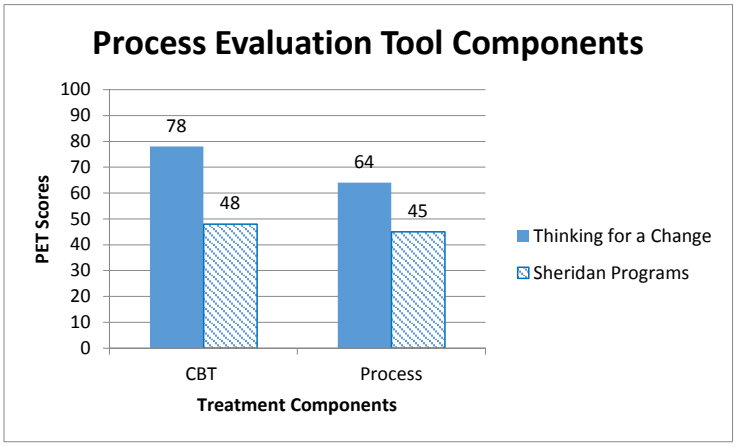
The Process Evaluation Tool (PET) is intended to assess program evaluation components of mental health group interventions including structuring skills, relationship building skills, behavioral techniques, cognitive techniques, and the link between cognitions and behaviors. Interventions were observed by researchers and scored on a 1-5 scale concerning the presence, quality, and effectiveness of the components listed above. Observations were also noted on the scheduled time of the session, actual time of the session, and the number of offenders in the group.

Thinking for a Change was observed with the PET at Pinckneyville CC and Sheridan CC. It is an evidence-based cognitive behavioral intervention that incorporates cognitive restructuring, social skills development, and problem-solving skills in a group therapy format. Targeted behaviors include modifying dynamic criminogenic risk factors to reduce recidivism. Thinking for a Change is considered a program as it meets more than once per week. It also meets for over two hours each session. Other Sheridan CC interventions included in the analysis consist of anger management, inside out dads, community, conflict resolution.

The CBT measure consists of the cognitive and behavioral components of the PET. These components are the most important for enacting positive change in the offenders and lead to a reduction in recidivism. The Process measure consists of the structuring skills and relationship building skills components of the PET. These components are important for ensuring intervention delivery. Scores for these items were standardized with 100 being a perfect score.

Thinking for a Change scored well above other Sheridan CC interventions on the CBT component (Figure 10). This indicates that Thinking for a Change demonstrates substantial utilization of these therapeutic components, while other Sheridan CC interventions are lacking these aspects. Thinking for a Change also scored higher than other Sheridan CC interventions on the Process component, indicating that the interventions are delivered at a higher quality in the Thinking for a Change program. Other Sheridan CC interventions scored slightly higher on CBT than Process components, indicating that the primary mechanism of change (CBT components) are being delivered at a high quality relative to Process components.

Figure 10: Process Evaluation Tool: Thinking for a Change and Sheridan Interventions




## *Persistence of Facility Treatment Efforts: Community Sample*

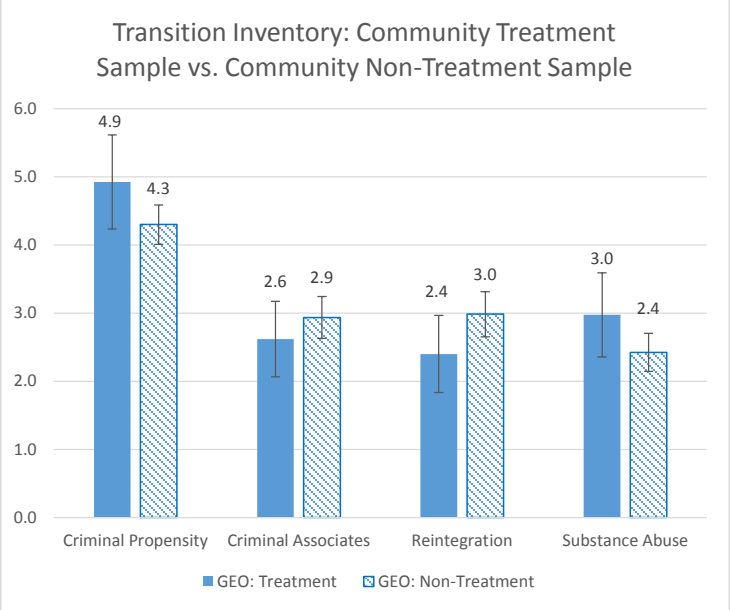
Treatment process was also assessed for a sample of offenders released from IDOC facilities. This community sample drew from offenders at day-reporting centers run by GEO Reentry Services. This sample consisted of 252 offenders

**Commented [EW3]:** Is this progress or process?

from 5 GEO Facilities. Data were collected at GEO facilities located in Chatham, Chicago Heights, Decatur, East St. Louis, and West Fulton.

The below analysis examines facility treatment effects persisting into the community. The treatment group consisted of offenders who completed programs within an IDOC facility, which included TRAC 1, substance abuse, anger management, and lifestyle redirection while in the facilities. As noted in Figure 11, the largest treatment impact is shown for reintegration potential, followed by criminal associates. The lowest treatment effect was with substance abuse and general criminal propensity.

Figure 11: Transition Inventory: Community Treatment and Community Non-Treatment Samples

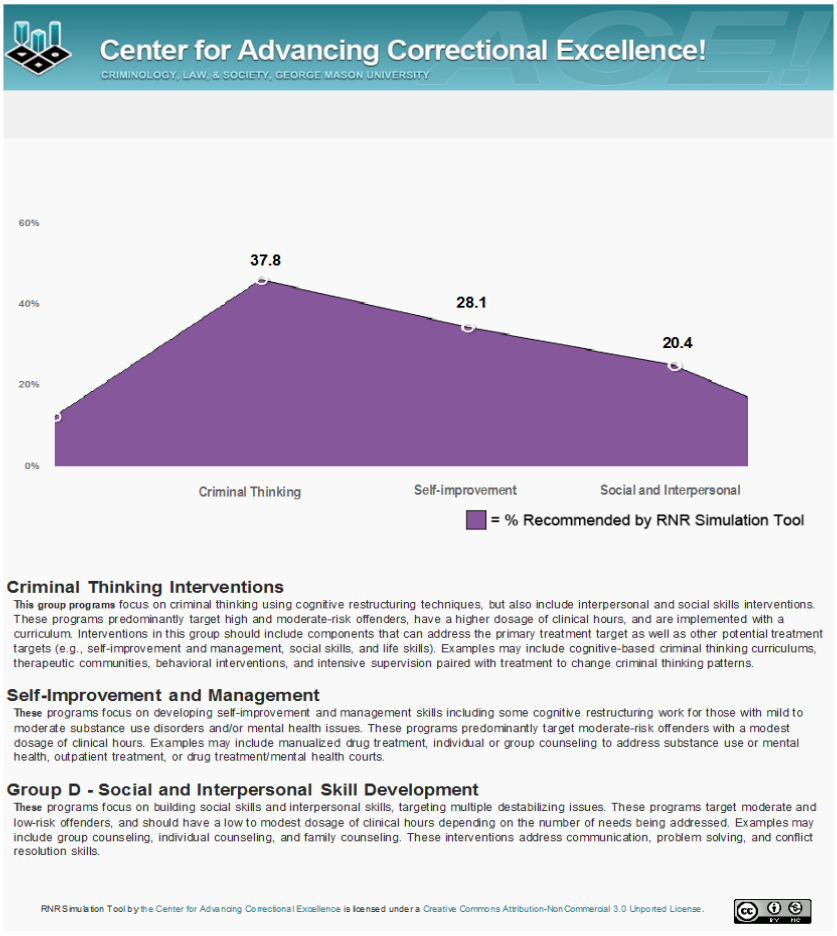



These results point to three conclusions. First, although there are indications of the effectiveness of substance abuse intervention (Olson, 2011), some of the process issues in the delivery of substance abuse treatment may be impacting sustained treatment results. Second, the results point to the need for effect booster or maintenance sessions. Third, the implementation of criminogenic need programs, such as Thinking for a Change, are likely to have a substantial impact on released offenders.

## *System Criminogenic Need Gap Analyses*

The results in Figure 12 above also speak to gaps criminogenic need. With treatment, there are still gaps with substance abuse and general criminal propensity. These results are confirmed with the RNR Simulation Tool. The greatest system need (37.8%) is criminal thinking. The second need area is self-improvement (28.1%), which covers moderate substance abuse.

Figure 12: RNR Simulation Tool



### *Summary*

Some facility treatment effects, such as criminal associates and reintegration potential, persisted into the community. Notably, substance abuse treatment effects did not have as strong persistence effect. Changes to substance abuse programming and the development and application of maintenance sessions will assist with these effects. The need for addressing criminal propensity (i.e., through criminal thinking programs) and substance abuse are confirmed with the RNR Simulation Tool results (STRAT; B5).

### *Summary of Treatment Process*

Overall, treatment process strengths included the use of homework, the use of worksheets, regular group sessions, and therapeutic process. There were occurrences of programs being conducted with minimal facilitator effort, cancelling programs without notification. Thus, in the strategies outlined to move forward there is an emphasis on intervention dosage (STRAT: C1, C2).

Frequently though, the homework was not integrated into the treatment sessions. Effective use of homework is an essential component of correctional interventions. The referral criteria for the Sheridan programming was inappropriate. This results in a waste of treatment resources, in addition precluding the treating of appropriate offenders in a timely fashion. Although the Sheridan programming is labelled as cognitive behavioral treatment, the techniques used in the sessions provide only limited support. This lack of treatment fidelity may contribute to facility treated offenders having substance abuse issues in the community.

## 1.4 Mental Health Interventions

Intervention programs among offenders are central to efforts in promoting safety. Appropriate offender interventions can reduce general recidivism (Lipsey & Cullen, 2007; Morgan & Flora, 2002; Tong & Farrington, 2008), with the typical general recidivism decrease between 10% to 27% (Bourgon & Armstrong, 2005; Prendergast, Hall, Wexler, Melnick, & Cao, 2004). Offenders who do not receive maximum treatment dosage miss the opportunity to benefit from these interventions. Facilitating full participation in an effective treatment intervention is, therefore, a public safety issue. In fact, offenders who dropout typically reoffend at a higher rate than those who complete treatment (Berman, 2005; Hepburn, 2005) and reoffend sooner (Prendergast et al., 2004; Serin, Gobeil, & Preston, 2009).

Treatment programs with sufficient “dosage” and treatment integrity have an increased likelihood of reducing recidivism (Andrews & Bonta, 2010; Andrews & Dowden, 2005). In the risk-needs-responsivity framework, the risk principle suggests that matching offenders to an adequate dosage level of treatment is important, which is supported by the evidence that sufficient dosage is related to reductions in recidivism (Bourgon & Armstrong, 2005; Kroner & Takahashi, 2012; Kroner, Power, Takahashi, & Harris, 2014).

Individuals with mental illnesses often experience criminogenic risk factors that compound the presenting illness. Research suggests that mentally ill offenders display significantly higher levels of criminal thinking than mentally ill individuals not involved in the criminal justice system (Gross & Morgan, 2012; Morgan, Fisher, Duan, Mandracchia, & Murray, 2010). Further, criminal lifestyles, criminal thinking, antisocial personality, and other risk factors are prevalent in mentally ill offender populations and may contribute to the revolving door of criminal justice involvement (Gross & Morgan, 2012.

Studies have found that treating psychiatric symptoms alone, even when a notable recovery is made, does not reduce future criminal behavior (Calsyn, Yonker, Lemming, Morse, & Klinkenberg, 2005; Gross & Morgan, 2012). Essentially, addressing only mental health issues in treatment is not conducive to the goal of reducing recidivism (Skeem, Manchak, & Peterson, 2011). Contrasting with media portrayals of mentally ill individuals, this is because mental illness does not cause criminal behavior. Instead, psychiatric issues and criminal thinking, attitudes, and actions co-occur in incarcerated mentally ill populations (Morgan et al., 2010). Morgan and colleagues (2010) found that overt criminal thinking leading to a criminal lifestyle was present in 66% of their

incarcerated psychiatric sample. Moreover, when compared to a comparable incarcerated non-psychiatric sample, these individuals score similarly or higher on the criminal thinking measurement. Thus, mentally ill offenders need treatment that is focused on criminogenic risk factors (e.g., criminal thinking and attitudes) as well as psychiatric.

### *Mental Health Evaluation Measures*

The evaluation of Mental Health interventions consisted of four sources of information. The Best Practices Survey and the Process Evaluation Tool were used to assess mental health interventions. The Best Practices Survey was used to evaluate intervention components as reported by staff. The Process Evaluation Tool is an observation tool that was used to evaluate the presence and use of cognitive-behavioral and process components in intervention sessions. The Offender Survey was administered to offenders at facilities offering mental health treatment and was used to evaluate offenders' self-reported risk, need, and criminal tendencies. An additional self-report survey instrument was developed that specifically focused on mental health treatment and was administered to offenders receiving mental health interventions. The Mental Health Offender Survey is a self-report measure intended to assess inmates' experience with, attitudes of, and perceptions toward mental health services they have received while incarcerated. The measure is written at a sixth-grade reading level and includes a wide range of mental health related issues, including access to services, motivation to discuss personal issues, confidentiality, staff relations, staff qualifications, program duration, program goals, and satisfaction with services. The survey took approximately 30 minutes to complete. Participation was completely voluntary and special care was taken to ensure confidentiality.

### *Mental Health Data Collection*

Data collection included the Mental Health Offender Survey, the Best Practices Survey, the Process Evaluation Tool, and the Offender Survey to assess mental health interventions. Best practices data was obtained from Big Muddy River, Centralia, Decatur, Graham, Illinois River, Jacksonville, Menard, Shawnee, Taylorville, and Vienna Correctional Centers. Mental health offender survey data was obtained from Dixon, Graham, Illinois River, Jacksonville, Pinckneyville, and Pontiac MSU Correctional Center. Process Evaluation observations was obtained from Dixon and Pinckneyville Correctional Centers. Offender Survey data was obtained from Dixon Correctional Center.

These facilities have varying levels of care and availability of mental health resources. Dixon CC has the most comprehensive mental health care system with a Therapeutic Community model consisting of various levels of care including: Out-patient care (from general population), Residential Treatment Unit (RTU), Special Treatment Community (STC), In-Patient, and Crisis Care. Offenders with severe mental illness (SMI) are housed throughout various levels of care. Logan CC also offers a small mental health Therapeutic Community consisting of the following levels of care: Out-patient care (from general population), RTU, Enhanced treatment (in-patient), and Crisis Care. Offenders with SMI are housed throughout various levels of care. All other facilities generally have two levels of care including general population and Crisis Care. Offenders with SMI are housed throughout both levels of care.

The Mental Health Offender Survey and Offender Survey was distributed to offenders in the Out-Patient, RTU, and STC levels of care. The Best Practices Survey was completed for programs directed to offenders in the Out-patient Care, RTU, and STC levels of care. The Process Evaluation Tool was used to observe groups within the Out-Patient, RTU, and STC levels of care.

### *Mental Health Interventions*

Most mental health interventions were delivered on a weekly basis and many were delivered on a bi-weekly or monthly basis. Thus, almost all mental health interventions were classified as services. Interventions were only classified as programs if the group met more than once per week (Table 37). Only seven mental health interventions were delivered twice a week or more, so a small number of mental health interventions were classified as programs (Table 38).

Table 37: Frequency of Mental Health Interventions

| Sessions Per Week | Programs | | Services | | |
|---|---|---|---|---|---|
| | 5 Days per week | Twice per week | Once per week | Bi-weekly | Once per month |
| Number of Interventions | 4 | 3 | 51 | 6 | 3 |

Table 38: Classification of Mental Health Interventions

| Type of Intervention | |
|---|---|
| Programs | 7 |
| Services | 60 |

The duration of mental health interventions had substantial variation. Most services were 8-10 weeks in length while many interventions were delivered over a 4-7-week period or a 12-week period (Table 39). Some interventions were delivered over the course of 6 to 9 months. Four services were delivered on a continuous basis.

Table 39: Duration of Mental Health Interventions

| Intervention Duration | 4-7 weeks | 8 weeks | 10 weeks | 12 weeks | 6 months | 9 months | Continuous |
|---|---|---|---|---|---|---|---|
| Number of Interventions | 10 | 17 | 16 | 8 | 4 | 2 | 4 |

The overwhelming majority of mental health interventions within IDOC were weekly services that met for one hour (Table 40). Almost all mental health interventions lasted one hour, but a small number lasted for 90 minutes. Two interventions met for less than one hour (STRAT: C2).

Table 40: Length of Mental Health Interventions

| Session Length | Less than one hour | One hour | One and a half hours |
|---|---|---|---|
| Number of Interventions | 2 | 58 | 7 |

Mental health interventions were assessed regarding the theoretical basis. Mental health services are fairly balanced in their theoretical basis. Most mental health programs were psychoeducational and only one program was cognitive-behavioral therapy based (Table 41). Cognitive-behavioral therapy (CBT) is one of the most empirically tested and effective forms of therapy. CBT is present-focused, structured, and problem-solving oriented. The goal of this therapy is to emphasize the link between cognitions and behaviors. Psychoeducational interventions utilize several techniques and activities depending on the specific topic of the intervention. These interventions include providing group participants with information on the topic including symptoms, treatments, resources and other services, and problem-solving strategies. “Other” represents dialectical behavior therapy, client-centered therapy, and mindfulness.

Table 41: Theoretical Basis for Mental Health Interventions

| Category | Programs | Services |
|---|---|---|

| | | |
|---|---|---|
| Cognitive-behavioral | 1 | 25 |
| Psychoeducational | 3 | 29 |
| Educational | 2 | 2 |
| Other | 1 | 3 |

Treatment manuals are essential for guiding the structure and content of the intervention. A majority of the programs utilized a treatment manual, but only one third of the mental health services use a manual (Table 42).

Table 42: Treatment Manual Use for Mental Health Interventions

| Category | Programs | Services |
|---|---|---|
| Treatment Manual Use | 4 | 19 |
| No Treatment Manual Use | 3 | 41 |

### *Summary of Mental Health Interventions*

Most mental health interventions were classified as services as they met less than two times per week. Only seven of the mental health interventions that were assessed can be classified as programs which meet two or more times per week. The majority of these sessions lasted for one hour each and for a duration of eight to ten weeks. Thus, the majority of mental health programs offer only eight to ten total hours of treatment intervention. This is not an adequate amount of hours to address criminogenic risks and needs, or to enact a great deal of treatment gain. Further, a majority of the interventions, even the programs, operate with a psychoeducational theoretical basis, not CBT, which is the preferred method.

### *Mental Health Offender Treatment*

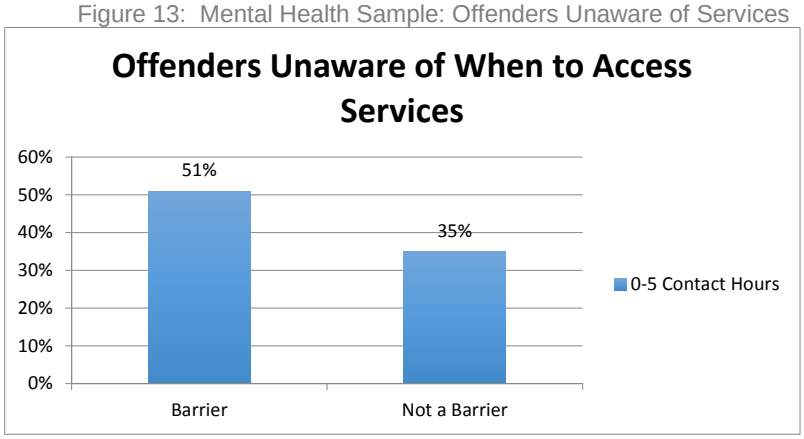
The graphs below report results from the self-report survey on barriers to accessing and utilizing quality mental health care. Surveys were administered to 145 offenders from the mental health population. The results of this survey indicated several barriers to accessing quality mental health care and continuing to utilize those services. Barriers to initial access prevent the therapeutic process from beginning, and barriers to utilization are not conducive to experiencing the

therapeutic process in full. Full participation and completion of treatment is necessary to obtain the desired outcomes.

*Treatment Access*

Over half of the offenders who do not receive many intervention contact hours indicate that they are unaware of when to seek out mental health services. This serves as a major barrier to accessing and receiving necessary services. Note, Figure 13 reports the percent of offenders reporting concern or no concern. Offenders who reported "neutral" are omitted from this analysis. Contact hours refer to total number of self-reported hours the offender spends with a mental health service provider per week, including group and individual sessions.

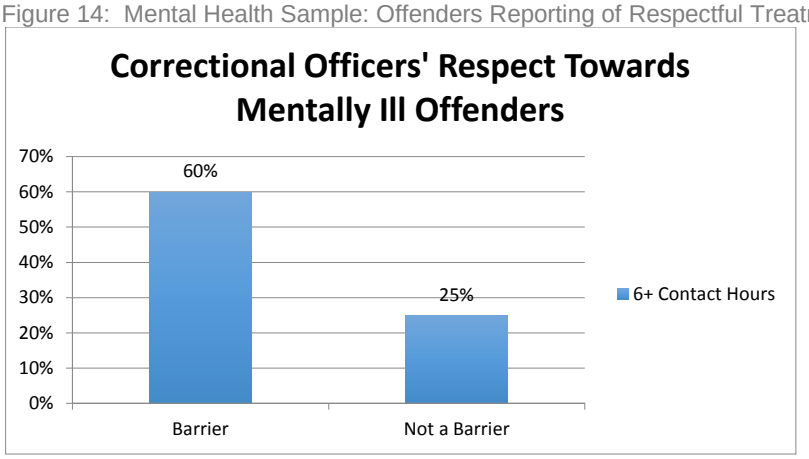
Figure 13: Mental Health Sample: Offenders Unaware of Services




*Treatment Utilization*

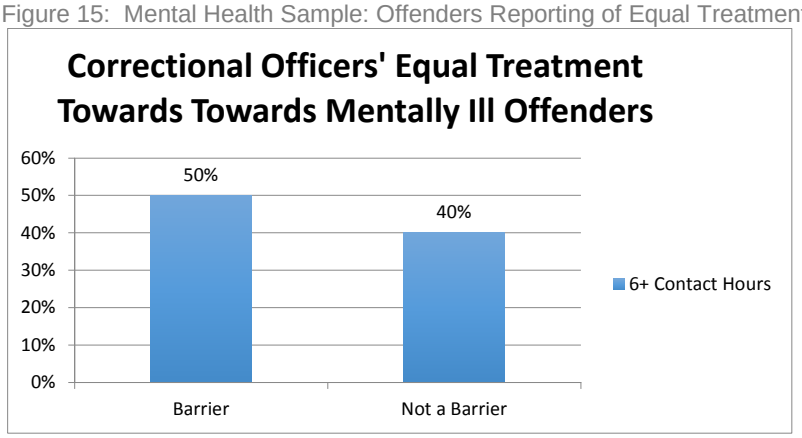
Over half of the offenders felt strongly that correctional officers' degree of respectful treatment toward mentally ill inmates was concerning. Offenders who report six or more contact hours in mental health interventions indicated that disrespectful treatment by correctional officers was a concern. Fear of disrespectful treatment serves as a barrier from further utilization of services. Note, Figure 14 reports the percent of offenders reporting concern or no concern. Offenders who reported "neutral" are omitted from this analysis. Contact hours refer to total number of self-reported hours the offender spends with a mental health service provider per week, including group and individual sessions.

Figure 14: Mental Health Sample: Offenders Reporting of Respectful Treatment



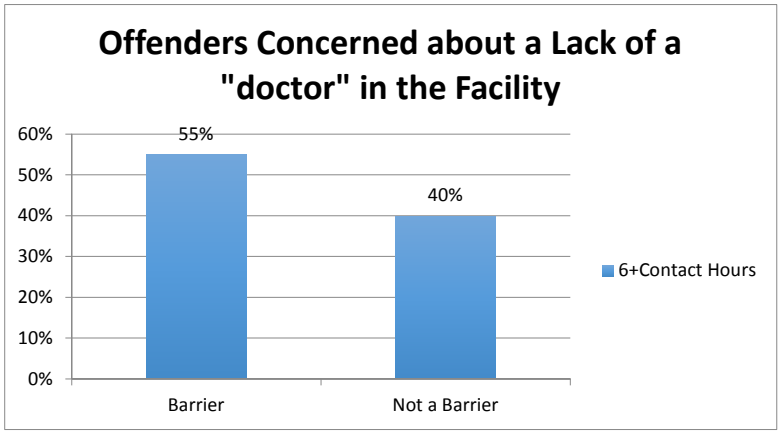

Half of the offenders receiving six or more contact hours reported concern that correctional officers do not treat mentally ill offenders the same as offenders without mental illness. Fear of poor treatment by correctional officers acts as a barrier preventing offenders from continuing to engage in mental health interventions. Note, Figure 15 reports the percent of offenders reporting concern or no concern. Offenders who reported "neutral" are omitted from this analysis. Contact hours refer to total number of self-reported hours the offender spends with a mental health service provider per week, including group and individual sessions.

Figure 15: Mental Health Sample: Offenders Reporting of Equal Treatment



A majority of the responding offenders who engaged in six or more hours of treatment contact hours indicated that lack of a doctoral level mental health provider in the facility was a concerning factor for continuing treatment. The lack of professional staff available and confidence in those staff members can prevent offenders from continuing with the mental health treatment process. Note, Figure 16 reports the percent of offenders reporting whether there was a barrier or not. Offenders who reported “neutral” are omitted from this analysis. Contact hours refer to total number of self-reported hours the offender spends with a mental health service provider per week, including group and individual sessions.

Figure 16: Mental Health Sample: Concerns on Levels of Staff Professionalization




### *Summary of Mental Health Treatment*

Mentally ill offenders face several barriers to receiving mental health treatment. Over half of the mental health sample who do not receive many contact hours with mental health staff reported that they are unaware of when to seek out mental health services. This barrier prevents them from accessing the services they need. Offenders who are involved in six or more hours of treatment also face barriers to further treatment utilization. A majority of this sample reports concern with correctional officers’ disrespectful and unequal treatment towards mentally ill offenders, as well as a lack of professional staff. These barriers impede the therapeutic process and prevent treatment gain.

### *Mental Health Interventions: Process Evaluation Tool*

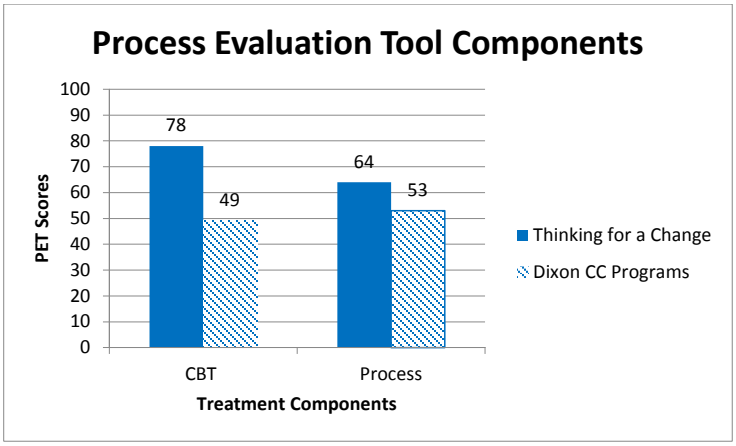
The Process Evaluation Tool (PET; Appendix E) is intended to assess program evaluation components of mental health group interventions including structuring skills, relationship building skills, behavioral techniques, cognitive techniques, and the link between cognitions and behaviors. Interventions were observed by researchers and scored on a 1-5 scale concerning the presence, quality, and effectiveness of the components listed above. Observations were also noted on the scheduled time of the session, actual time of the session, and the number of offenders in the group.

Thinking for a Change was observed with the PET at Pinckneyville CC and Sheridan CC. It is an evidence-based cognitive behavioral intervention that incorporates cognitive restructuring, social skills development, and problem-solving skills in a group therapy format. Targeted behaviors include modifying dynamic criminogenic risk factors to reduce recidivism. Thinking for a Change is considered a program as it meets more than once per week. It also meets for over two hours each session. Dixon CC interventions included in the analysis consist of anxiety, problem solving, conflict resolution, creative writing, current events, life skills, anger management, and structure groups.

The CBT measure consists of the cognitive and behavioral components of the PET. These components are the most important for enacting positive change in the offenders and lead to a reduction in recidivism. The Process measure consists of the structuring skills and relationship building skills components of the PET. These components are important for ensuring intervention delivery. Scores for these items were standardized with 100 being a perfect score. Thinking for a Change scored well above Dixon CC interventions on the CBT component (Figure 17). This indicating that Thinking for a Change demonstrates substantial utilization of these therapeutic components, while Dixon CC is lacking these aspects. Thinking for a Change also scored higher than Dixon CC programming on the Process component, indicating that the interventions are delivered at a higher quality in the Thinking for a Change program.

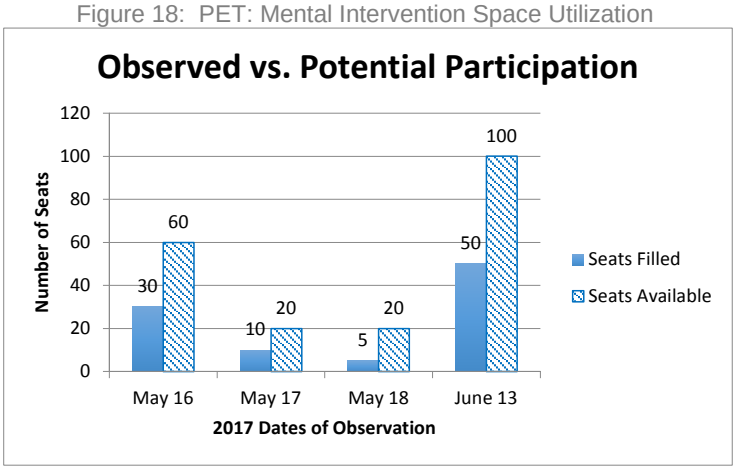
Dixon CC interventions scored higher on the Process component than the CBT component of the PET, indicating that the process of delivery is of better quality than the therapeutic contents. Ideally, the CBT components should be of the same or better quality than the Process as these components are the mechanisms or change.

Figure 17: PET: Thinking for a Change and Dixon CC Programs



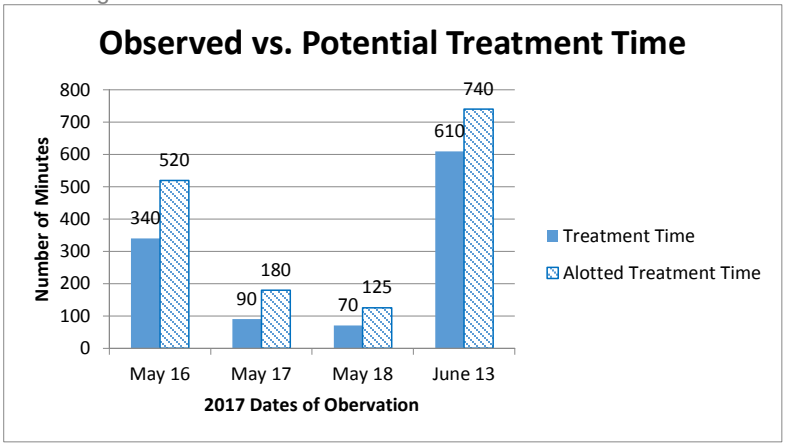

Observations were taken on the number of seats available in the session space and the number of seats filled. Reported numbers are an aggregate of all sessions observed by researchers for the date indicated (Figure 18). Dixon CC intervention observations indicate that only 25 percent or 50 percent of seats that are available in the session space are filled with offenders. This demonstrates a substantial underutilization of available intervention space (STRAT: B1).

Figure 18: PET: Mental Intervention Space Utilization



Observations were taken on the scheduled time allotted of the interventions and the actual duration. Reported numbers of minutes are an aggregate of all sessions observed by researchers for the date indicated (Figure 19). Dixon CC observations indicate that actual treatment time is far less than the allotted treatment time for the interventions. Results reveal that session time is underutilized by either starting interventions late or dismissing them early (STRAT: C1).

Figure 19: PET: Mental Health Intervention Time Utilization



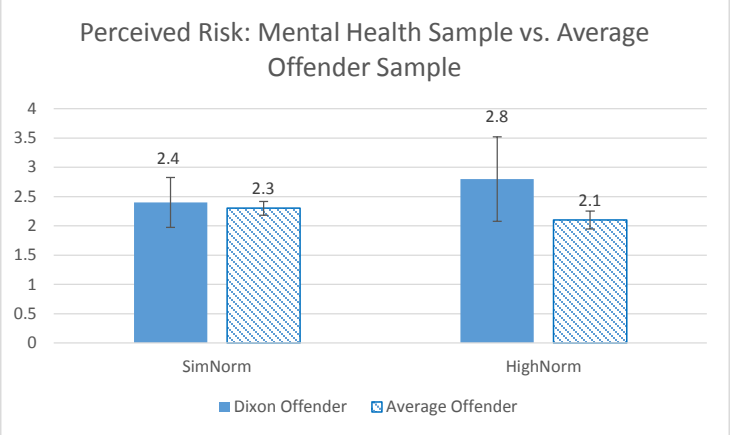

## *Mental Health Interventions: Process Evaluation Tool Summary*

Thinking for a Change demonstrated quality use of CBT and Process components. This program is evidence-based, targets dynamic criminogenic risk factors, and aims to reduce recidivism in participating offenders. This program scored much higher on the PET in both components than the interventions at Dixon CC. To better address criminogenic risk and improve treatment gain, Dixon CC interventions should improve CBT and Process components. Further, Dixon CC interventions demonstrate an underutilization of allotted session time and space.

### *Mental Health Sample: Criminogenic Needs*

The Perceived Risk Inventory (PRI) was used to assess the offenders' self-reported perception of risk. Scores on the 'SimNorm' item indicate that the offender perceives their risk to commit crime to be similar to the risk of a typical offender. Dixon CC offenders (mental health sample) report their risk of committing a crime to be relatively equal to that of a typical offender (average offender sample is a non-mental health caseload sample). Scores on the 'HighNorm' item indicate that the offender perceives their risk to commit crime to be higher than the risk of a typical offender (Figure 20). Dixon CC offenders report their risk to offend to be much higher than the average offender without mental health issues. These results demonstrate that the risk levels of the mentally ill offender sample are higher than the typical offender without mental health issues.

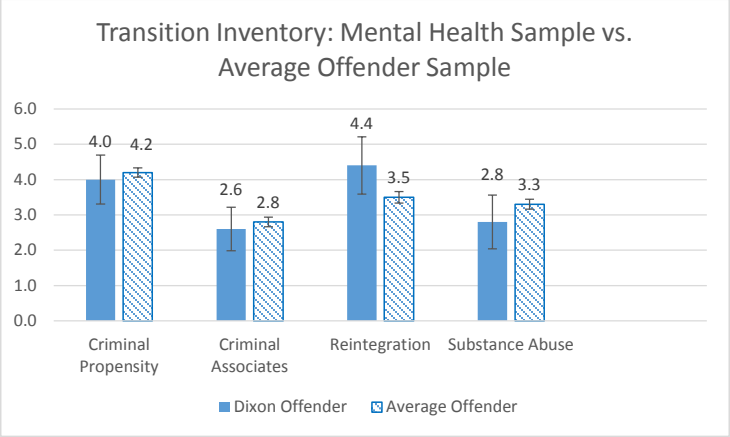
Figure 20: Perceived Risk: Mental Health Sample and Average Offender Sample




The Transition Inventory (TI) was used to assess the offenders' self-reported needs. Criminal propensity measures impulsivity and their inclination for committing crime. Criminal associates measure the extent of their associations with criminal peers (Figure 21). Both measures were relatively the same for the Dixon sample and the average offender samples, indicating that their need levels are similar. Reintegration measures assessed offenders' perceived ability and resources available to reintegrate upon release. Dixon offenders scored higher on this measure, demonstrating that they have higher needs than the typical

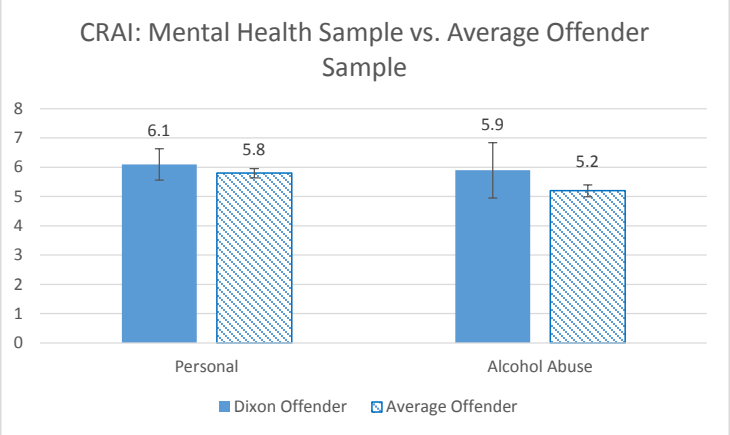
offender. Needs relating to substance abuse was slightly lower for the Dixon offender sample than the typical offender sample.

Figure 21: Transition Inventory: Mental Health Sample and Average Offender Sample




The CRAI was used to assess offenders' self-reported criminal need areas. The 'Personal' item measures the degree that personal characteristics and actions are responsible for crime. Dixon CC offenders scored slightly higher on this measure, indicating that these offenders take less personal responsibility for their actions (Figure 22). For alcohol abuse, Dixon CC offenders also score higher on this measure than the typical offender, which demonstrates that this sample has greater alcohol abuse for criminal conduct more than the typical offender.

Figure 22: CRAI: Mental Health Sample and Average Offender




### *Mental Health Criminogenic Needs Summary*

These measures of the Offender Survey indicate that the mental health sample from Dixon CC reports their risks to reoffend and needs to be similar to or higher than the average non-mentally ill offender. This indicates that criminogenic risks and needs must be addressed in addition to psychiatric symptoms. This integrated approach is necessary to achieve treatment gains and reduce recidivism. Treating these criminogenic risk and needs will also result in a safer institution (Gendreau et al., 2004). Treating only mental health-related symptoms will not achieve these outcomes (STRAT: B4).

## 1.5 Strategic Intervention Plan

This Strategic Intervention Plan is based on the gathered evidence and is intended to integrate empirically supported correctional interventions from other correctional systems to further IDOC's vision and mandate to increase public safety through the delivery of successful reentry programs will be met.

Central to this Strategic Intervention Plan is the development and application of the Intervention Demonstration Assessment Tool (IDAT; Appendix L) and System Logic Model (Appendix M). The IDAT incorporates empirically-derived and contemporary factors regarding effective correctional programming. Utilizing the results of the IDAT, the System Logic Model provides a roadmap to ensure IDOC matches offenders to program opportunities, appropriately allocating resources to maximize efficiency and effectiveness.

Three key strategies for recidivism reduction include:

A. Increase the evidence based components of current treatment programs and eliminate programs that have limited evidenced based support
B. Increase evidenced based treatment engagement
C. Increase treatment dosage

After covering the details of these three key strategies, suggested timeframes and milestones for these strategies are outlined.

## A. Increase the Evidence Based Components of Current Treatment Programs

**Rationale:** Effective treatment interventions require appropriate risk assessments, appropriate criminogenic need content, engagement strategies, qualified staff, and an environment that facilitates change. These areas are integral to the Risk-Needs-Responsivity framework, which has repeatedly shown to be an evidenced-based approach for correctional interventions to reduce recidivism.

**Implementation:**

1. Add evidenced based components and remove non-evidence based components from the list of recommended programs.
2. Combine programs and services for more effective treatment delivery. Cancel non-evidenced based interventions (Appendix K).
3. Provide appropriate support staff for the Chief of Programs and Support Services to ensure that this strategy is accomplished

Recommendations 1 and 2 will incorporate the Intervention Demonstration Assessment Tool (IDAT; Appendix L) components and score.

## B. Increase Evidenced Based Treatment Engagement

**Rationale:** Effective application of evidenced-based programs requires a culture that encourages change.

**Implementation:**

1. Offer an inmate pay grade and good time for participation in treatment programs.
2. Replace TRAC I with an evidenced based program to engage offender in the recidivism reduction process. All other programs should incorporate and build upon these principles.
3. Develop licensed doctoral level IDOC staff to lead the delivery of evidenced based programs.
4. For identified offender groups (i.e., mental health), require an integrated intervention approach.
5. Offer a greater number and breadth of evidenced based programs to engage more offenders in the recidivism reduction process.

Evidence based programs are defined by a cut-score on the Intervention Demonstration Assessment Tool.

## C. Increase Treatment Dosage

**Rationale:** Treatment dosage is a simple metric. It is easy to assess (number of hours in treatment) and can be easily tracked in Offender 360. Based on the evaluation, most time slots and resources associated with these time slots are under-utilized.

Treatment dosage positively impacts reductions in recidivism and institutional misconduct. The more treatment dosage the safer the institution. The requirement of treatment dosage increases the routine structure of an institution. This results in greater predictability of offenders, and de facto, further increases the safety of an institution, for staff and offenders.

Treatment dosage is defined as active face-to-face contact time between a qualified staff person and an inmate.

**Implementation:** Develop security and program integrated policies and strategies. Place security over the monitoring of treatment dosage.

Treatment dosage can be increased three ways:
1. Maximize current schedules. The standard should be 90% time usage (i.e., 60 minutes scheduled, 50 minutes of actual treatment dosage occurs).
2. Alter current schedules for greater treatment dosage. A small change in treatment dosage of 15 minutes will translate into a large system difference.
3. Maximize number of occupied seats in each session. Altering conflicting scheduled activities to make a large system difference. Select waitlists based on risk/need factors will ensure program efficiency. This criterion determined by the Chief of Programs and Support Services.

See System Logic plan for an overall integration of treatment dosage (Appendix M).

## Time frame and Milestones

### 6 Month

1. Develop a 360 metric to measure treatment dosage. Increase treatment dosage by 35% at four facilities via security staff.

2. For two programs, add evidenced based components and remove non-evidence based components.

3. Application of the IDAT to all vendor requests (B3). Set the IDAT scores for Expected Standard, Sub-threshold Standard, Below Standard, and Well Below Standard.

4. Develop and implement a new evidenced-based TRAC I and Domestic Violence programs.

5. Cancel and remove 25% of non -evidenced based interventions.

6. Refine the Logic Systems model (Appendix M).

7. Add 2 staff to Chief of Programs and Support Services.

### 1st Year

1. Develop and implement a new evidenced-based Criminal Associates, Self-Regulation, and Anger Management programs. Increase administration of Thinking for a Change.

2. Increase treatment dosage by 20% across IDOC.

3. Implement the security reduction criteria via the Logic System model at four facilities.

4. Prioritize the administration of the SPIn for offender waitlists.

5. Cancel and remove remaining 75% of non -evidenced based interventions.

6. Full implementation of the IDAT. Quality Assurance schedule.

7. Pay and good time for evidenced based treatment implemented.

8. Add a third staff to Chief of Programs and Support Services.

## 3rd Year

1. Conduct a formal evaluation of treatment dosage.

2. Use SPIn to determine program assignment and program resource allocation

3. A unified organization structure for IDOC programs.

4. Programming six criminogenic need areas in place across IDOC.

## 5th Year

1. Evaluate Risk assessment tool. Re-norm and re-calibrate.

2. Revise Security Reduction of the System Logic Model using empirical findings.

3. Program capacity at 100% to treat identified offenders requiring intervention.

4. Treatment dosage system criteria replaced by risk/needs assessment and analysis

# Appendix A – List of Data Collected per Facility

Legend: **BPS** – Best Practices Survey; **OS** – Offender Survey (PRI, TI, CRAI); **PET** – Process Evaluation Tool

| | |
|---|---|
| Pinckneyville | BPS (13), OS (20), PET (1) |
| Sheridan | BPS (12), OS (72), PET (20) |
| Big Muddy River | BPS (6), OS (49) |
| Centralia | BPS (12), OS (46) |
| Danville | BPS (12), OS (37) |
| Decatur | BPS (10), OS (85) |
| Dixon | BPS (27), OS (51), PET (20) |
| East Moline | BPS (11), OS (66) |
| Graham | BPS (12), OS (53) |
| Hill | BPS (6), OS (44) |
| Illinois River | BPS (10), OS (60) |
| Jacksonville | BPS (15), OS (19) |
| Lawrence | BPS (15) |
| Lincoln | BPS (13), OS (76) |
| Logan | BPS (22), OS (114) |
| Menard | BPS (23) |
| Menard MSU | BPS (1), OS (22) |
| Pontiac | BPS (3), OS (20) |
| Pontiac MSU | BPS (8), OS (19) |
| Robinson | BPS (3), OS (30) |
| Shawnee | BPS (8) |
| Southwestern IL | BPS (8), OS (65) |
| Stateville | BPS (11) |
| Stateville MSU | BPS (5) |
| Taylorville | BPS (7), OS (121) |
| Vandalia | BPS (6), OS (39) |
| Vienna | BPS (11), OS (114) |
| Western IL | BPS (8), OS (58) |
| Dixon Springs IIP | BPS (12), OS (83) |
| DuQuoin IIP | BPS (10), OS (55) |
| Peoria ATC | BPS (2), OS (19) |
| GEO-Chatham | BPS (6), OS (65) |
| GEO-Chicago Heights | BPS (6), OS (22) |
| GEO-Decatur | BPS (6), OS (61) |
| GEO-East St. Louis | BPS (6), OS (23) |
| GEO-Rockford | BPS (7) |
| GEO-West Fulton | BPS (6), OS (82) |
| Kewanee Life Skills Reentry Center | OS (36) |

## Appendix B: Perceived Risk Inventory Measures

Low Comparison Scale

**Lower than Normative** (Agree/Disagree)

My chances of doing crime are lower compared to other people my age.
My chances of doing crime are lower compared to other people with similar personalities.

**Lower than High** (Agree/Disagree)

Compared to those with disgusting personalities, my risk level is lower.
Compared to offenders who have done violence, my risk is lower.

Similar Comparison Scale

**Similar to normative/low** (Agree/Disagree)

My risk to offend is similar to those with minor legal violations.
My chance of criminal activity is close to someone who has one minor conviction.

**Similar to elevated** (Agree/Disagree)

I have a similar risk for crime as someone who has done a serious offense.
Compared to the average person who has done crime, my risk level is similar.

High Comparison Scale

**Higher than Normative** (Agree/Disagree)

My risk to offend is higher than people with similar personal characteristics.
I know my risk level is higher than those with like personal characteristics.

**Higher than Non-crime comparisons** (Agree/Disagree)

My risk level is higher compared to those who are disadvantaged.
It is more possible that I do a crime than someone from a difficult neighborhood.

## Appendix C: Transition Inventory Measures

**Behavioral Impulsivity** (Agree/Disagree)
I will do some things because it will feel good at the time.
I will regret acting too quickly.

**Social Pressures and Associates** (Agree/Disagree)
I will lack the right type of friends.
Based on my past, I will have some difficulty being with positive friends.

**Negative Affect** (Agree/Disagree)
I may feel anxious or frustrated.
Not knowing my future will make me somewhat anxious.

**Social Alienation** (Agree/Disagree)
Others knowing that I was in hospital/prison will be of concern to me.
Because of hospital/jail, I will have difficulties fitting in with others.

**Substance Misuse** (Agree/Disagree)
Drugs or alcohol will be a problem for me.
I will need to be careful with how much I drink.

**Financial/Employment** (Agree/Disagree)
I may not have enough cash to get going.
Based on my past, I expect to have money problems.

**Interpersonal and Family Concerns** (Agree/Disagree)
Based on my past, being close to my family I grew up with will be difficult.
Fitting in with family may be difficult.

**Leisure** (Agree/Disagree)
I will spend my free time listening to music.
Based on my past, more of my free time will be spent listening to music that doing a hobby.

## Appendix D: Criminal Attribution Inventory (CRAI) Measures

**Psychopathology** (Agree/Disagree)
Criminal behavior is often caused by mental illness.
Most crimes are related to mental difficulties.
**Personal** (Agree/Disagree)
People who do crime do so because of their personality traits.
Good lifelong habits prevent people from getting into trouble.
**Victim** (Agree/Disagree)
Victims frequently add to their stories.
Victims should feel some responsibility.
**Alcohol** (Agree/Disagree)
Alcohol can be blamed for most crimes.
Alcohol makes people commit crime.
**Societal** (Agree/Disagree)
When crime occurs, society should be partially blamed.
Society supports behaviors which are related to doing crime.
**Randomness** (Agree/Disagree)
A lot of crime happens when people are in the wrong place at the wrong time.
For the most part, people get involved in crime by chance.

# Appendix E: Process Evaluation Tool

The Process Evaluation Tool (PET) is used via direct observation of interventions.

Process Components

A. Structuring Skills

Four components of the session including Check in, Review, Intervention, and Round up. (1-5)

Presence of collaborative efforts with the individual to establish personal goals, explore the individual's contributions to their problems, and use problem-solving skills to address these problems. (1-5)

B. Relationship Building Skills

The promotion of interpersonal skills within the session. (1-5)

Session characterized by an authoritarian or authoritative (preferred) approach. (1-5)

CBT Components

A. Behavioral Techniques

Session's use of effective reinforcement (timely, concrete, specific). (1-5)

Effective disapproval, specific example of prosocial modeling and/or role playing of a behavior skill within the session. (1-5)

B. Cognitive Techniques

Session's use of the core technique and lessons of the specified treatment manual that primarily teach thought-behavior link and/or common vocabulary. (1-5)

Use of and modification of thinking styles and patterns during the session. (1-5)

# Appendix F: Catalog of IDOC Interventions

| Department | Name of Intervention | Number of Facilities |
|---|---|---|
| **Chaplaincy** | 180 Class | 1 |
| | 2 Day Dads | 9 |
| | 3 ABN | 1 |
| | A Sure Foundation | 2 |
| | AA (Alcoholics Anonymous) | 10 |
| | AA/NA combined | 2 |
| | Abundant Faith | 2 |
| | Action 2:17 | 7 |
| | African Hebrew Israelite | 3 |
| | Al Islam- Jumah | 17 |
| | Al Islam- Taleem | 17 |
| | Angel Tree | 4 |
| | Apostolic | 2 |
| | Band | 2 |
| | Band/Choir | 3 |
| | Baptism Service | 2 |
| | Baptist | 5 |
| | Basketball Tournament | 1 |
| | Berean Bible Study | 1 |
| | Bi-Lingual Catholic Mass | 1 |
| | Bible Study | 19 |
| | Black Hebrew Israelites | 1 |
| | Black History Events | 3 |
| | Buddhist | 7 |
| | Buddhist Meditation | 1 |
| | Cathedral Ministries | 1 |
| | Cathedral of Worship | 2 |
| | Catholic Catechesis | 1 |
| | Catholic Cursillo Retreat | 2 |
| | Catholic Cursillo Reunion | 2 |
| | Catholic Mass | 25 |
| | Catholic Bible Study | 1 |
| | Catholic Choir | 1 |
| | Catholic Deacons | 1 |
| | Celebrate Recovery | 4 |
| | Centering Prayer | 1 |
| | Chapel Library | 2 |
| | Chapel Prayer | 1 |
| | Chaplain's Ministry Team | 1 |
| | Chaplaincy | 3 |
| | Chapmans | 1 |
| | Choir | 10 |
| | Christ Foundation | 1 |
| | Christian Doctrine | 1 |
| | Christian Motorcycle Association | 1 |
| | Christian Prayer | 1 |
| | Christian Worship Services | 6 |
| | City Hope Church | 1 |

| | | |
|---|---|---|
| **Chaplaincy cont'd** | City Hope Church- Spanish Service | 1 |
| | City of Refuge | 1 |
| | Clean, Sober, & Saved | 1 |
| | Concert of Prayer | 1 |
| | Coping with Grief and Loss | 1 |
| | Curt Darling Worship Service | 1 |
| | DaVinci's Last Supper | 1 |
| | Deaf Services | 1 |
| | Disciple Bible Study | 1 |
| | Discipleship Class | 2 |
| | Ditch the Baggage, Change Your Life | 1 |
| | Divine Hope Bible Seminary | 1 |
| | Drug Out Bible Study | 1 |
| | Dunamis Disciples | 1 |
| | Effingham Prison Ministry | 1 |
| | Examples of Christ | 1 |
| | Experience Jesus | 1 |
| | Face your Fears | 1 |
| | Faith Based Fathers | 1 |
| | Faith, Hope, and Love | 5 |
| | Fatherhood Initiative | 5 |
| | Freedom from Fear Seminar | 1 |
| | Freedom God's Way | 2 |
| | Freedom in the Word Ministries | 1 |
| | Friendship of Faith | 1 |
| | Godly Men Program | 1 |
| | Good News Ministries Retreat | 1 |
| | Gospel Echoes | 1 |
| | Great Banquet Retreat | 2 |
| | Great Banquet Reunion | 1 |
| | Gridley Apostle | 1 |
| | Guiding Light Ministries | 1 |
| | Hebrew Israelite | 5 |
| | House of Refuge | 1 |
| | House of Yahweh | 1 |
| | Houses of Healing | 2 |
| | Image Builders | 1 |
| | In Covenant Ministry | 1 |
| | Inner Circle | 1 |
| | Inside Out Dads | 3 |
| | Inside the Lines Fellowship | 1 |
| | Integrity Group | 1 |
| | Islamic Services | 6 |
| | Islamic Studies | 1 |
| | Jehovah Jireh | 3 |
| | Jehovah Witness | 24 |
| | Jesus is the Way | 2 |
| | Jewish Services/Rabbi | 17 |
| | Jobs Partnership | 9 |
| | John Muchison | 1 |

| | | |
|---|---|---|
| **Chaplaincy cont'd** | Joy | 1 |
| | Kairos | 5 |
| | Kevin Grier | 1 |
| | Kingdom Lifeline | 1 |
| | Kingdom Messengers Choir | 1 |
| | Koinonia House | 4 |
| | Koran Studies | 2 |
| | Laugh Your Way to a Better Marriage | 1 |
| | Liberty Temple | 2 |
| | Life Plan Seminar | 1 |
| | Living Truth Ministry | 1 |
| | Living Well Church | 1 |
| | Living Word | 2 |
| | LTO creative art | 1 |
| | LTO creative writing | 1 |
| | LTO financial skills | 1 |
| | LTO further learning | 1 |
| | LTO inside out dads | 1 |
| | LTO life skills | 1 |
| | LTO math skills | 1 |
| | LTO P-NAP art | 1 |
| | LTO P-NAP guest lecture series | 1 |
| | LTO P-NAP history | 1 |
| | LTO P-NAP poetry | 1 |
| | LTO P-NAP social sciences | 1 |
| | LTO philosophy | 1 |
| | LTO religion | 1 |
| | LTO restorative justice | 1 |
| | LTO scientific approaches | 1 |
| | LTO urban studies | 1 |
| | LTO values | 1 |
| | LTO creative art | 1 |
| | LTO creative writing | 1 |
| | LTO financial skills | 1 |
| | LTO further learning | 1 |
| | LTO inside out dads | 1 |
| | LTO life skills | 1 |
| | LTO math skills | 1 |
| | LTO P-NAP art | 1 |
| | LTO P-NAP guest lecture series | 1 |
| | LTO P-NAP history | 1 |
| | LTO P-NAP poetry | 1 |
| | LTO P-NAP social sciences | 1 |
| | LTO philosophy | 1 |
| | LTO religion | 1 |
| | LTO restorative justice | 1 |
| | LTO scientific approaches | 1 |
| | LTO urban studies | 1 |
| | LTO values | 1 |

| | | |
|---|---|---|
| **Chaplaincy cont'd** | Lutheran | 5 |
| | LWCC Chicago Service | 1 |
| | Malachi Dads | 3 |
| | Master Life | 1 |
| | Meditation/Mindfulness | 1 |
| | Men of Valor | 1 |
| | Men's Fraternity, "Power of Potential" | 1 |
| | Mennonite | 2 |
| | Message of Holiness | 1 |
| | Methodist | |
| | MH Unit and Health Care Unit Visit | 1 |
| | MH Unit Bible Study | 1 |
| | Midwest Christian's Center | 1 |
| | Mission Gate | 1 |
| | Mom and Me Camp | 1 |
| | Moorish Science Temple | 10 |
| | Mormon | 1 |
| | Mt. Pleasant Church Sing | 1 |
| | NA (Narcotics Anonymous) | 4 |
| | Nations of Gods and Earth | 2 |
| | Nation of Islam | 4 |
| | New Covenant | 1 |
| | New Life Ministries | 6 |
| | New Life Singers | 1 |
| | Non-Denominational | 7 |
| | Odinism/Asatru | 7 |
| | Old Testament | 1 |
| | Open Heart | 1 |
| | Operation Push | 2 |
| | Operation Rainbow Push Collation | 1 |
| | Out of Darkness into Beautiful Light | 1 |
| | Pagan | 1 |
| | Pastoral Counselling | 1 |
| | PEL Grant | 1 |
| | Pentecostal | 3 |
| | Peter Schneider Ministry | 1 |
| | Power Team | 1 |
| | Prayer Programs | 1 |
| | Prayer Service | 2 |
| | Pre-Baptism Clinic | 3 |
| | Pre-Marriage Clinic | 2 |
| | Prison Evangelism | 1 |
| | Prison Fellowship | 9 |
| | Protestant | 4 |
| | Protestant Spanish Study | 1 |
| | Purpose Driven Life | 2 |
| | Purpose Driven Life Spanish | 1 |
| | Quad Counties | 1 |
| | Quest for Authentic Manhood | 1 |

| | | |
|---|---|---|
| **Chaplaincy cont'd** | Rastafarian | 1 |
| | RCIA | 1 |
| | REC Retreat | 2 |
| | REC Reunion | 2 |
| | Reformers Inst. Program | 1 |
| | Release Through Jesus | 4 |
| | Remnant Life | 1 |
| | Retreats (Weekend) | 4 |
| | Revelation Paradigms | 1 |
| | Rock of Ages | 1 |
| | Rosary | 1 |
| | Salvation Army | 4 |
| | Saving Grace Ministry | 1 |
| | Seminar with Bishop Warren | 1 |
| | Seventh Day Adventist | 5 |
| | Singing Men of GNN | 1 |
| | Spanish Bible Study | 8 |
| | Spanish Choir | 1 |
| | Special Events- Guest Speaker | 1 |
| | Speech Craft | 1 |
| | Storybook | 4 |
| | Sydney Thomas Ministry | 1 |
| | The Crossing Ministries | 1 |
| | Toastmasters | 1 |
| | Torah Study | 1 |
| | Transformational Ministries | 1 |
| | Transformed Life | 1 |
| | Transforming Incarcerated Dads | 4 |
| | Transforming Incarcerated Veterans | 1 |
| | Trinity United Church of Christ | 1 |
| | Uprooting Anger Prison Fellowship | 1 |
| | Veterans' Program | 2 |
| | Victory Walk | 1 |
| | Walking the 12 Steps with Jesus | 1 |
| | Wardell | 1 |
| | Wesley Weekend | 1 |
| | Whittington Ministries | 1 |
| | Wicca | 4 |
| | Women Aglow | 1 |
| | Word and Spirit Worship | 1 |
| | Word of Life Prison Ministries | 1 |

| | | |
|---|---|---|
| **Clinical Services** | 12-Step | 3 |
| | 12-Step & 12-Step AA Book Study | 1 |
| | 24/7 Dads | 1 |
| | A new Direction | 1 |
| | AA (Alcoholics Anonymous) | 11 |
| | AA/NA combined | 3 |
| | Anger Management | 8 |
| | Black History Events | 2 |
| | CAAP | 2 |
| | CEC* | 5 |
| | Comprehensive Connections* | 1 |
| | Dave Ramsey Financial Peace | 2 |
| | Design for Living | 1 |
| | Domestic Violence | 2 |
| | Drug Education | 10 |
| | Drug Summit | 1 |
| | Drug Symposium | 2 |
| | Etiquette | 1 |
| | Expressions Creative Writing | 2 |
| | Fatherhood Initiative | 2 |
| | Females in Transition* | 1 |
| | Good Time | 2 |
| | Hispanic History Events | 2 |
| | Hot Topics | 15 |
| | Houses of Healing | 2 |
| | IL Veterans' History Project | 1 |
| | Impact of Crime on Victims | 2 |
| | Incarcerated Veterans' Transition Program | 5 |
| | Inside Out Dads | 8 |
| | LARK (Dog Program) | 1 |
| | Life Commandments | 1 |
| | Lifestyle Redirection | 21 |
| | Making Men | 1 |
| | Malachi Dads | 1 |
| | Mentorship | 1 |
| | Mind Over Mood | 1 |
| | Moms & Babies | 1 |
| | NA (Narcotics Anonymous) | 6 |
| | Non Good Time | 2 |
| | Orientation | 24 |
| | Parenting | 5 |
| | Parole School 1 month | 22 |
| | Parole School 6 month | 22 |
| | Parole School (1&6 month at same time) | 1 |
| | Parole/Post Staffings | 1 |
| | PAST (Passed Abusive Substances Today) | 1 |
| | Peer Mentoring | 1 |
| | Prison Smart | 1 |

| | | |
|---|---|---|
| **Clinical Services cont'd** | Re-Entry Summit | 21 |
| | Restorative Justice Initiative for Administrative Detention | 2 |
| | Reunification Program | 1 |
| | Secretary of State | 1 |
| | Seeking Safety | 1 |
| | Sesame Street | 2 |
| | Sex Offender Program (VSO & SPD)* | 1 |
| | SMI Lifestyle Redirection | 1 |
| | Spanish AA | 1 |
| | Storybook | 4 |
| | Substance Abuse Class | 6 |
| | TASC* | 2 |
| | Thinking for Change | 5 |
| | Time for Change | 1 |
| | Toastmasters | 3 |
| | TRAC1 | 20 |
| | Transitions Program | 1 |
| | Transitional Work | 1 |
| | Ultimate Edge | 1 |
| | VA Representative | 1 |
| | Veteran's Group | 6 |
| | Violence Awareness Month | 2 |
| | West Care* | 1 |
| | Wells Center* | 1 |
| **Education/Skill Building** | ABE | 26 |
| | Advanced ABE | 15 |
| | ALS (Associate of Liberal Studies)/night classes from Lakeland | 9 |
| | Automotive Body | 2 |
| | Automotive Mechanics | 2 |
| | Automotive Technology | 4 |
| | Barber School | 2 |
| | Career Technology | 15 |
| | Construction | 13 |
| | Cosmetology | 3 |
| | Culinary Arts | 12 |
| | Culinary Arts Bridge | 1 |
| | Custodial Maintenance | 14 |
| | Danville Community College ALS | 1 |
| | First Responder | 1 |
| | Helping PAWS | 2 |
| | High School Equivalency | 26 |
| | Horticulture | 9 |
| | Industries | 18 |
| | Nail Technology | 1 |
| | Print Management | 1 |
| | Remedial | 1 |
| | Restaurant Management | 4 |

| | | |
|---|---|---|
| **Education/Skill Building cont'd** | Second Chance Ranch Equine Training Program | 1 |
| | Study Group | 1 |
| | Support Dogs, Inc. | 1 |
| | Tutoring | 1 |
| | U of I Education Justice Program | 1 |
| | Warehousing | 2 |
| | Welding | 2 |
| **Family Services** | 12 Steps Boot Camp | 1 |
| | Baby Talk | 1 |
| | Back on the Streets | 1 |
| | Caregivers | 1 |
| | Keys to Success | 1 |
| | Leadership | 1 |
| | Lifestyle Redirection | 1 |
| | Meditation | 1 |
| | Mom and Me Camp | 1 |
| | Parenting from the Inside | 1 |
| | Parenting with Teens | 1 |
| | PAWS | 1 |
| | Phoenix Rising | 1 |
| | Purple Purse | 1 |
| | Reentry Summit | 1 |
| | Storybook | 1 |
| | TRAC1 | 1 |
| | Unconditional Self-Acceptance | 1 |
| | Woman's Way Through the 12 Steps | 1 |
| **Mental Health** | All Faith Group | 1 |
| | Anger Management | 12 |
| | Angry Heart | 1 |
| | Anxiety Group | 6 |
| | Art Group | 2 |
| | Balancing my Life | 1 |
| | Behavior Modification | 2 |
| | Beyond Criminal Thinking | 2 |
| | BHT Anxiety | 1 |
| | BHT Art Expression | 1 |
| | BHT Coloring Activity | 1 |
| | BHT Games | 1 |
| | BHT Group Choice Activity | 1 |
| | BHT Mindfulness | 1 |
| | BHT Music Relaxation | 1 |
| | BHT Skits | 1 |
| | BHT Structured Activities | 1 |
| | Bipolar Group | 5 |
| | Brain Builders | 1 |
| | CBT and Problem Solving | 1 |
| | Co-Dependency | 1 |
| | Co-Occurring Mental Illness and Substance Abuse | 2 |

| | | |
|---|---|---|
| **Mental Health cont'd** | Cognitive Behavioral Thinking | 1 |
| | Community Meeting | 1 |
| | Conflict Resolution | 4 |
| | Coping Skills | 2 |
| | Coping Skills for Stress and Anger | 2 |
| | Counselling | 1 |
| | Creative Writing | 2 |
| | Criminal Thinking | 2 |
| | CTRS Acting | 1 |
| | CTRS Exercise | 1 |
| | CTRS Games | 1 |
| | CTRS Guided Journaling | 1 |
| | CTRS Pressure Points | 1 |
| | CTRS Sensory Exploration | 1 |
| | CTRS Sign Language | 1 |
| | CTRS Sports | 1 |
| | CTRS Stretching | 1 |
| | Current Events | 2 |
| | Cutting | 1 |
| | Daily Life Skills | 1 |
| | DBT | 4 |
| | Depression Group | 8 |
| | Discussion Group | 1 |
| | Dual Diagnosis/Co-morbidity | 1 |
| | Early Intervention for Children with Incarcerated Parents | 1 |
| | Eating Disorders | 1 |
| | Effective Communication | 1 |
| | Emotional Regulation | 2 |
| | Food and Feeling | 1 |
| | Gender Specific Emotion Management | 1 |
| | General Mental Health | 1 |
| | Glee Music Therapy | 1 |
| | Grief and Loss | 7 |
| | Grief and Loss Peer Support | 1 |
| | Healthy Relationships with Family | 1 |
| | Healthy Boundaries | 1 |
| | Healthy Relationships | 1 |
| | Healthy Thinking | 1 |
| | Homecoming | 1 |
| | Houses of Healing | 4 |
| | Inside Out Dads | 1 |
| | Insomnia Group | 4 |
| | Interpersonal Relationships | 1 |
| | Intro Into Constructive Living | 1 |
| | Life Skills | 2 |
| | Long Term Seg | 1 |
| | Medication Compliance | 1 |
| | Men and Anger | 1 |
| | Men's Perceptions | 1 |

| | | |
|---|---|---|
| **Mental Health cont'd** | Mental Health Seg Release Group | 1 |
| | Mental Health Support Group | 1 |
| | Mental Health Therapy | 1 |
| | Mindfulness | 1 |
| | MISA Group | 1 |
| | Monasteries of the Heart | 1 |
| | Mothering from a Distance | 1 |
| | Moving Beyond Criminal Thinking | 2 |
| | Pain Management | 1 |
| | Panic Management | 2 |
| | Parenting from Prison | 1 |
| | Pet Therapy | 1 |
| | Poetry | 1 |
| | Problem Solving | 3 |
| | Psychotic Disorders | 1 |
| | PTSD Group | 4 |
| | Reaching a Higher Power | 1 |
| | Reading Group | 1 |
| | Relationship Coping Skills | 1 |
| | Relationships and Interpersonal Skills | 3 |
| | Seeking Safety | 1 |
| | Self-Esteem | 1 |
| | Sex Offender Group | 1 |
| | Sexual Abuse | 1 |
| | Shame and Resiliency | 2 |
| | Social Skills | 1 |
| | Stress Management | 4 |
| | Structured Group | 1 |
| | Structured Group Orientation | 1 |
| | Structured Group Re-Entry | 1 |
| | Symptom Management | 1 |
| | Toastmasters | 1 |
| | Trauma Group | 8 |
| | Treatment Engagement | 1 |
| | Unstructured Day Room | 1 |
| | Velveteen Rabbit | 1 |
| | Veterans' Group | 1 |
| | Young at Heart | 1 |
| | Youthful Offender | 1 |

# Appendix G: List of Interventions Evaluated

| **Interventions Included in Program Evaluation** | |
|---|---|
| 12 Step | Hot Topics |
| AA | Houses of Healing |
| AD – SEG group | Illinois Veteran's History Project |
| ADAPT for AD | Impact of Crime on Victims |
| AMD/PMD Groups | Incarcerated Veterans Transition Program |
| Anger Management | Inner Circle |
| Anger Management (SEG) | Inside Out Dads |
| Angry Heart | Insomnia Group |
| Anxiety Group | Integrity Group (Westcare) |
| Bipolar Disorder Management | Intercircle (TASC) |
| CAAP | Interpersonal Relationships |
| CBT Group | Intro to Constructive Living |
| Celebrate Recovery | Job Readiness |
| Communication Skills | Jobs Participation |
| Community Meetings | Leadership in Life |
| Conflict Resolution | Life Building Group |
| Connections - Dual Diagnosis | Life Skills |
| Creative Writing | Lifestyle Redirection |
| Current Events | Long-Term Severe Mental Illness SEG Group |
| Dave Ramsey – Financial Peace University | Longer Time Offender Group |
| DBT Group | Managing Co-Occurring Disorders |
| Depression Group | Master Life |
| Dog program | Meditation |
| Double Trouble | Men & Anger |
| Drug Symposium | Men's Peer Group |
| Early Intervention for Children with Incarcerated Parents | Mental Health Reentry Group |
| Emotion Regulation | Mental Health/Severe Mental Illness Long Term SEG Group |
| Etiquette | Mind Over Mood |
| Fatherhood Initiative | Mom & Me Camp |
| Film Club | Moms & Babies |
| Grief | Motivated to Change |
| Hazeldon Drug Awareness | Mutual Self-Help Group Education |
| Healthy Relationships | NA |

| **Interventions Included in Program Evaluation** | |
|---|---|
| Orientation | Thinking for a Change |
| Panic Management | Time for Change |
| Parenting | TRAC1 |
| Parenting in Prison | Transgender Support Group |
| Parole School – 1 month | Trauma Group |
| Parole School – 6 months | Trauma Group-SEG |
| Pathways to Freedom | Ultimate Edge |
| PAWS | Unconditional-Self Acceptance |
| Phoenix Rising | Understanding & Coping with Depression |
| Problem Solving Skills | Understanding & Coping with Grief and Loss |
| Process Groups | Veteran's PTSD Support Group |
| Program Sentence Credit (S/A)/EGCC-PSC | Veterans |
| Psychoeducational Modules | WestCare Mutual Help Groups |
| Reentry Summit | |
| Relapse Prevention | |
| Relationship and Interpersonal Coping Skills | |
| Self-Esteem | |
| Sesame Street | |
| Severe Mental Illness Parole School 1 | |
| Severe Mental Illness Parole School 2 | |
| Shame & Resiliency | |
| Socialization | |
| Spanish AA | |
| Storybook | |
| Stress Management | |
| Structured Groups | |
| Substance Abuse Education | |
| Substance Abuse Protective Custody | |

## Appendix H: List of IIP Interventions and Summary

| Name of Intervention | Number of Facilities |
|---|---|
| Orientation | 2 |
| Parole School | 2 |
| Reentry Summit | 1 |
| WestCare CBT Groups | 2 |
| WestCare Fatherhood Group | 2 |
| WestCare Motherhood Group | 1 |
| WestCare Orientation Group | 2 |
| WestCare Program | 2 |
| WestCare Reentry Group | 2 |
| WestCare Self-Help Group | 2 |
| Career Technology | 2 |
| GED | 2 |

The SIU team requested historical data for the IIPs to examine actual recidivism rates for that population. The data included any offender who spent time in an IIP between 2012-2013. The group consisted of 2,436 offenders. Of those offenders, 1,383 were African American, 784 were White, and 269 were classified as Other. There were 1,429 offenders falling into the 21-27-year-old age range, 773 offenders in the 28-34-year-old age range, and 234 offenders in the 35-41-year-old age range. Note that 1,124 (46. 15%) offenders from this sample recidivated, either through reoffending or technical violation.

# Appendix I: List of Community Interventions

| Name of Intervention | Number of Facilities |
|---|---|
| Moral Reconation Therapy | 6 |
| Anger Management | 6 |
| Substance Abuse Education | 6 |
| Employment Services | 6 |
| Domestic Violence | 1 |

# Appendix J – List of Community Interventions

| | |
|---|---|
| Moral Reconation Therapy | 6 |
| Anger Management | 6 |
| Substance Abuse Education | 6 |
| Employment Services | 6 |
| Domestic Violence | 1 |

# Appendix K: List of Programs to Retain

Criminogenic Need Area: Substance Abuse

*Program: Substance Abuse Class (Several Facilities)*

This intervention is classified as a program, rather than a service, due to the group meeting 5 days per week for a period of 3 hours each time. The program is scheduled to run for 90 days and there is one group running at a time. The theoretical basis of the program is educational and offenders can receive "good time" for successfully completing the intervention. Offenders are to be motivated to engage in the program as there is a waitlist numbering 300 at one facility.

*Program: Drug Abuse Education (Combine)*

This intervention would benefit from being combined with other substance abuse interventions to come up with one, uniform intervention. Each facility uses a different name for substance abuse/drug abuse education and this creates some confusion regarding what the treatment target is. In addition, streamlining the curriculum for these educational interventions would allow for greater uniformity across facilities. There is a solid theoretical foundation right now as most facilities report substance abuse/drug abuse as an educational basis.

Criminogenic Need Area: Criminal Thinking

*Program: Thinking for a Change (Pinckneyville & Sheridan)*

Thinking for a Change is a cognitive-behavioral theoretical intervention. This program offers "good time" for eligible offenders and maintains a waitlist of 50 offenders at one facility. This program is a relatively new intervention for IDOC, with it being adopted from the National Institute of Corrections (NIC). Social workers with IDOC have been trained and are starting to train other facilitators throughout the department for state-wide implementation.

Criminogenic Need Area: Interpersonal Skills

*Program: Fatherhood Initiative/Inside Out Dads (Some Male Facilities)*

This intervention is adopted from a national curriculum that provides manuals for both the facilitator and the offender. While Fatherhood Initiative is educational from a theoretical standpoint, it qualifies as a program due to its frequency of contact (2 times per week, for 2 hours, for 6 weeks). Fatherhood Initiative is a structured adaptation of a parenting program and benefits from the use of the manual for facilitators and offenders alike. During the Phase 1 cataloguing of all interventions used throughout IDOC, 6 of the male facilities reported Fatherhood Initiative as a program being run.

Criminogenic Need Area: Life Skills

*Program: Retooling Emotional Regulation*

This intervention meets 1 time per week for 8 weeks, qualifying it as a service. There is a manual that is used for delivery of the service, of which homework is a part, but the intervention would benefit from meeting more frequently. It is recommended that this service be retooled to meet the standards of a program (frequency of contact, theoretical basis, duration of intervention, etc.). Using the IDAT will assist with this.

List of Mental Health Interventions to Retain or Modify

Interventions to Modify or Modify and Merge Together

| | |
|---|---|
| Anxiety Group | Modify |

| | |
|---|---|
| Anger Management | Modify and Merge |
| Men and Anger | |

| | |
|---|---|
| Behavior Modification | Modify and Merge |
| CBT and Problem Solving | |
| Cognitive Behavioral Thinking | |
| DBT | |
| Problem Solving | |

| | |
|---|---|
| Criminal Thinking | Modify and Merge |
| Beyond Criminal Thinking | |
| Healthy Thinking | |
| Moving Beyond Criminal Thinking | |

| | |
|---|---|
| Bipolar Group | Modify |
| BHT Mindfulness | Modify |
| Co-Dependency | Modify |
| Co-Occurring Mental Illness and Substance Abuse | Modify and Merge |
| Dual Diagnosis/Co-morbidity | |
| Community Meeting | Modify |
| Structured Group | Modify and Merge |
| Structured Group Orientation | |
| Conflict Resolution | Modify |
| Coping Skills | Modify and Merge |
| Coping Skills for Stress and Anger | |
| Relationship Coping Skills | |
| Cutting | Modify |
| Depression Group | Modify |
| Eating Disorders | Modify and Merge |
| Food and Feeling | |
| Effective Communication | Modify and Merge |
| Interpersonal Relationships | |
| Relationships and Interpersonal Skills | |
| Emotional Regulation | Modify and Merge |
| Gender Specific Emotion Management | |
| General Mental Health | Modify and Merge |
| Mental Health Support Group | |
| Mental Health Therapy | |
| Grief and Loss | Modify and Merge |
| Grief and Loss Peer Support | |
| Healthy Relationships with Family | Modify and Merge |
| Healthy Relationships | |
| Inside Out Dads | |
| Mothering from a Distance | |
| Parenting from Prison | |
| Insomnia Group | Modify and Merge |

| | |
|---|---|
| Long Term Seg | Modify |
| Mental Health Seg Release Group | Modify |
| Panic Management | Modify |
| Psychotic Disorders | Modify |
| PTSD Group | Modify |
| Trauma Group | |
| Self-Esteem | Modify |
| Sex Offender Group | Modify |
| Sexual Abuse | Modify |
| Shame and Resiliency | Modify |
| Social Skills | Modify |
| Stress Management | Modify |
| Symptom Management | Modify |

# Appendix L: Intervention Demonstration Assessment Tool (IDAT)

The purpose of the IDAT is to systematically examine the effectiveness of interventions. The IDAT can be applied to both existing and proposed interventions. Below is a description of two of the eight components.

There are eight components. Each component is scored “0”, “1” or “2”. “0” will reflect content not addressed, “1” content partially addressed, “2” content adequately addressed. The total score of the IDAT will be between 0 and 16.

The components are:

1. Description of Intervention
2. Rationale for Risk Reduction and Strength/Asset[1] Promotion
3. Participant Selection
4. Recidivism Risk Factors Addressed and Strength/Asset Promotion
5. Targeted and Acquired Skills
6. Retention Strategies
7. Quality Assurance
8. Evaluation

Several programs were asked to complete the #1 and #2 component of the IDAT. The responses varied, ranging from focusing on criminogenic needs to areas less related to recidivism reduction. Although a variety of mechanisms of change were reported, several programs did not have clear reasons why their program should reduce recidivism. These responses were informative to developing this tool and for composing the scoring criteria.

With SIU research staff, it is recommended that the complete IDAT be completed on the same programs that completed components #1 and #2. The complete IDAT is in Appendix D. It is recommended that this tool be given to any outside requests to deliver programs within IDOC.

[1] Asset is a term used in the Illinois Crime Reduction Act of 2009.

| Component #1 | Descriptive | Required |
|---|---|---|
| Description of Intervention | A statement of the components of the intervention and who is expected to benefit from the intervention | 300 word description and rating (0, 1, or 2) |
| | | |

a. Intended outcome of the intervention.
b. Define the type of offender who will benefit from this intervention?
c. Methods used in the intervention.
d. The activities offenders engage in, for how long, and in what order.
e. How are these activities linked together? And how do the activities help offenders learn and change?
f. How will offenders understand what this intervention will do for them?
g. How will they apply it to their plan to reduce criminal activities?
h. Comment on the reasons for the length (i.e., dosage) of the program.

| Component #2 | Descriptive | Required |
|---|---|---|
| Rationale for Risk Reduction and Strength/Asset Promotion | An understanding of the evidence for how the intervention will target the recidivism risk factors (#4) and deliver its intended outcomes. | 150 word description and rating (0, 1, or 2) |
| | | |

a. Provide a theoretical justification for these methods in relation to the targeted risk factors that the intervention addresses.

b. How do these methods change the risk factors? What are the mechanisms for change (i.e., how will change occur)?

c. Cover the evidence that shows the likely effect of the chosen approach in relation to the targeted offender group.

| Component #3 | Descriptive | Required |
|---|---|---|
| Participant Selection | The group of participants targeted with this intervention needs to be clearly explained | 150 word description and rating (0, 1, or 2) |
| | | |

a. Detail who the program is designed for.
b. How will appropriate participants will be targeted and selected? Cover appropriate inclusion and exclusion criteria.
c. Show the application of risk, need, and responsivity principles
d. If the program is for low risk offenders, explain the reasons.
e. How will inappropriate referrals (i.e., those for whom the program is not suited program be dealt with? How will the processes assure that these participants are excluded?
f. Demonstrate how your proposed program methods are going to match the participants learning needs, diverse backgrounds, and asset characteristics.

| Component #4 | Descriptive | Required |
|---|---|---|
| Rationale for Risk Reduction and Strength/Asset Promotion | Programs that address multiple risk factors and promote multiple strengths/assets are more likely to be effective. | 150 word description and rating (0, 1, or 2) |
| | | |

a. Please describe which risk factors and strength/asset promotion factors are addressed in the program.
b. Programs that target other factors must provide a rationale for why the target issues are relevant to enabling a crime free life.

The following are principal factors likely to be linked to reoffending:
☐drug misuse
☐ alcohol misuse (especially binge drinking)
☐ impulsivity/low self-control
☐ criminal thinking patterns
☐ attitudes that support crime
☐ personality disorder and/or other clinical syndromes
☐ social networks that are engaged in crime
☐ lack of pro-social personal and family relationships
☐ lack of positive recreation or leisure activities
☐ lack of, or unstable, employment
☐ homelessness, or living in a criminogenic neighborhood

The following are principal strengths or protective factors likely to be linked to desistance:

a. Person-based Factors
- internal resources/skills
- behavioral controls
- skills in problem solving and emotional management
- sobriety (including reduced binge-dinking)

b. Social Connectedness
- valued prosocial relationships
- strong affective connectedness to others
- strong family relationships and prosocial community networks

- engaged participation in pro-social activities

c. Social Structures
- integrated into positive social structures
- regular positive activities
- finding (and keeping) suitable housing
- having a place within a non-criminal social community

d. Purpose/Goals/Directionality
- employability, and meaningful work
- non-criminal identity; hopeful about giving up crime

| Component #5 | Descriptive | Required |
|---|---|---|
| Targeted and Acquired Skills | The program develops and promotes skills that lead to a crime free life. | 300 word description and rating (0, 1, or 2) |
| | | |

a. Detail the skills developed and promoted through the program
b. Describe the methods used to teach these skills

i. integration of goal setting in the method of change
ii. use of TRAC I goal setting chart.

c. Describe the processes used to implement skill practice (i.e., practice time in session, use of homework, etc.)
d. How well does the manual guide the acquisition of skills (i.e., session plans, relevant examples, multi-modal methods)?
e. Describe how the manual contains sufficient structure to direct the program
- If the program works differently, refer to #3 to explain how the approach is likely to be effective.

Comments: If TRAC I goal setting chart is not used, provide a detail rationale for an alternative method. This will involve presenting the evidence for an alternative method of risk reduction.

| Component #6 | Descriptive | Required |
|---|---|---|
| Retention Strategies | The program should engage and retain participants to enable them to complete all aspects. | 150 word description and rating (0, 1, or 2) |
| | | |

Please describe how the program engages and retains participants, including:
a. how participants' goals are integrated into relevant aspects of the program.
b. how participants understand that completion of the program contributes to an holistic set of skills that will help them lead safer, better and more fulfilling lives.
c. boosters

| Component #7 | Descriptive | Required |
|---|---|---|
| Quality Assurance | The program has an effective quality assurance process in place. It pays attention to staff skills and training, and checks they deliver the program as intended. Monitoring systems need to be in place, to ensure the program is delivered as intended. Procedures for employing flexibility when appropriate to meet individual needs must be precisely described in the application, if flexibility is applicable for the program. | 150 word description and rating (0, 1, or 2) |
| | | |

Please explain how you plan to do this, including:
a. your monitoring system and key measures including feedback from participants
b. how you will use the information to improve the service quality
c. how you will maintain capability and effectiveness of staff
d. Comment on staff selection, frequency of staff training

| Component #8 | Descriptive | Required |
|---|---|---|
| Evaluation | The program is evaluated to confirm it has the desired effect. There are measures in place to monitor the impact of the program on participants and others, and to make revisions in the event of unexpected negative and unwanted consequences. | 150 word description and rating (0, 1, or 2) |
| | | |

Please present your research and evaluation plan, including a suggested timetable and an outline of your proposed outcome study. We recommend the research plan reports on the data you are collecting, including:
a. Demographic variables, criminal history, risk level, and other relevant characteristics of participants and any individuals excluded from the program.
b. Changes in the factors the program targets using recognized, reliable, and valid methods of measuring change.
c If research is available (e.g. from other jurisdictions), please include a brief summary and appropriate references or links.
d. Where available, experiences and findings from a pilot implementation of the program should be reported in the application.

The scoring of the eight components results in the follow matrix:

### *IDAT Scoring Matrix*

| Level | Scores | Recommendations |
|---|---|---|
| Expected Standard | xx-xx | Continue program for 4 years<br><br>If new external vendor/agency application, grant program for 2 years |
| Sub-threshold Standard | xx-xx | Continue for 1 year<br>Address deficit areas to increase score to Expected Standard level.<br><br>If new external application, allow program to be ran temporally for 1 year. |
| Below Standard | xx-xx | Suspend program for 3 months<br><br>(internal) If upon re-assessment program is still at the Below Standard level, cancel the program or re-integrate it into another program.<br><br>(external) If upon re-assessment program is still at the Below Standard level, cancel the program.<br><br>If new external application, deny, but encourage re-application. |
| Well Below Standard | xx-xx | Cancel Intervention<br><br>If new external application, deny and do not encourage re-application |

IDAT Score Sheet

| Program Name _____<br>New Program ___ Yes ___ No | | IDAT Score Sheet |
|---|---|---|
| Item | Comments | Score (0,1,2) |
| | | |
| 1. Description of Intervention | | |
| 2. Rationale for Risk Reduction and Strength/Asset Promotion | | |
| 3. Participant Selection | | |
| 4. Recidivism Risk Factors Addressed and Strength/Asset Promotion | | |
| 5. Targeted and Acquired Skills | | * |
| 6. Retention Strategies | | |
| 7. Quality Assurance | | |
| 8. Evaluation<br>Expected Standard | | |
| | Total | |

* Vendors require a “2”.

Rubric

0 = Content not addressed
- -Less than half of all sub-questions (annotated by a letter) addressed
- -Answers are not thorough
- -Unlikely to be relevant/applicable to offender populations
- -Unlikely to be relevant/applicable for IDOC capabilities

1 = Content partially addressed
- -Half or more of all sub-questions (annotated by a letter) addressed
- -Answers to most sub-questions are sufficiently thorough
- -Most answers relevant/applicable to offender populations
- -Most answers relevant/applicable for IDOC capabilities

2 = Content adequately addressed
- -All sub-questions (annotated by a letter) addressed
- -All answers are sufficiently thorough
- -All answers relevant/applicable to offender populations
- -All answers relevant/applicable for IDOC capabilities

# Appendix M: System Logic Model

**System Logic Model**

**Placement:**

1. Placement based on Risk and Security instruments.

An integrated model allows for the usage of both.

Rationale: Both contribute to placement (i.e., capacity to delivery treatment and security issues).

**Security Reduction:**

1. Reduction in security is based on both treatment dose (i.e., hours of treatment) and security concerns (i.e., tickets).

Comments:

Risk / security measure determines initial placement in five levels.

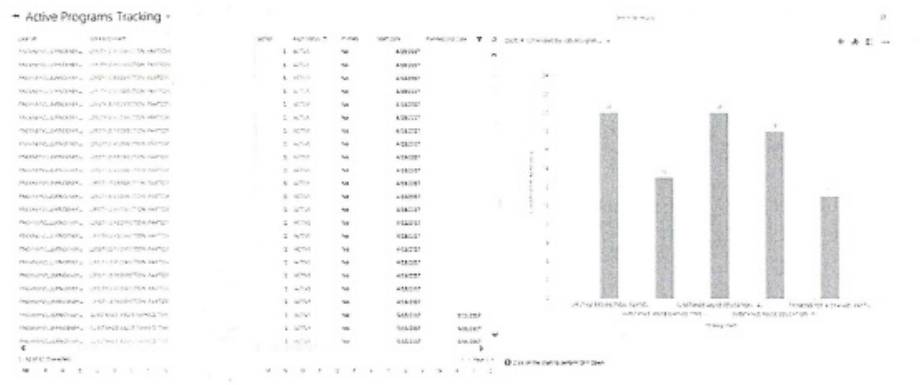
Dosage is determined by actual face time intervention with qualified staff/vendor.

Security measure can increase risk level (maybe only at upper levels).

Mental health concerns, increase level.

| Placement | Security Reduction | | | | |
|---|---|---|---|---|---|
| **SECURITY/RISK LEVEL** | **INSTITUTIONAL TREATMENT DOSE** | **TIME WITHOUT TICKET** | **CRITERIA FROM IDAT** | **TREATMENT NEED LEVEL** | **TREATMENT INTENSITY/ CONTENT** |
| **I** | Minimal/ TRAC I — Less than 40 | | Items # 1, 3, 5 | None or few— if any, mild and/or transitory | **Re-entry** |
| **II** | Moderate— 40 to 100 hours | 10 months - Major<br>4 months - Minor | Full tool Score of "1" on items # 7 & 8 | A few— some mild and transitory, or possibly acute | **Re-entry, client workbooks, community referral** |
| **III** | Significant— 100–200 hours | 12 months - Major<br>4 months - Minor | Full tool | Multiple— some severe | **Target criminogenic needs, programs can be additive** |
| **IVa**<br>**IVb** | Very significant— 200–450 hours | 18 months - Major<br>6 months - Minor | Full tool | Multiple— some chronic and severe | **Target criminogenic needs, clinical oversight, each program must be standalone and evidence-based, can be additive, some evidence of change** |
| **V** | 80 hours per year | 24 months - Major<br>8 months - Minor | Full tool | Multiple— chronic, severe, and entrenched, likely across psychological, interpersonal, and lifestyle domains | **Target behavioral needs, clinical oversight, each program must be standalone and evidence-based, behaviorally based. Demonstration of behavior change** |

## Appendix N – Quality Assurance Dashboard




How and when information is reported into Offender 360 limits the availability of much information that should be monitored to ensure Quality Assurance of intervention strategies. A simple view of interventions from the Clinical department of Pinckneyville Correctional Center shows that there are 3 interventions active at the time of the view. The five bars are representative of the different “sections” of the three interventions currently active in the view. This allows for the quick viewing of scheduled roster. Note that this does not reflect how many attended.

Attendance is not monitored in Offender 360 at the individual level, only sign-up. In addition to attendance issues, other reporting issues include assignment classifications being too broad (no program codes to separate from other assignments), staff not reporting correctly or in a unified fashion (multiple codes for one intervention across the system), and interventions being reported as active but having no enrollment. These are a few of the issues limiting the use of a system-wide dashboard. However, a simple view such as the above for each facility would allow for some accountability to be implemented for staff reporting issues.

# Appendix O: Research Bulletins

SIU Southern Illinois University
CARBONDALE

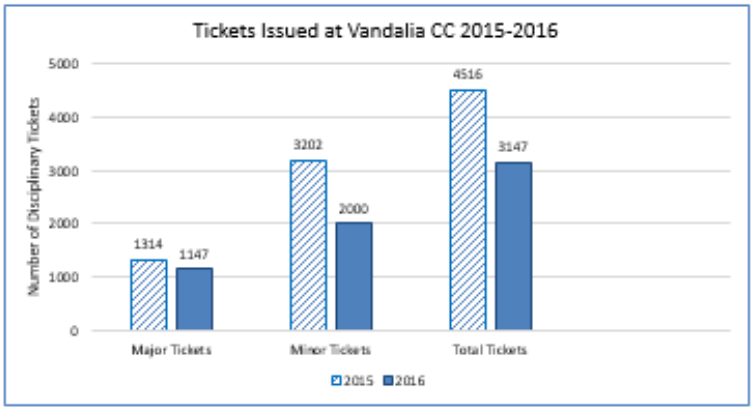
**Research Bulletin Issue 1**
**February 2017**

A research team from Southern Illinois University in Carbondale is conducting a comprehensive evaluation of Illinois Department of Corrections offender programs. The team has spent the past 12 months interviewing staff at all IDOC facilities. The goal is to learn more about how programs help to improve safety and recidivism. In this bulletin, we highlight programs that lead to positive change in offender behaviors.

For more information contact: Dr. Daryl Kroner, Southern Illinois University Carbondale, Department of Criminology and Criminal Justice, dkroner@siu.edu

**Program Spotlight: Lifestyle Redirection**
Lifestyle Redirection is a popular offender program in IDOC. It is a 12-week intervention focused on reducing recidivism. Lifestyle Redirection is a well-rounded program that emphasizes personal responsibility in making a change away from the criminal lifestyle.

**Facility Spotlight: Vandalia Correctional Center**
Vandalia Correctional Center had one of the highest success rates for Lifestyle Redirection. Vandalia CC delivers Lifestyle Redirection 4 days per week in 2-hour sessions. In 2015, their completion rate for Lifestyle Redirection was 75%. Subsequently, as illustrated in the graph below, there was a decline in disciplinary tickets issued at Vandalia CC from 2015 to 2016.




From 2015 to 2016, Vandalia CC saw **30% decrease** in total disciplinary tickets issued.
Effective program delivery can lead to better safety for IDOC staff!

**Research Bulletin Issue 2**

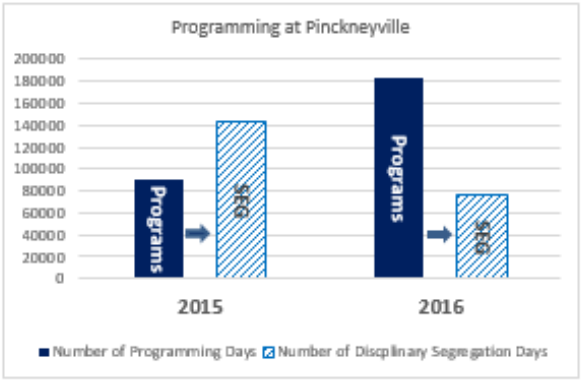
A research team from Southern Illinois University in Carbondale is conducting a comprehensive evaluation of Illinois Department of Corrections offender programs. The team has spent the past 12 months interviewing staff at all IDOC facilities. The goal is to learn more about how programs help to improve safety and recidivism. In this bulletin, we highlight how programs lead to positive change in offender behaviors.

For more information contact: Dr. Daryl Kroner, Southern Illinois University Carbondale, Department of Criminology and Criminal Justice, dkroner@siu.edu

**Facility Spotlight: Pinckneyville Correctional Center**

Pinckneyville Correctional Center offers several offender program aimed at reducing recidivism and increasing public safety. Clinical programs offered include: 12-Steps, AA/NA, Drug Education, Fatherhood Initiative, Lifestyle Redirection, Parenting, Thinking for a Change, TRAC 1, and a Veteran's Group.

From 2015 to 2016, Pinckneyville CC almost doubled the amount of days offenders spent in programs. As illustrated in the graph below, Pinckneyville also had a 50% reduction in the number of days offenders spent in restrictive housing (disciplinary SEG). Programs contribute to better inmate discipline, improvement in safety of the staff, and better communities upon offenders' release.




From 2015 to 2016, **programming nearly doubled** and **segregation time was cut in half.**
Effective program delivery can lead to better outcomes for inmates!